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The Immigrant Health Care Narrative and What it Tells Us About the U.S. Health Care System

*Brietta R. Clark**

In San Diego, California, a hospital used the private company Nextcare to “transfer” undocumented immigrants to a clinic in Mexico after providing stabilizing emergency care.¹ A Los Angeles Times (“L.A. Times”) article recounted one patient’s experience: the patient was brought to the emergency room because he had been in a car accident.² He required a rod for his shattered right leg and his broken jaw had to be wired shut.³ Unfortunately, the patient was transferred to the Mexican clinic before the wires were taken off, and due to poor communication and follow-up, his gums became infected and grew over the wires in his mouth.⁴ He subsequently suffered severe pain and hunger.⁵ Physicians and immigrants’ rights groups have criticized this as a “de facto deportation” but hospital and Nextcare officials have insisted the “transfers are voluntary, the result of an unpressured discussion between Nextcare officials and the patient.”⁶ According to the patient, however, he had agreed to move primarily because he was hungry and had been promised that he could get his braces removed in Tijuana so he could resume eating solid food.⁷

As of November 2003, Nextcare had contracted with five U.S. hospitals to remove at least fifty uninsured, allegedly unauthorized, immigrant patients to Mexico for follow-up care.⁸ The method of how hospital

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1. See Lisa Richardson, *Patients Without Borders: Amid Rising Health Costs, Illegal Immigrants in San Diego-Area Hospitals are Being Transferred Back to Mexico for Treatment*, L.A. TIMES, Nov. 5, 2003, at A1.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Richardson, *supra* note 1, at A1.

7. See Richardson, *supra* note 1.

8. See *id.* (noting that Nextcare has a promotional video in which a positive testimonial is given by a patient formerly transferred back to Mexico, but this patient was not interviewed by the L.A. Times).

officials determined the patients' immigration status is not clear from the L.A. Times article, given that hospital policy prohibits the officials from asking an individual about his or her citizenship status when coming to the emergency room for treatment.⁹ It is also unclear whether the hospital correctly identified each patient's status as illegal, whether Mexico was in fact each patient's country of origin, why the patients agreed to the transfer, whether the transfer was truly voluntary, or how the transfer affected the patients' quality of care.¹⁰

A variety of other less extreme, but still effective, methods are being used by hospitals to discourage uninsured and undocumented immigrant patients in the United States from seeking care, especially in states along the Mexican border. For example, one hospital in Texas had its own security personnel wear uniforms that resembled border patrol.¹¹ Another Texas hospital questioned suspected immigrants about their status and asked for their papers when they arrived at the hospital, sending a clear "message that illegal immigrants are not welcome."¹² Finally, a number of hospitals in the border states and in New York have been cited for failing to provide appropriate care, including epidurals, for non-English speaking pregnant women.¹³

Most recently, as immigration enforcement has increased and the number of detainees has risen, another healthcare problem has emerged—overcrowding in detention centers and denial of medically necessary care.¹⁴ In fact, this problem has drawn considerable attention, with sixty-two people dying in custody since 2004 from lack of medical treatment, among them people with AIDS, high blood pressure, and kidney disease, who died because they did not receive medication.¹⁵

Denial of medically necessary care for undocumented immigrants is not simply due to the isolated acts of hospital or detention center officials. Restricting health care access for immigrants is a touchstone of immigration-related and welfare reform initiatives enacted at the state and federal levels. Immigrant health care access is often part of a broader package of "immigration-related" initiatives designed either to limit immigrants' access to public services generally or to use public service

9. *See id.*

10. *See id.*

11. Thomas Perez, Dir., Office for Civil Rights, Dep't of Health & Human Servs., Address at the New England Regional Minority Health Conference (Apr. 13, 1999).

12. Julia Preston, *Texas Hospitals' Separate Paths Reflect the Debate on Immigration*, N.Y. TIMES, July 18, 2006, at A1 [hereinafter *Texas Hospitals*].

13. *See Perez, supra* note 11.

14. *See Rachel Swarns, 2 Groups Compare Immigrant Detention Centers to Prisons*, N.Y. TIMES, Feb. 22, 2007, at A17.

15. *See Nina Bernstein, New Scrutiny As Immigrants Die in Custody*, N.Y. TIMES, June 26, 2007, at A1.

agencies as de facto immigration agents to collect and report data relating to status. Since 1996, federal law has severely circumscribed public healthcare benefits for immigrants in the United States illegally, legally, and for those of uncertain status.¹⁶ There has also been a resurgence of immigration-related initiatives at the state level over the last few years, with many states considering bills to further restrict immigrants' access to state and local public services, including health care.¹⁷

Increasingly, attention is being paid to the significant harmful effects on immigrants as well as the deleterious public health effects of these immigration-related benefit restrictions. This article examines the political, legal, and popular discourse in favor of and against healthcare benefit restrictions for immigrants in order to focus on a different aspect of this problem. Through this discourse, narratives are created of immigrants' character and relationship to the rest of society. These narratives influence our perception of immigrants and their effect on society, and this perception, in turn, seems to influence the policies enacted to regulate immigrants and immigration.

These narratives have been constructed predominantly by those advocating for increased immigration control and benefit restrictions designed to make life in the United States for unauthorized immigrants less tolerable. Arguments favoring benefit restrictions reflect the narrative of an "Us-Them" dichotomy in which immigrants are labeled as criminals and welfare-abusers who jeopardize the health care of law-abiding citizens. Advocates for expanded health care access try to undermine this dominant narrative and offer a different one that portrays a more positive and complex relationship between immigrants, the health care system, and society generally. For example, those challenging benefit restrictions paint a very different picture of immigrants as self-sufficient, generally law-abiding, especially vulnerable to discrimination, and fearful of using public benefits. Immigrant rights groups and legal scholars also argue that many immigrant benefit restrictions are unduly harsh, racist,¹⁸ and irrational because they undermine public health goals.¹⁹

It is important to examine this discourse and determine the true impact of the immigrant health care narratives on policymaking. Narratives can influence popular opinion and grassroots coalitions that can either facilitate or hinder public advocacy for expanded access. They also help create or undermine the political will exerted on policy makers. But can pro-access

16. See *infra* Part I.B (discussing the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"), 8 U.S.C. §§ 1601–46 (2001)).

17. See *infra* Part I.A.

18. See *infra* Part IV.

19. See *infra* Part IV.

advocates reconstruct the immigrant health narrative in a way that leads to greater health care access for immigrants? To the extent that pro-access groups hope to influence policy making through these reconstructed narratives, they should recognize two very important challenges they face.

First, they should be mindful of whether the narrative they create supports their policy goals. If their discourse unintentionally reinforces parts of the dominant narrative used to fuel anti-immigrant initiatives, then they are undermining their own goals. Unfortunately, to some extent the pro-access narrative unintentionally encourages a view of immigrants as potentially dangerous and as outsiders. Moreover, to the extent that the pro-access narrative labels supporters of benefit restrictions as anti-immigrant or racist, this can facilitate public divisiveness among groups that might otherwise have common interests in reforming the health care system in ways that benefit both groups. Such characterizations may have the perverse effect of strengthening demand for anti-immigrant measures, which some political officials will support (or at least not aggressively oppose), even if irrational or harmful to citizens.

Second, any attempt by pro-access advocates to use the immigrant narrative to influence policy will be constrained by the structural defects and linedrawing inherent in our existing healthcare framework. Apart from any consideration of immigration status, our health care system is largely based on an "Us-Them" paradigm in which access is not guaranteed for all, requests for coverage are automatically viewed with suspicion, and decisions about which groups in society should have access to health care are based on an amorphous analysis of who is most "deserving." Moreover, immigrants suffer discrimination along a number of axes, including race or ethnicity, socioeconomic status, and, in many cases, gender. Thus, discourse that successfully changes the immigrant narrative or increases public consciousness about their unique concerns will not necessarily garner public support for eliminating immigrant-specific barriers or ensure immigrants' access to care. Immigrants will still be left to compete with others for access to a health care system that perpetually pits one group against another.

Considering our health system from the perspective of immigrants who are excluded because of immigration-specific barriers is still useful for a number of reasons. It shows how gaps in our current healthcare system have particularly harsh effects on those marginalized in society due to immigration status. It highlights the inherent, structural defects in our health system and shows how fighting for more rights for immigrants within an inherently inequitable system will only produce a limited benefit for some. Finally, it suggests that more creative approaches should be explored to enhance coalition building and effect fundamental health care reform that will improve health care access for everyone, including immigrants.

I. LIMITS ON HEALTH CARE ACCESS FOR IMMIGRANTS

Before examining the discourse surrounding these restrictions, it is important to understand the scope and type of laws limiting immigrants' health care access. Barriers to health care have not always been used as an immigration tool. In fact, before 1996, while there were some federal limits to the eligibility of immigrants for federal benefits, publicly-funded healthcare providers routinely provided necessary health services regardless of immigration status, without interference from the federal or state government.²⁰ While some state and local governments have enacted policies that expanded health care access for immigrants regardless of status,²¹ the trend at the state and federal levels has been in the other direction.

A. State Benefit Restrictions

Although the federal government is charged and vested with the authority to regulate immigration, the costs of illegal immigration are primarily borne by state and local governments responsible for providing public services to the indigent and uninsured.²² Illegal immigration is viewed as one of the main sources of financial problems in many states, especially those along the Mexican border.²³ Restricting benefits for immigrant health care is one of the first ways governments try to reduce expenditures and relieve their financial struggle.²⁴

20. Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the "Contract With America" Congress*, 90 KY. L.J. 1043, 1047 (2002).

21. *Id.* at 1056 (noting that fourteen states used state funds only to extend Medicaid coverage to legal immigrant children who were otherwise ineligible under federal law and ten states used SCHIP funds to provide health insurance to some recent immigrant children). See Julia Preston, *Surge in Immigration Laws Around U.S.*, N.Y. TIMES, Aug. 6, 2007, at A12 [hereinafter *Surge in Immigration Laws*] (describing how some states have adopted measures in recent years to protect illegal immigrants against exploitation and extending education and health care to their children).

22. U.S. CONST. art. I, § 8, cl. 4 ("The Congress shall have Power . . . [t]o establish a uniform Rule of Naturalization"). See *Texas Hospitals*, *supra* note 12; Costich, *supra* note 20, at 1057.

23. See Julia Preston, *Immigration at Record Level, Analysis Finds*, N.Y. TIMES, Nov. 29, 2007, at A20 [hereinafter *Immigration at Record Level*] (noting that the Center for Immigration Studies, which advocates reducing immigration, found that "[i]mmigration over the past seven years was the highest for any seven-year period in American history, bringing 10.3 million new immigrants, more than half of them without legal status . . .").

24. See Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A1 (describing Governor Schwarzenegger's proposal to expand healthcare coverage in California to include coverage of all children, including undocumented immigrants, and the backlash from Republican legislators who do not support coverage of illegal immigrants). See also Senator John Edwards, CNN Democratic Presidential Debate (Jan. 21, 2008), <http://www.cnn.com/2008/POLITICS/01/21/debate.transcript2/index.html?iref=newssearch> (in response to concerns about illegal immigration, it

A number of states have enacted laws designed to prohibit undocumented immigrants and possibly even those immigrants of legal or uncertain status from using state and local public benefits. For example, in 2005, “about 80 bills in 20 states sought to cut noncitizens’ access to health care or other services, or to require benefit agencies to tell the authorities about applicants with immigration violations.”²⁵ In 2007, eleven states enacted fifteen laws affecting public benefits, most of which denied state assistance to unauthorized immigrants.²⁶ Some laws heightened documentation requirements for proving eligibility for public benefits, designed specifically to prevent ineligible immigrants from seeking services, but with the result of creating an intimidation element which could be a barrier to access even for immigrants with legal status.²⁷

B. Federal Limits on Access to Health Care Benefits

Congress has enacted a series of laws which severely circumscribed immigrants’ access to federal and state government benefits and paved the way for even greater state and local restrictions on health care access for immigrants here legally and illegally. The federal government has also increased scrutiny and enforcement of benefit restrictions, and has increased reporting requirements relating to the status of immigrants seeking emergency and nonemergency health care.

1. Narrowing Eligibility Categories

Before 1996, only immigrants who were clearly unauthorized and deportable were denied access to Medicaid benefits.²⁸ An immigrant whose status was ambiguous, under consideration, or even clearly irregular, could still be eligible for government-sponsored benefits.²⁹ However, through the

appears that a leading democratic presidential candidate’s reform proposals would exclude unauthorized immigrants).

25. See Nina Bernstein, *Recourse Grows Slim for Immigrants Who Fall Ill*, N.Y. TIMES, Mar. 3, 2006, at B1 [hereinafter *Recourse Grows Slim for Immigrants*]. See also National Council of La Raza (“NCLR”), *Policy on State and Local Immigration Initiatives*, <http://www.nclr.org/content/policy/detail/48106> (last visited Feb. 12, 2008) [hereinafter *Policy on State and Local Immigration*] (“For many years, states have been involved in restricting immigrants’ access to health care, licenses, and public benefits. In recent months, however, an increasing number of states and localities are seeking to drive unwanted immigrants out of their communities and make it less attractive for new immigrants to arrive.”).

26. See *Surge in Immigration Laws*, *supra* note 21.

27. See Erin Fuchs, *Medical Needs of Hispanics Targeted*, CHATTANOOGA TIMES/FREE PRESS, July 29, 2007, <http://www.timesfreepress.com/news/2007/jul/28/Medical-needs-of-Hispanics-targeted/>.

28. See Costich, *supra* note 20, at 1046.

29. See *id.* (the only limit was that the immigrant could not be under active INS pursuit for deportation).

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”), Congress narrowed the group of immigrants eligible for federal benefits by treating immigrants of uncertain status more harshly than before.³⁰ Now these groups are treated as undocumented persons who are ineligible for benefits.³¹

Despite the focus on illegal immigration in the rhetoric surrounding the 1996 legislation, PRWORA also narrowed access for immigrants whose status was clearly legal.³² Prior law had defined eligibility broadly and only excluded narrowly-defined immigrant categories, but PRWORA created a broad rule against access to certain federally-funded public benefits for legal permanent and temporary residents, with exceptions created for certain narrowly defined groups.³³ For example, lawful permanent residents are ineligible for most forms of federal benefits; these individuals and foreign-born children who entered the United States legally after 1996 must wait five years to become eligible for federally-funded health services.³⁴

One of the most significant provisions limiting access is not a specific benefit exclusion, but rather the anti-public charge provision in immigration law.³⁵ Sponsors of immigrants are required to sign an affidavit or bond agreement attesting that the sponsor has the means to provide for the immigrant’s needs and that the person will not become a public charge.³⁶ This longstanding provision has been seen as an integral part of the immigration law, as officials have frequently relied on this exclusion to deny immigrant and nonimmigrant visas to persons seeking to come to the United States and penalize legalization applicants.³⁷ To determine whether an immigrant is “likely to become a public charge,” government officials

30. Personal Responsibility and Work Opportunity Reconciliation Act (“PRWORA”), 8 U.S.C. §§ 1601-46 (2001).

31. See 8 U.S.C. §§ 1611, 1642 (2001) (an immigrant must be qualified in order to be eligible for benefits).

32. See 8 U.S.C. § 1631(b)–(c) (2001).

33. See Costich, *supra* note 20, at 1046, 1053. See also 8 U.S.C. § 1631(b)–(c) (2001).

34. See Costich, *supra* note 20, at 1048.

35. See 8 U.S.C. § 1601 (2001) (describing self-sufficiency as a basic principle of United States immigration law and noting that this policy should discourage aliens’ reliance on public resources, instead requiring them to “rely on their own capabilities and the resources of their families, their sponsors, and private organizations.”). See also Kevin R. Johnson, *Public Benefits and Immigration: The Intersection of Immigration Status, Ethnicity, Gender, and Class*, 42 UCLA L. REV. 1509, 1521-24 (1995); Costich, *supra* note 20, at 1047-50.

36. See Johnson, *supra* note 35, at n.52; Costich, *supra* note 20, at 1047 (describing affidavits of support).

37. See Johnson, *supra* note 35, at n.52 (describing how it was used to penalize legalization applicants under the amnesty program created as part of the 1986 Immigration Reform and Control Act).

consider the immigrant's health, age, income, education, skills, and affidavits of support.³⁸ After PRWORA was enacted, officials at the Immigration and Naturalization Service ("INS") began using receipt of public benefits, such as Medicaid, to deny immigrants reentry to the United States or temporary or permanent legal status, unless they repaid these benefits.³⁹ In response to protests from immigrants' rights and health care advocates, the INS stopped this practice and issued a policy stating that the use of health care programs and benefits would not jeopardize immigrants' status or be used to label them a public charge in danger of deportation.⁴⁰

There are some important exceptions to these restrictions on immigrants' access to care. First, hospitals are required to provide emergency health care for anyone who comes to the emergency room, regardless of immigration status.⁴¹ Second, medical care to diagnose and treat communicable diseases is exempted from the ban on access.⁴² Finally, detainees also have a limited right to health care, which arises from the fact that they have been temporarily deprived of the ability to access care any other way.⁴³ However, despite these standards governing detainee access to care, "no government body is charged with accounting for deaths in immigration detention."⁴⁴

2. Heightened Enforcement and Reporting Requirements

The federal government has also increased enforcement of existing policies and encouraged information reporting by health officials. The legislative wave restricting benefits access in 1996 renewed interest and vigor in enforcing the anti-charge provision.⁴⁵ Prior to 1996, affidavits of support were treated as moral obligations rather than legally enforceable commitments.⁴⁶ The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 ("IIRIRA"), however, made these affidavits legally enforceable, creating a legal right of government agencies to seek reimbursement from sponsors for public benefits provided to the sponsored

38. NATIONAL IMMIGRATION LAW CENTER, INS GUIDANCE ON "PUBLIC CHARGE," (Sept. 2004), http://www.nilc.org/ciwc/ciwc_ce/pubchgce_9-22-04.pdf.

39. See TANYA BRODER, NATIONAL IMMIGRATION LAW CENTER, OVERVIEW OF IMMIGRANT ELIGIBILITY FOR FEDERAL PROGRAMS, 4.5-4.6 (Oct. 2007), http://www.nilc.org/immspbs/special/pb_issues_overview_2007-10.pdf [hereinafter OVERVIEW OF IMMIGRANT ELIGIBILITY].

40. See *id.*

41. Costich, *supra* note 20, at 1051; Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (2000 & Supp. IV 2004).

42. Costich, *supra* note 20, at 1060.

43. See Bernstein, *supra* note 15.

44. *Id.*

45. See Costich, *supra* note 20, at 1049.

46. See *id.*

immigrant.⁴⁷ Moreover, sponsors must demonstrate that they meet a certain economic threshold to sponsor an immigrant and reduce the likelihood that immigrants will become public charges.⁴⁸ Once immigrants meet the five-year eligibility requirement, if they do seek public benefits, the sponsor's income is included in the calculations determining whether the immigrant qualifies financially.⁴⁹

One of the most controversial reporting requirements was proposed by President Bush. President Bush's policy would have required hospital personnel to check the immigration status of patients and report it to the federal government.⁵⁰ While he ultimately abandoned this proposal, Congress found another way to encourage collection of this data.⁵¹ In 2003, Congress authorized some funding relief to hospitals providing uncompensated care to unauthorized immigrants.⁵² In order to qualify for federal reimbursement for emergency care provided to undocumented persons, however, hospitals are required to collect information proving that the patient is ineligible for public insurance, which necessarily involves gathering information related to immigration status.⁵³

Finally, Congress heightened citizenship proof requirements for demonstrating Medicaid eligibility.⁵⁴ These requirements were purportedly designed to prevent immigrants from making fraudulent claims to steal Medicaid benefits. In fact, these heightened requirements have created additional hurdles for citizens who are eligible for Medicaid.⁵⁵

3. States and Local Restrictions on Immigrant Access to Public Benefits

At one level, PRWORA seemed to be Congress' response to the growing state-federal tension surrounding the issue of whether states could limit public benefits to immigrants. As noted above, many state and local governments enacted benefit restrictions to address their perceived financial burdens caused by illegal immigration. States were frustrated with the

47. *See id* at 1047, 1049.

48. *Id.* at 1049.

49. *Id.*

50. Robert Pear, *Payments to Help Hospitals Care for Illegal Immigrants*, N.Y. TIMES, May 10, 2005, at A11 [hereinafter *Payments to Help Hospitals*].

51. *See id.*

52. *See id.*

53. *Id.*

54. Deficit Reduction Act ("DRA"), 42 U.S.C.A. §§ 1396(i)(22), 1396b(x) (West 2007) (allows states to use only certain documents to verify U.S. citizenship).

55. *See* National Health Law Program, Fact Sheet: Citizenship Documentation Requirements Under the Deficit Reduction Act and Interim Final Rule 1, (2006), <http://www.healthlaw.org/library/attachment.89880> (changes were added to the DRA at the request of two Republican Representatives who said they wanted to prevent undocumented immigrants from enrolling in Medicaid).

federal government not only because of its failure to curb illegal immigration, but because federal law limited the states' ability to deal with this problem by restricting benefits.⁵⁶

One limit is found in the 1986 Emergency Medical Treatment and Active Labor Act ("EMTALA"). EMTALA requires any hospital with an emergency room that receives federal funding (which includes nearly all hospitals) to screen individuals who come to the emergency room and provide stabilizing care if the individual has an emergency medical condition.⁵⁷ Hospitals cannot turn people away based on immigration status, ability to pay, or any other ground unrelated to medical need.⁵⁸ This law is consistent with many state laws and has not been particularly controversial.⁵⁹

A more controversial limit on state autonomy was announced by the Supreme Court in *Plyler v. Doe* in 1981.⁶⁰ The Court struck down a state law that denied undocumented immigrant children a public education.⁶¹ Although the 5-4 majority noted the unfairness in penalizing children for the violations of their parents, an important part of the Court's opinion turned on federalism concerns and limits on states' ability to regulate immigration matters, which is reserved for the federal government.⁶² The majority and dissent agreed generally that the federal government could use benefit restrictions as a tool of immigration control.⁶³ The majority opinion also suggested that had the federal government expressly condoned state action in this area, such actions would not violate interests of federalism.⁶⁴

56. See, e.g., *Plyler v. Doe*, 457 U.S. 202 (1982).

57. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2000 & Supp. IV 2004). See also *Brooks v. Md. Gen. Hosp.*, 996 F.2d 708, 710 (4th Cir. 1993) (EMTALA enacted in response to reports of "patient dumping" by private hospitals to public hospitals, largely due to inability to pay and discrimination on the basis of race or ethnicity).

58. See 42 U.S.C. § 1395dd(1) (2000 & Supp. IV 2004) ("if any individual, (whether or not eligible for benefits under this subchapter) . . .").

59. See Judith L. Dobbertin, *Eliminating Patient Dumping: A Proposal for Model Legislation*, 28 VAL. U.L. REV. 291, 326-30 (1993) (discussing the statutes prohibiting patient dumping in twenty-one states); Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 AM. J. L. & MED. 561, 567-79 (1988) (discussing state common law prohibitions on patient dumping).

60. *Plyler v. Doe*, 457 U.S. 202 (1982).

61. *Id.*

62. *Id.* at 226.

63. *Id.* at 219 n.19 (majority opinion), 242-54 (Burger, C.J., dissenting).

64. *Id.* at 219 n.19 ("With respect to the actions of the Federal Government, alienage classifications may be intimately related to the conduct of foreign policy, to the federal prerogative to control access to the United States, and to the plenary federal power to determine who has sufficiently manifested his allegiance to become a citizen of the Nation. No state may independently exercise a like power. But if the Federal Government has by uniform rule prescribed what it believes to be appropriate standards for the treatment of an alien subclass, the States may, of course, follow the federal direction.").

PRWORA was widely understood as Congress' attempt to answer *Plyler's* federalism concerns by authorizing the kind of state restriction on benefits that were previously vulnerable to constitutional attack⁶⁵ and increasing state flexibility in designing public benefit programs.⁶⁶ Specifically, *Plyler* did this by explicitly authorizing states to limit immigrants' access to public benefits in ways that are consistent with federal eligibility classifications.⁶⁷ Ironically, PRWORA has effectively restricted state discretion at the other end, by removing an important source of federal funding and erecting onerous procedural hurdles for states that choose to provide public benefits regardless of immigration status, a federally disfavored policy choice.⁶⁸ Although, technically PRWORA allowed states to provide benefits to undocumented persons under certain conditions, if legislation authorizing this use was enacted after August

65. See 8 U.S.C. §1601 (2001) (noting that it is a "compelling government interest" to enact eligibility and sponsorship rules to encourage self-reliance and discourage illegal immigration by aliens and providing that "a State that chooses to follow the Federal classification in determining the eligibility of such aliens for public assistance shall be considered to have chosen the least restrictive means available for achieving [this] compelling government interest.") See also Cindy Chang, *Health Care for Undocumented Immigrant Children: Special Members of an Underclass*, 83 WASH. U. L. REV. 1271, 1285-86 (distinguishing state statutes limiting health from those limiting educational benefits: "[w]hereas no federal rule barred undocumented immigrant children from public schools, PRWORA excludes undocumented immigrant children from state health care benefits. Thus, given the federal directive on the matter, it is unlikely that *Plyler* will provide constitutional grounds for overturning state statutes limiting undocumented immigrant children's access to state health care benefits."); Recent Legislation: *Welfare Reform – Treatment of Legal Immigrants – Congress Authorizes States to Deny Public Benefits to Noncitizens and Excludes Legal Immigrants from Federal Aid Programs*, 110 HARV. L. REV. 1191, 1192-93 (1997) (arguing that by authorizing states to deny public benefits on the basis of immigration status, PRWORA attempts to sanction an Equal Protection Clause violation by states). But see *Aliessa v. Novello*, 754 N.E.2d 1085, 1098 (N.Y. 2001) (holding that New York's exclusion of certain legal immigrants from Medicaid coverage despite their eligibility under federal law was an unconstitutional exercise of state discretion, while also finding that the provision of PRWORA that expressly allows states to treat discrimination between different categories of immigrants in benefits decisions violates the equal protection law); Ellen M. Yacknin, *Migration Regulation Goes Local: The Role of States in U.S. Immigration Policy Aliessa and Equal Protection for Immigrants*, 58 N.Y.U. ANN. SURV. AM. L. 391, 392-93 (2002) (describing "the legal battle over the constitutionality of congressionally authorized state discrimination against lawful immigrants.").

66. See *Plyler v. Doe*, 457 U.S. 202, 226-30 (1982) (PRWORA's expansion of categories of ineligible immigrants may be seen as giving states more leeway in using these categories to also deny state benefits. See also Candice Hoke, *State Discretion Under New Federal Welfare Legislation: Illusion, Reality and a Federalism-Based Constitutional Challenge*, 9 STAN. L. & POL'Y REV. 115, 115 (discussing the widely held perception that PRWORA increased states' flexibility).

67. See 8 U.S.C. §§ 1621-1625 (2001).

68. See Hoke, *supra* note 66, at 119-20 (describing hurdles such as requiring legislative enactment to provide benefits for undocumented immigrants); Costich, *supra* note 20, at 1067 (PRWORA was perceived as making it more difficult for states to use their own resources to provide benefits to undocumented persons).

1996,⁶⁹ such legislation could be very difficult and politically unpopular in light of the surge in anti-immigrant sentiment. Moreover, in at least one state, this has been used to try to prevent hospitals from providing public health services to undocumented immigrants.⁷⁰

II. BACKGROUND ON IMMIGRATION DISCOURSE GENERALLY

Before examining the discourse of immigrant health care, it is important to understand the normative underpinnings of immigration control generally, and the justifications for benefit restrictions specifically as means for accomplishing these goals and enforcing these values.

A. *Immigration Norms*

One normative justification for immigration control is the necessity of defining a shared culture and for state building.⁷¹ By defining conditions of entry or legal status, values for certain behavioral norms are expressed and used to define our culture. For example, professionals who will contribute to our intellectual development and certain refugees seeking asylum may receive preference, but persons who have engaged in conduct that is considered undesirable, such as criminal or politically unpopular activity, are suspect and excluded.⁷² The ethnic and racial identity of the population is also constructed where national origin, ethnicity, and racial criteria are used covertly or overtly in immigration decisions and enforcement.⁷³

Internal policies affecting the rights and benefits of immigrants while here are viewed as related to these goals if they could undermine immigration criteria and control mechanisms. For example, there are concerns that the prospect of jobs and other economic benefits can lure immigrants here and even encourage them to circumvent legal channels to enter the United States or to overstay visas.⁷⁴ This concern is fueled by

69. See Costich, *supra* note 20 at 1067.

70. *Id.* at 1067-68 (describing how the Attorney General of Texas opined that PRWORA required a post-PRWORA state law authorizing free or discounted care to unauthorized immigrants, and the District Attorney initiated a criminal investigation of the hospital district for providing such care).

71. See, e.g., MICHAEL WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY 39 (Basic Books 1983).

72. See generally Johnson, *supra* note 35, at 1519-25.

73. See, e.g., Leti Volpp, 2005 *Survey of Books Related to the Law: Impossible Subjects: Illegal Aliens and Alien Citizens*, 103 MICH. L. REV. 1595, 1598-99 (2005) (book review) (describing how the Johnson Reed Immigration Act of 1924 tried to curtail immigration from Southern and Eastern Europe through a quota system that tried to maintain the statistical advantage of Northern Europeans). See also MAE NGAI, IMPOSSIBLE SUBJECTS: ILLEGAL ALIENS AND THE MAKING OF MODERN AMERICA (Princeton Univ. Press 2004).

74. See Johnson, *supra* note 35, at 1546 (“Contrary to the popular stereotype that all undocumented persons surreptitiously entered the country, the INS estimated that

increasing illegal immigration from Mexico and Central America, where the economic disparity with the United States is significant and preventing access across the Mexican border is difficult.⁷⁵ Even immigrants who come legally may be labeled undesirable if they do not assimilate easily or seem likely to become public charges. This “undesirability” is demonstrated by the fact that, subject to certain narrow exceptions, evidence of self-sufficiency or other private support is an important factor in excluding certain groups.⁷⁶ Thus, benefit restrictions may be considered part of an overall package of immigration policy which reflects value judgments about the path one takes to come to the United States, as well as who is considered to be worthy and desirable to join American society.

Another goal of immigration regulation is to protect the safety and welfare of those who are legal and full-fledged U.S. citizens.⁷⁷ This goal is closely linked to the behavioral and other criteria used with respect to immigration control discussed above. Excluding or deporting people who are considered dangerous or destabilizing, such as immigrants with criminal backgrounds, is the most obvious example.⁷⁸ Immigrant utilization of public resources also can trigger these concerns to the extent that it threatens the amount of resources available generally to others in the United States.⁷⁹ This is especially compelling where the resources are used for health care, education, housing, and other services directly related to ensuring economic stability, physical safety, and good health. Immigrants are often seen as threatening our economic stability and security by stealing our jobs, identities, and scarce public resources.⁸⁰ Indeed, concerns about

roughly one-half of the undocumented persons in the United States were visa overstays.”).

75. See *Immigration at Record Level*, *supra* note 23 (analysis by the Center for Immigration Studies finding that the majority of the immigrants arriving in recent years are from Mexico and Central America, and more than half of them are illegal).

76. See Costich, *supra* note 20, at 1045; Johnson, *supra* note 35, at 1519-25.

77. See WALZER, *supra* note 71.

78. See David Cole, *The Idea of Humanity: Human Rights and Immigrants' Rights*, 37 COLUM. HUM. RTS. L. REV. 627, 630 (2006) (“[D]iscrimination against immigrants is also founded on the fact that, as in every other serious national security crisis in our past, government officials have found it easier to sacrifice the rights of non-voting foreign nationals for the purported security of the nation than to ask voting Americans to sacrifice their own rights and liberties in the name of promises of greater security . . . [i]n such situations, deportation of foreign nationals is ‘the course of least resistance,’ especially when they are viewed as ‘them’ in the us-them dichotomy that so often dominates public discourse and consciousness in a time of war.”).

79. See Johnson, *supra* note 35, at 1531-34.

80. See generally Minty Siu Chung, Symposium, *United States Immigration Policy – A History of Prejudice and Economic Scapegoatism? Proposition 187: A Beginner’s Tour Through a Recurring Nightmare*, 1 U.C. DAVIS J. INT’L L. & POL’Y 267, 284-85 (1995); Michael Curran, *Flickering Lamp Beside the Golden Door: Immigration, the Constitution, & Undocumented Aliens in the 1990s*, 30 CASE W. RES. J. INT’L L. 58, 71, 76 (1998); Johnson, *supra* note 35.

illegal immigration tend to rise as economic downturns occur, and immigrants are one of the first groups society and public officials point to as a source of the problem.⁸¹

While many immigration-related policies and proposals, including benefit restrictions, are justified primarily on deterrence or distributive justice grounds, there is an increasingly powerful retributive element to them as well. This is reflected most clearly in the Sensenbrenner bill, proposed in 2005, which would have criminalized people here illegally, as well as criminalizing those who provide them aid or support.⁸² This punitive element is also reflected in the trend of “criminalizing” immigration violations by creating and prosecuting more immigration-related criminal offenses.⁸³ Indeed, a number of people have justified many recent immigration policies, from stricter employment penalties to increasing barriers for getting drivers licenses, on retributivist grounds.⁸⁴

Benefit restrictions may be viewed in the following light: to the extent benefit restrictions make unauthorized immigrants’ lives more difficult while here, they are seen by some as a fitting punishment for those who could avoid this difficulty by choosing to leave.⁸⁵ The U.S. Supreme Court has even acknowledged the government’s right to use benefit restrictions as a type of punishment for those who have chosen to violate our immigration laws:

Persuasive arguments support the view that a State may withhold its beneficence from those whose very presence within the United States is the product of their own unlawful conduct . . . At the least, those who elect to enter our territory by stealth and in violation of our law should be prepared to bear the consequences, including, but not limited to, deportation.⁸⁶

81. See Chung, *supra* note 80, at 284-85.

82. See News Release, National Council of La Raza, NCLR Terms Sensenbrenner Bill “Appalling,” (Dec. 8, 2005), <http://www.nclr.org/content/news/detail/35482> [hereinafter National Council of La Raza].

83. See Stephen H. Legomsky, *The New Path of Immigration Law: Asymmetric Incorporation of Criminal Justice Norms*, 64 WASH. & LEE L. REV. 469, 469, 476 (2007); Teresa Miller, *Blurring the Boundaries Between Immigration and Crime Control After September 11th*, 25 B.C. THIRD WORLD L.J. 81 (2005); Juliet Stumpf, *The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power*, 56 AM. U. L. REV. 367 (2006).

84. See *Surge in Immigration Laws*, *supra* note 21.

85. See *Recourse Grows Slim for Immigrants*, *supra* note 25 (these restrictions are viewed by some as an attempt to end tolerance for country’s illegal residents).

86. *Plyler v. Doe*, 457 U.S. 202, 219-20 (1982) (distinguishing benefit restrictions of undocumented adults from those of children).

To the extent policies affect immigrants harshly, but do not really serve purported deterrence or distributive justice principles, the retributive element of the law is much more prominent.

B. *Dominant Narrative*

The dominant picture in our media and public discourse is created by those lamenting illegal immigration and emphasizing immigration control. A number of scholars have identified that the general immigration discourse creates an “Us-Them” dichotomy and labels immigrants as “outsiders” or “others” in ways that fuel misunderstanding, fear, and mistrust.⁸⁷ Scholars have also documented that in immigration discourse, a vivid picture is painted of “the illegal immigrant” whom we should fear, punish, and exclude.⁸⁸ The stereotypical symbol in the discourse has been a male immigrant from Mexico or somewhere in Central America who comes to the United States through deceptive and illegal means, or comes legally, but then overstays his visa only to “disappear” into society in violation of the terms of the visa.⁸⁹ Immigrants are seen as a threat to our culture if they fail to assimilate and demand special accommodations for their language difference in schools, hospitals, and the workplace.⁹⁰ These concerns are probably further exacerbated by a change in the stereotypical profile of illegal immigrants to Mexican women who come here to give birth to children.⁹¹ These children, though technically U.S. citizens if born here, are still socially and culturally labeled as outsiders who are benefitting from a moral and legal wrong, and thus not truly accepted.⁹²

Immigrants are also painted as dangerous and a threat to our safety.⁹³ Certainly, this tendency is heightened after a major terrorist attack or national security threat.⁹⁴ However, we also see this trend among Hispanic immigrants, as growing numbers of unauthorized immigrants come from

87. See generally NGAI, *supra* note 73; Volpp, *supra* note 73; Chung, *supra* note 80; Cole, *supra* note 78.

88. See Volpp, *supra* note 73, at 1601.

89. See Johnson, *supra* note 35, at 1545-49 (“The illegal alien stereotype fails to incorporate women . . .”).

90. See generally NGAI, *supra* note 73 (discussing the “alien citizen”). See also *infra* Part V.

91. See *infra* Part III.A (discussion of unauthorized immigrant mothers and concern about “anchor babies”).

92. See *infra* Part III.A.

93. Cole, *supra* note 78, at 629-30 (noting the rise of anti-immigrant feeling in the U.S. after September 11, 2001); Johnson, *supra* note 35, at 1531 (noting the correlation between immigrants who are also criminals and all immigrants generally). See generally NGAI, *supra* note 73.

94. See generally NGAI *supra* note 73; Cole *supra* note 78.

Mexico and Central America.⁹⁵ Stories of violent criminal activity by immigrants from these areas create an image of the “dangerous immigrant.”⁹⁶ The terms “illegals” and “illegal aliens,” used to describe immigrants residing in the United States in violation of immigration law, also reinforce this picture by putting unauthorized immigrants on the same footing as other criminals in our society. In fact, much of the immigration rhetoric mirrors language used in talking about domestic criminal policies. For example, some presidential candidates try to distinguish themselves by claiming to be “tough on illegal immigrants” in the same way that state and local politicians claim to be “tough on crime.”⁹⁷

95. See, e.g., NGAJ, *supra* note 73 (a number of scholars have noted the racialization of the “immigrant” that leads to profiling of certain racial and ethnic communities with either large numbers of “unauthorized immigrants” or groups who share the same racial profile as immigrants labeled as dangerous).

96. See Legomsky, *supra* note 83, at 472 (“Public perceptions of criminals and foreigners have become ever more intertwined.”); Jennifer M. Chacon, *Whose Community Shield?: Examining the Removal of the “Criminal Street Gang Member”*, 2007 U. CHI. LEGAL F. 317, 318-319 (2007) (“Throughout U.S. history, many commentators and scholars have ascribed gang activity to new immigrant groups. This linkage between gangs and immigrants in turn forms part of a broader social preoccupation with correlations between crime and immigration. Although the factual validity of the linkages between new immigrant groups and criminality is questionable, assumptions about migrant criminality are rampant in U.S. discourse. Along with vivid historical accounts of ethnic gangs in the United States, these flawed but lurid contemporary accounts of the criminality of the immigrant population and the general presumption of group dangerousness all serve to render the iconography of ‘alien gangs’ extremely powerful.”); A simple google search of immigrants and criminal activity yielded too many articles to cite. The following articles represent a very small sample of the results: Heather Mac Donald, *The Immigrant Gang Plague*, CITY JOURNAL (2004), http://www.city-journal.org/html/14_3_immigrant_gang.html; Chelsea Schilling, *Illegal Aliens Linked: The Crime Epidemic No One Will Talk About*, World Net Daily, Aug. 22, 2007, http://www.worldnetdaily.com/news/article.asp?ARTICLE_ID=51424; Pierre Thomas et al., *Gang Crackdown Targets Illegal Immigrants: “Worst of the Worst” Taken Off the Streets, Says Top ICE Official*, ABC News (Oct. 9, 2007), <http://abcnews.go.com/TheLaw/story?id=3707904>. See also, Eunice Moscoso, *Immigration Ads a Staple in Presidential Primary*, PALM BEACH POST, Dec. 13, 2007, http://www.palmbeachpost.com/localnews/content/shared_news/immigration/IMMIG_A_DS13_COX.html?cxntlid=inform_sr. (describing the prominent role of ads depicting gang activity among immigrants in political campaigns: “One features the bloody victims of Central American gang violence. Another warns that 800,000 foreigners are crossing the border every year. And another denounces driver’s licenses for illegal immigrants. Immigration ads are permeating the airwaves in early primary states more than ever before and experts say they could be a harbinger of what to expect in the general election . . . One spotlights Central American gangs such as MS-13 and shows bloody pictures of victims of gang violence. A voice-over says that the gangs are now on American soil ‘pushing drugs, raping kids, destroying lives’ and blames the violence on ‘gutless politicians who refuse to defend our borders.’”).

97. See Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 488 (2007) (noting that according to the National Conference of State Legislatures, over 500 bills were filed, most of which were attempting to get tough on illegal immigration).

The mere act of coming here through improper channels or violating some condition of legal status taints every other activity of the immigrant while here. Unauthorized immigrants are seen as criminals who come to steal jobs, education, and benefits.⁹⁸ Immigrants who need public assistance are viewed even harsher: they are labeled not only as criminals, but as welfare abusers, who steal from the most vulnerable and needy among our citizens.⁹⁹

III. JUSTIFYING RESTRICTIONS TO ACCESS

We see much of this dominant narrative reflected in the discourse justifying benefit restrictions on deterrence, distributive justice, and retribution grounds. Policies limiting immigrants' access to healthcare benefits are touted as important tools for discouraging unauthorized and undesirable immigrants, protecting scarce resources to ensure citizens health and safety, and punishing immigrants who violate the law. In the process, they tell a story that reinforces the dominant narrative of immigrants as criminals and welfare abusers who come here to steal benefits and threaten our safety and security.

A. Benefit Restrictions as a Deterrent to Illegal or Undesirable Immigration

Federal and state officials have repeatedly cited deterrence as one justification for benefit restrictions.¹⁰⁰ To the extent benefit restrictions are justified on deterrence grounds, the discourse must tell stories that link the availability of benefits to immigration decisions about who will come here and how they do it. To support this justification, the discourse must emphasize the nature of immigrants' choices, especially their expectation and desire for such benefits. Although largely contradicted by evidence discussed in the next part, this discourse has nonetheless been asserted in mainstream discourse and generally accepted by courts and the public as a

98. *Id.* at 466.

99. See Johnson, *supra* note 35, at 1533 (describing the powerful image of the "predatory criminal alien").

100. See, e.g., 8 U.S.C. § 1601 (2001) ("The Congress makes the following statements concerning national policy with respect to welfare and immigration: . . . (2) It continues to be the immigration policy of the United States that [] (B) the availability of public benefits not constitute an incentive for immigration to the United States" . . . "(6) It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits."). See also Plyler v. Doe, 457 U.S. 202 (1981); Matthews v. Diaz, 426 U.S. 67 (1976); Monica Rhor, *Lawmaker Seeks to Limit Benefits for Babies of Illegal Immigrants*, LUBBOCK AVALANCHE-JOURNAL, Feb. 23, 2007, http://www.lubbockonline.com/stories/022307/sta_022307108.shtml (Texas legislator claims that denial of health care to babies born to unauthorized immigrants would deter illegal immigration).

legitimate justification for linedrawing based on citizenship, at least for adult immigrants.¹⁰¹

This link between immigration decisions and access to benefits has been reinforced in the justifications used for heightened enforcement mechanisms: namely, to prevent ineligible immigrants (whether here legally or illegally) from “stealing” Medicaid or Medicare benefits. Increasing monitoring for fraud and erecting additional barriers for proving eligibility diverts scarce money and time from other important goals.¹⁰² In order to justify these costs, restrictionists must tell a story of a costly and significant problem of immigrants “stealing” benefits that builds upon the general picture of unauthorized immigrants as criminals and welfare abusers.

While it is very difficult to link expectations about health care access specifically to immigrants’ decision-making, restrictionists have nonetheless created a narrative that tries to do this. The most direct link between health care access and a decision to immigrate is made by focusing on pregnant women who come to hospitals in the United States to give birth to U.S. citizens.¹⁰³ This link is used by politicians, such as Texas State Representative Berman and 2008 Presidential candidate Ron Paul, to propose denying automatic U.S. citizenship for these babies in order to cut them off from public health and education benefits.¹⁰⁴ Restrictionists, especially those in border states, create a fear of “anchor babies” and Mexican women darting across the border to give birth. Such fears rely on statistics highlighting the high number of births to unauthorized immigrants in U.S. hospitals, without any data showing how long the women had been in the United States before the delivery.¹⁰⁵

101. See Costich, *supra* note 20, at 1044 (despite the data from population-based research, “[a]necdotal evidence of immigration motivated by access to the high quality of health care available in the U.S. abounded in the early 1990s and was consistent with the movement of the Republican “Contract with America” towards cutting federal expenditures regardless of the consequences. These scattered anecdotes appear to constitute the only evidence for health services–related immigration . . .”). See also, e.g., *Plyler*, 457 U.S. at 219 (“Persuasive arguments support the view that a State may withhold its beneficence from those whose very presence within the United States is the product of their own unlawful conduct.”); *Political Ticker: Clinton Has No Answers for Undocumented Immigrants*, <http://politicalticker.blogs.cnn.com/2007/09/17/clinton-health-plan-has-no-answers-for-undocumented-immigrants/> (Sep. 17, 2007) [hereinafter *Political Ticker*] (providing examples of comments by the public generally about immigration and health care).

102. See *infra* Part IV.B.

103. See Rhor, *supra* note 100 (Texas State Representative Leo Berman sponsored a bill to deny birthright citizenship to children born to unauthorized immigrants).

104. See *id.* See also Katerina Valdivieso & Jennifer Ludden, *Election 2008 Presidential Candidates Weigh in on Immigration*, NATIONAL PUBLIC RADIO, Jan. 30, 2008, <http://www.npr.org/news/specials/election2008/issues/immigration.html>.

105. See *Texas Hospitals’*, *supra* note 12; Rhor, *supra* note 100 (noting that approximately one of four births at public hospitals in Houston, Dallas, and Fort Worth are

The link between health care and immigration decisions is implicitly suggested in popular discussions: the most common complaint about undocumented immigrants and health care is that offering access to “free” emergency care lures undocumented immigrants to the United States, at the expense of tax-paying citizens who subsidize this care and then must suffer overcrowded emergency rooms.¹⁰⁶ One example of this is found in Lisa Richardson’s L.A. Times article, describing the transfer to Mexico of suspected unauthorized immigrants seeking emergency care in U.S. hospitals.¹⁰⁷ The article begins as follows:

Jose Lopez stole across the U.S. border with dreams of prosperity and a craving for adventure – but his grand plans didn’t last long. On his second day as a fieldworker, a car wreck left him lying in a Brawley roadway with his right leg shattered. Lopez, 19, was taken to Scripps Memorial Hospital in La Jolla, where surgeons put a rod in his leg and wired his broken jaw shut. As Lopez recuperated at the hospital, his bill mounted by the day, and Scripps had no choice but to absorb the cost. Lopez had no money.¹⁰⁸

This attitude flourishes despite the fact that emergencies are by definition unanticipated, and are therefore unlikely to be a primary motivation for entering the United States illegally.

Another element of the narrative surrounding health care access is the “foreignness” or “strangeness” of immigrants, which is perceived as threatening the culture-building and norm-creation functions of immigration control. In the same L.A. Times article, this element is used subtly through a focus on the differences in the patient’s culture and his ultimate choice to return to Mexico. For example, one of the co-founders of Nextcare defended these transfers by describing how they convince patients to go to the Tijuana facility:

We . . . say, ‘Let us take you out of this very expensive hospital and take you to our facility in Tijuana,’ . . . ‘The level of care you’re going to receive is the same, maybe even better. You’ll have a physician and nurses you understand. The food is something you’re comfortable with. The TV is Mexican. You can call your home and have your family come and visit you.’ [Someone] visited Lopez’s room at Scripps [offering] to return him to a familiar diet, language and surroundings.¹⁰⁹

to illegal immigrant mothers: in 2006, approximately 8,000 babies were born to illegal immigrants in the Harris County Hospital District and 11,000 at Parkland Health & Hospital System).

106. See, e.g., *Political Ticker*, *supra* note 101.

107. Richardson, *supra* note 1, at A1.

108. *Id.*

109. *Id.*

The article also repeatedly emphasizes Lopez's desire to have a good meal and food that was *his* food, even noting that the San Diego hospital nurses "once whirred a burrito through a blender, at his request."¹¹⁰

While the description of food was significant because of the nature of Lopez's injury—his jaw was wired shut which meant he could only have liquids and oatmeal—it seems to take on a powerful meaning as a symbol of Lopez's culture as different and foreign to U.S. culture. The language barrier is another powerful symbol of this and can be an important barrier where hospitals or local governments do not provide or adequately fund translation services for non-English speakers. Thus, the undercurrent of "otherness" or "strangeness" of culture that pervades immigration discourse generally is also present in the rhetoric surrounding immigrant health care access.

B. Benefit Restrictions are Necessary to Protect Our Health Care Resources

Health care benefit restrictions are also justified on distributive justice grounds. Restrictionists create a framework for discourse that assumes resource allocation decisions are a zero-sum proposition, where granting access to one person, necessarily means depriving someone else.¹¹¹ This paradigm forces us to prioritize different groups' rights to access health care. Immigration status becomes an easy basis for linedrawing as citizens are viewed as more deserving and with a stronger claim to healthcare benefits than immigrants, especially unauthorized immigrants.¹¹²

This need for prioritizing claims in ways that exclude immigrants becomes more compelling as one considers the current healthcare financing crisis and the dwindling supply of quality healthcare providers. Healthcare financing is critical for people to be able to access care and for healthcare professionals and facilities to continue to operate and provide necessary

110. *Id.*

111. See *Matthews v. Diaz*, 426 U.S. 67, 83-84 (1976) ("The task of classifying persons for medical benefits . . . inevitably requires that some persons who have an almost equally strong claim to favored treatment be placed on different sides of the line . . .").

112. See, e.g., 8 U.S.C. § 1601 (2001): ("The Congress makes the following statements concerning national policy with respect to welfare and immigration: (1) Self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes. (2) It continues to be the immigration policy of the United States that (A) aliens within the Nation's borders not depend on public resources to meet their needs . . . (3) Despite the principle of self-sufficiency, aliens have been applying for and receiving public benefits from Federal, State, and local governments at increasing rates. (4) Current eligibility rules for public assistance and unenforceable financial support agreements have proved wholly incapable of assuring that individual aliens not burden the public benefits system . . .").

care. Our current system provides public health insurance only to select groups: the poorest children and their parents (including pregnant women), the disabled, elderly, and government employees and veterans.¹¹³ We rely on private insurance, primarily through employment, to cover the rest of society.¹¹⁴ However, employers are not required to provide coverage and increasingly employers are either offering coverage at a cost that is too high for the employees to afford or choosing not to offer coverage at all.¹¹⁵ In the individual insurance market, insurance companies have so much discretion that the individuals who are most in need of insurance are often priced out of the market, leaving millions of people in the United States uninsured.¹¹⁶

Shrinking financial resources also affect the ability and willingness of quality providers to serve communities with the greatest need. Growing numbers of uninsureds and declining reimbursement rates have led to nursing and physician shortages in hospitals, especially in emergency rooms.¹¹⁷ It has also led to a financial strain causing many public and private hospital closures and relocations to more affluent communities.¹¹⁸ While these shortages occur disproportionately in areas with lower socioeconomic status, higher minority populations, and high need, they can create a cascade effect that increases the burden on remaining hospitals which must absorb these patients.¹¹⁹ In essence, limited healthcare financing and a dwindling healthcare safety net mean that many people are vying for ever-shrinking resources.¹²⁰

It is against this backdrop of a financial crisis that a picture is created of immigrants as a threat to the already fragile health system on which citizens currently depend.¹²¹ Indeed, the mere presence of immigrants who are not

113. See generally Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023 (2005); LAURIE KAYE ABRAHAM, *MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA* (Chicago Univ. Press 1993); DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (Univ. of Michigan Press 1999); JONATHAN COHN, *SICK: THE UNTOLD STORY OF THE AMERICAN HEALTH CARE SYSTEM* (Harper Collins Press 2007).

114. See COHN, *supra* note 113, at 8-10.

115. See COHN, *supra* note 113, at 8-10; ABRAHAM, *supra* note 113, at 1.

116. See ABRAHAM, *supra* note 113, at 1.

117. See generally Clark, *supra* note 113.

118. See Clark, *supra* note 113; ABRAHAM, *supra* note 113, at 1024; SMITH, *supra* note 113, at 195-200.

119. Clark, *supra* note 113, at 1024, 1035; ABRAHAM, *supra* note 113, at 6. See generally SMITH, *supra* note 113, at 195-200.

120. See Clark, *supra* note 113, at 102.

121. See John M. Broder, *Schwarzenegger Budget Denies Some Health Care*, N.Y. TIMES, Jan. 18, 2004, at A16 (describing California's shrinking state resources and budget cuts, including health services to immigrants of legal, illegal, and various statuses).

entitled to be here or who are admitted on the condition that they not become public charges, seems to threaten public resources, because many immigrants are uninsured¹²² and are more likely to serve in dangerous jobs with an increased likelihood of workplace injury or illness.¹²³ For example, one article by the Center for Immigration Studies, known for advocating immigration control and reduction, highlighted these concerns.¹²⁴ The Center for Immigration Studies reported that 30% of all immigrants and their children lack health insurance and receive some kind of public assistance, while immigrant families account for almost 75% of the increase in the uninsured in the past fifteen years.¹²⁵

The picture of immigrants as an economic drain is reinforced with statistics about the cost of hospital care for undocumented immigrants. For example, the L.A. Times quoted an estimated annual cost of \$200 million for facilities in California, Arizona, New Mexico, and Texas and described the cost as “staggering.”¹²⁶ Restrictionists have blamed the financial crisis in health care on unauthorized immigrants, predicting that care for unauthorized immigrants will force hospitals already on the verge of bankruptcy to close their doors.¹²⁷

Recently, the argument has shifted to a more imminent, direct healthcare threat in the form of hospital emergency room closures. Hospital closures are the most visible example of the implications of shrinking healthcare resources and the implications for our health. Rates of hospital closures have exploded in the last decade, especially public hospitals and hospitals treating a high proportion of uninsured patients.¹²⁸ As hospitals close, remaining hospital emergency rooms become overcrowded and qualified physicians often refuse to serve on-call or

122. See Costich, *supra* note 20, at 1042-45.

123. See generally JENNIFER GORDON, *SUBURBAN SWEATSHOPS: THE FIGHT FOR IMMIGRANT RIGHTS* (Harvard Univ. Press 2005).

124. See *Immigration at Record Level*, *supra* note 23.

125. *Id.* (“A large proportion of recent immigrants, both legal and illegal, are low-skilled workers and about one-third of those have not completed high school, giving them significantly less education than Americans born in the United States . . . [a]bout 30 percent of all immigrants and their children lack health insurance . . . compared with 13 percent of native-born Americans. One of every three uninsured people in the country is an immigrant or a young American-born child with at least one immigrant parent . . . [i]mmigrant families account for almost three-quarters of the increase in the uninsured in the past 15 years . . . [a]bout one-third of immigrant families receive some kind of public assistance.”).

126. See Richardson, *supra* note 1.

127. See, e.g., Rhor, *supra* note 100 (state legislator “blames illegal immigrants for the financial crisis facing [Texas] public hospitals”); *Texas Hospitals*, *supra* note 12, at A1 (“With more than 1.4 million of California’s residents uninsured and more than half of California’s hospitals operating in the red, [the president of the California Hospital Association in 2006] warned that care for illegal immigrants could tip some hospitals into bankruptcy.”).

128. See generally Clark, *supra* note 113.

they leave the community altogether, thereby jeopardizing access and quality of care for everyone.¹²⁹

Consider the story of a man from San Diego, California, one of many people concerned about whether Senator Clinton's healthcare plan will provide coverage for unauthorized immigrants and the effect this will have citizens' access:

Illegals already have free health care. Drop by any emergency room in your local general hospital and you will likely see a lobby full of Mexicans. It almost cost my 18 month old son his life when on Oct. 6, 2005 he was diagnosed as being in extreme DKU or Diabetic Keto-Acidosis, when I thought he was having an asthma attack. His pediatrician called Children's Hospital in San Diego only to find the emergency room was full. Full of Mexicans I was to find out when I drove him myself to the hospital. Fortunately my son survived, but I felt upset that the resources available for my son were almost denied due to the immigration situation we have here. Hopefully Sen. Clinton's plan will address this issue.¹³⁰

Certainly equating Mexican with "illegals" is problematic as a factual and policy matter, and it is not clear from this comment whether the author would support or oppose coverage for unauthorized immigrants in light of his apparent concern about overcrowded emergency rooms. This story is useful, however, in demonstrating the extent to which the very presence of unauthorized immigrants is viewed as life threatening because of disruptions to emergency care access in the discourse of immigrant health care.

These concerns assume a choice between "us" or "them." The numbers of uninsured citizens are compared to uninsured, unauthorized immigrants in need of health care to trigger a public fear that "they" will use up our resources and that none will be left for "us."¹³¹ In fact, the executive vice president of the Hospital Association of Southern California described the Nextcare "transfers" to Mexico as "a responsible and inventive way of dealing with a shortage of beds for indigent patients" for border states and counties that are "tired of waiting for the federal government to deal with this problem."¹³² In other words, hospitals, as well as state and local governments, are in the position of making unfortunate, but necessary, choices about which people will receive scarce healthcare resources.

129. *See id.* at 1033.

130. Posting of Philip to <http://politicalticker.blogs.cnn.com/2007/09/17/clinton-health-plan-has-no-answers-for-undocumented-immigrants/> (Sept. 17, 2007, 11:53 EST).

131. *See Texas Hospitals'*, *supra* note 12 ("We have a lot of U.S. citizens that need our help in health, and we should pull them up before we pull up someone here illegally.")

132. Richardson, *supra* note 1.

C. Benefit Restrictions as Punitive for Violations of the Social Contract

At one level, there is a punitive aspect to the distributive justice justifications for benefit restrictions. The linedrawing done in this area has typically been based on economic and medical need, as well as on notions of who is deserving. In order for people to have a legal claim to scarce healthcare resources, they must demonstrate some compelling need and reason for the special entitlement. In the case of health insurance, unlike many other social service programs, the “benefit” is access to health care, not money. This “benefit” will always be limited by need—healthcare insurance will only pay for medically necessary care, and even then it does not pay for every type of necessary care. Moreover, when talking about the groups who are vying for Medicaid benefits, the discussion turns to people who demonstrate clear economic need, both because of their low income and failure to secure private insurance. Thus, exclusions of immigrants who otherwise fit these criteria are viewed primarily on grounds of “desert” and the fact that they are “undeserving” of government-funded health care.

This retributive element is most powerful in two proposals that have not gained much traction politically, but nonetheless have sent a clear message to immigrants. The first is a proposal to deny U.S. citizenship to the children of unauthorized immigrants’ in order to exclude them from public health insurance, which punishes citizen children for their mothers’ immigration violations.¹³³ The second is Bush’s proposal to require hospital officials to report undocumented immigrants’ status to immigration authorities. Such reporting requirements are viewed by immigrants as penalties for seeking health care.¹³⁴ These sentiments are also expressed widely among popular discussions by people angry about the rights given to U.S.-born children of unauthorized immigrants and in statements that hospitals should facilitate the deportation of unauthorized immigrants.¹³⁵

This retributive rhetoric has focused on “illegal” immigrants viewed as “undeserving” because of their status. In popular commentary,

133. See National Council of La Raza, *supra* note 82 (Representative Tom Tancredo, labeled by the NCLR as the “most anti-immigrant member of Congress,” proposed an amendment to the Sensenbrenner bill that would eliminate birthright citizenship for babies born to immigrants). See also Valdivieso & Ludden, *supra* note 104 (“[Ron] Paul opposes legalizing immigrants already in the U.S. He has called for greater border security and has denounced the longstanding policy of granting citizenship to babies born on U.S. soil regardless of their parents’ legal status.”). But see *Lewis v. Thompson*, 252 F.3d 567, 591 (2d Cir. 2001) (holding that citizen children born to undocumented immigrants were entitled to Medicaid coverage as long as they otherwise met the eligibility criteria, making the status of the mother irrelevant).

134. See *infra* Part IV.

135. See generally Political Ticker, *supra* note 101 (comments posted).

exclusions are described as necessary punishment for immigrants who would otherwise benefit from their illegal activity and are labeled as fair because unauthorized immigrants always have the choice to leave to avoid the policy's harsh effects.¹³⁶ Indeed, we often hear people who favor tough immigration policies as distinguishing themselves as being against "illegal immigration," not anti-immigrant, in order to emphasize the element of culpability among unauthorized immigrants that justifies differential and harsher treatment.¹³⁷

Ironically, in the political discourse, as well as in popular commentary, restrictionists often use health care as an example of society's compassion and fair treatment of even unauthorized immigrants. They often cite the fact that emergency care is provided to anyone, regardless of immigration status and ability to pay, and other exceptions written into PRWORA also support this narrative.¹³⁸ This narrative emerged during the 2008 presidential race, especially in the Republican primaries, where immigration was a critical issue. For example, Republican candidate Mike Huckabee seemed to be straddling a fine line between wanting to be viewed as "tough on illegal immigration," yet compassionate in supporting policies that do not punish or discourage immigrants in particularly vulnerable positions, such as victims of crime in need of police assistance or victims of an illness or injury requiring emergency care.¹³⁹

IV. DISCOURSE IN FAVOR OF EXPANDING ACCESS TO IMMIGRANTS

Arguments made in favor of expanding access to immigrants challenge the wisdom of benefit restrictions and corresponding enforcement measures on deterrence, distributive justice, and retribution grounds. Pro-access advocates argue that policies limiting immigrants' access to healthcare benefits do not influence immigration-related decisions, undermine public health as well as health financing goals, and are not morally justified. In doing this, they challenge the dominant narrative of immigrants as morally blameworthy, undeserving criminals, and welfare abusers, who threaten citizens' access to health care. They also try to show why benefit restrictions are unduly punitive measures fueled by "anti-immigrant" and racist sentiments rather than necessary, rational measures to protect citizens.

136. See generally *Political Ticker*, *supra* note 101 (comments posted).

137. See, e.g., Democracy Now!, Fact-Checking Dobbs: CNN Anchor Lou Dobbs Challenged on Immigration Issues, Dec. 4, 2007, http://www.democracynow.org/2007/12/4/fact_checking_dobbs_cnn_anchor_lou [hereinafter Fact-Checking Dobbs].

138. See, e.g., Costich, *supra* note 20.

139. See generally Mike Huckabee for President, Issues: Immigration, http://www.mikehuckabee.com/?FuseAction=Issues.View&Issue_id=4 (last visited April 7, 2008).

A. Challenging Deterrence Links

A number of studies, as well as anecdotal evidence, undermine the asserted link between benefits availability and immigration decisions. Pro-access advocates always begin by noting that for years the data has shown that employment, not public benefit, is the primary motivator for illegal immigration or overstays.¹⁴⁰ No correlation has been shown in the rate of immigration and narrowing of benefits eligibility; illegal immigration has continued to grow despite the state and federal trend toward greater restrictions and stepped up enforcement over the last decade.¹⁴¹

To counter the picture of the immigrant lured here by the prospect of getting public benefits, critics of health policy exclusions offer a competing narrative of immigrants as self-reliant and less likely than citizens to seek public benefits, even those to which they may be entitled. They criticize statistics about the number of immigrant families on public assistance as painting a misleading and very narrow picture of immigrants' use of public resources. For example, a demographer at the University of Southern California who has studied immigrants' use of public services found no evidence of large scale use of public benefits by unauthorized immigrants.¹⁴² In fact, statistics show that immigrants tend to underutilize public benefits and generally have a net positive effect on the economy.¹⁴³

Considering the link between immigration and health care specifically reveals an even weaker case for deterrence justifications. A direct connection between health care access and decisions to immigrate usually is not and cannot be made for two reasons. The first is inherent in the healthcare market: health care tends to be given a much lower priority than

140. See Johnson, *supra* note 35, at 1513; Costich, *supra* note 20, at 1044-45 ("Population-based research indicates [that] government-sponsored services are so far down the list of reasons for immigration to the U.S. that they scarcely arise at all.").

141. See Johnson, *supra* note 35, at 1513; Costich, *supra* note 20, at 1044-45; *Immigration at Record Level*, *supra* note 23; Pew Hispanic Center, Fact Sheet: Indicators of Recent Migration Flows from Mexico, May 30, 2006, <http://pewhispanic.org/files/factsheets/33.pdf> ("Overall migration flows to the U.S. – the number of foreign-born coming to live in the U.S. – surged at the end of the 1990s, peaked in 2000 and then fell off by more than a quarter following the 2001 recession and the slow recovery of the U.S. labor market. The size of migration flows then began to increase again in 2004.").

142. See *Immigration at Record Level*, *supra* note 23 (citing research showing that unauthorized immigrants underutilized the healthcare system, including emergency room services and public primary care).

143. See, e.g., Robert Pear, *White House Report Lauds Immigrants' Positive Effects*, N.Y. TIMES, June 20, 2007, at A17 (noting that the President's Council of Economic Advisers recently reported that immigrants have "a positive effect on the American economy as a whole [because] in the long run they pay more in taxes than they consume in benefits." The report also found "small negative effects" on the wages of the least-skilled American workers and acknowledged that "the positive fiscal impact tends to accrue at the federal level, while net costs tend to be concentrated at the state and local level.").

employment, which is necessary for food and shelter, especially by people suffering from severe economic circumstances.¹⁴⁴ The second reason is that the type of health care complained about often is unanticipated emergency health care.¹⁴⁵ Even the “anchor baby” claim used by the Texas legislators to fight healthcare coverage for children of illegal immigrants is undermined by the Texas Hospital Association’s own policy director who admits that “most illegal immigrants who go to major hospitals in Texas can show that they have been living here for years.”¹⁴⁶

Pro-access arguments that public health benefits are not a motivating factor for immigrants are also supported by the data on immigrants’ use of health services. Studies show that immigrants, especially unauthorized immigrants, underutilize healthcare benefits.¹⁴⁷ Even legal immigrants and children of immigrants entitled to care tend to underutilize the healthcare system as a result of immigration-related benefit restrictions and enforcement policies.¹⁴⁸ Moreover, some data suggests that immigrants are much more likely to pay for their health care than citizens in many cases, undermining the view of immigrants as welfare abusers.¹⁴⁹ For example, although there are many reasons why immigrants may have trouble getting insurance and may need to rely on public benefits or assistance initially,

144. See generally ABRAHAM *supra* note 113; Costich, *supra* note 20.

145. See, e.g., *Political Ticker*, *supra* note 101 (a number of comments describe concerns about overcrowded emergency rooms). See also *Texas Hospitals’*, *supra* note 12; *Immigration at Record Level*, *supra* note 23.

146. See *Texas Hospitals’*, *supra* note 12.

147. *Immigration at Record Level*, *supra* note 23 (field research by a professor at University of California – San Diego showed that “illegal immigrants from Latin America are far less likely than American Hispanics to use emergency room services or seek public primary care”). See Fuchs, *supra* note 27 (describing the intimidation factor of current laws restricting immigrant access that makes immigrant parents afraid to go to the clinic to get their children immunized for fear of having to show immigration papers); Bernstein, *supra* note 15 (“Immigrants have long been on the fringes of medical care. But in the last decade and especially since the terrorist attacks of Sept. 11, 2001, steps to include them have faltered in a political climate increasingly hostile to those who face barriers of language, cost and fear of penalties like deportation, say immigrant health experts, providers, and patients. More and more immigrants are delaying care or retreating into a parallel universe of bootleg remedies and unlicensed practitioners”); Mary Engel, *Study Finds Immigrants’ Use of Healthcare System Lower Than Expected*, L.A. TIMES, Nov. 27, 2007, at B1.

148. See Costich, *supra* note 20, at 1060 (noting that this underutilization is because many immigrants, while here legally, are often part of “mixed” families comprised of persons of illegal or uncertain status, and they worry that seeking benefits will expose undocumented family members to scrutiny or jeopardize the legal status of immigrants in need of public benefits and could ultimately lead to deportation). See also *Recourse Grows Slim for Immigrants*, *supra* note 25 (noting that legal immigrants fear that public medical insurance will hurt their chances for citizenship, bar relatives from coming or break up their families, and that visits to the emergency room could result in deportation).

149. See *Immigration at Record Level*, *supra* note 23; *Texas Hospitals’*, *supra* note 12 (quoting administrators at the Dallas and Fort Worth hospitals who said that immigrants have a better record of paying their bills than low-income Americans).

data suggests that this reliance tends to be temporary and that “within a decade, new immigrants in California moved up quickly to steadier jobs with more benefits, and the rates of uninsured immigrants dropped sharply.”¹⁵⁰

All of this underlying-motivation data is consistent with a trend that many scholars and immigrants’ rights groups have found to result from increased restrictions and stepped-up immigration enforcement. Illegal immigration continues and has even grown, despite the recent laws that make it increasingly difficult for unauthorized immigrants to live in the United States.¹⁵¹ Illegal immigrants are still crossing the border, and they literally live as outlaws in hiding because these restrictionist policies have made life much harder for them. Many flock to urban areas where they can more easily “disappear” or blend in to society, while those in less urban areas try to avoid contact with others as much as possible.¹⁵² These laws may deter immigrants from seeking certain kinds of benefits and keep them segregated in society, but they do not deter immigration decisions and they cannot deter immigrants’ need for care for injury or illness that is beyond their control.

B. Flaws in Distributive Justice Claims

Health and legal advocates who criticize benefit restrictions do so primarily on the ground that they do more to harm us than protect us. They criticize as too simplistic the paradigm of health care as an economic good that can be preserved by narrowing coverage.¹⁵³ Concern with dwindling public benefits only makes sense to the extent that we worry about those dwindling resources jeopardizing our access to care and thus our health status. Health care is a public good, however, in the sense that the benefits of healthcare resource decisions cannot simply be restricted to a particular individual receiving services, but rather, it is dispersed nationally. Denying certain groups access to health care can have deleterious economic, health, and psychic effects on the public generally, and thus changes the cost-benefit analysis of providing health care to immigrants.

Essentially, pro-access advocates focus on showing how policies purportedly aimed at unauthorized immigrants or other excluded immigrants actually affect *citizens* negatively. The most common and compelling arguments center around public health and the importance of

150. See *Immigration at Record Level*, *supra* note 23.

151. See Julia Preston, *Facing Deportation but Clinging to Life in the U.S.*, N.Y. TIMES, Jan. 18, 2008, at A14.

152. See *id.*

153. See generally Costich, *supra* note 20; Seam Park, *Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change*, 18 GEO. IMMIGR. L.J. 567 (2004); Mahmoudzadeh, *supra* note 97.

ensuring that everyone, regardless of status, can be diagnosed and treated for communicable diseases.¹⁵⁴ Tuberculosis (“TB”) is one of the diseases most often listed as an example of the importance of these measures, with pro-access advocates providing statistics regarding the prevalence of TB, especially in countries from which large numbers of immigrants come each year.¹⁵⁵ Pro-access arguments highlight the significance of these public health consequences by noting that many of the unauthorized immigrants work in industries producing and preparing food for consumption by citizens.¹⁵⁶

Even restrictionists agree that this is a public health concern and state and federal legislation has carved out exceptions precisely for this kind of treatment.¹⁵⁷ The problem is that the broader policy exclusions coupled with heightened scrutiny and reporting of status have created a general climate of hostility that makes unauthorized and legal immigrants afraid to seek any care, even that to which they are legally entitled. This discourages immigrants from seeking care in time to be diagnosed and prevent exposure of communicable diseases to others.¹⁵⁸ This is one of the most common examples of how using health policy as an immigration tool creates collateral effects which undermine public health needs.

Pro-access advocates commonly cite two other examples of how using health policies as an immigration tool directly impacts citizens’ health care in serious and imminent ways. One is the denial of prenatal care for both undocumented pregnant women and pregnant women living in the United States legally, but excluded from coverage under PRWORA.¹⁵⁹ Prenatal care is important not only for women’s health, but to ensure the health of the baby. Failure to get prenatal care can lead to babies being born with a

154. See, e.g., Costich, *supra* note 20, at 1058-59 (noting the high percentage of tuberculosis patients who are immigrants and the danger of prolonged periods of transmission by individuals who are afraid of seeking treatment in addition to an inability to afford the same).

155. See, e.g., *id* at 1059 (“A recent assessment of tuberculosis among foreign-born persons in the U.S. found that 41.6% of U.S. cases in 1998 occurred in immigrants, and that the case rate per 100,000 persons was more than five times as high in foreign-born as in U.S.-born residents. However other investigators have noted the substantial presence of tuberculosis in the undocumented population and their recourse to treatment strategies that allow the patient to avoid contact with the health care system.”).

156. See, e.g., Park, *supra* note 153, at 579. See also Mahmoudzadeh, *supra* note 97, at 494.

157. See 8 U.S.C. § 1611(b)(1)(C) (2001). See also 8 U.S.C. § 1613(c)(2)(E) (2001).

158. See Costich, *supra* note 20, at 1060; Fuchs, *supra* note 27 (parents afraid to get immunizations for kids because hospitals told to ask about status); *Payments to Help Hospitals*, *supra* note 50 (asking technical questions about immigration status will discourage immigrants from seeking care).

159. See, e.g., Costich, *supra* note 20, at 1061-63.

variety of health problems.¹⁶⁰ Given that the babies will be born in the United States, they qualify as citizens, and if they are uninsured, they fit within the category of people considered most in need and deserving of public health care. It is counterproductive to deny care and thereby increase the likelihood of harm. Again, policies purportedly aimed at immigrants create a direct health threat to citizens' health.

A more recent example of how U.S. citizens are harmed directly is in the heightened documentation requirements for citizenship. This proof requirement applies to citizens who are eligible for Medicaid, making it more difficult for them to prove eligibility.¹⁶¹ Heightened requirements were justified, however, on the ground that they were necessary to prevent fraud by ineligible immigrants trying to steal Medicaid benefits.¹⁶² Yet, since implementation, a number of government reports and private studies have found that these requirements have resulted in delays in care for citizens who had trouble getting the necessary documentation.¹⁶³ One study also found that these delays have caused a loss in funding for certain healthcare providers, jeopardizing their ability to provide needed services for all patients.¹⁶⁴

160. See Johnson, *supra* note 35 (discussing estimated cost of denial of prenatal care under Proposition 187); Costich, *supra* note 20, at 1061.

161. Ctrs. for Medicaid & Medicare Servs., Documentation of Citizenship for Medicaid, <http://www.cms.hhs.gov/MedicaidEligibility/downloads/citdocoutreachtoolkit.pdf> (last visited March 30, 2008).

162. See *supra* Part I.B.2.

163. See Donna Cohen Ross, *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show: Rule Mostly Hurts U.S. Citizen Children, Not Undocumented Immigrants*, Ctrs. on Budget & Policy Priorities, July 10, 2007, <http://www.cbpp.org/7-10-07health.pdf> (data from Alabama, Kansas, and Virginia shows that white and African-American children are much more likely than Hispanic children to have Medicaid coverage delayed, denied, or terminated as a result of this new requirement). See also PETER SHIN ET AL., GEORGE WASHINGTON UNIV. SCH. OF PUB. HEALTH & HEALTH SERVS., DEP'T OF HEALTH POLICY, POLICY BRIEF: AN INITIAL ASSESSMENT OF THE EFFECTS OF MEDICAID DOCUMENTATION REQUIREMENTS ON HEALTH CENTERS AND THEIR PATIENTS (2007), http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/downloads/Medicaid_Doc_Requirements.pdf (describing the results from a random nationwide survey of 300 health centers that revealed several significant, harmful effects of the new documentation requirements, including, but not limited to, disruption in coverage, enrollment and application delay that impacts ability to arrange for specialty care, inpatient deliveries for pregnant women, and securing supplies and equipment.). See also Mike Mitka, *Proving Citizenship Difficult*, 298 JAMA 1153 (Sept. 12, 2007) (citing conclusions from the Government Accountability Office ("GAO") and a House committee's majority staff that "22 [out of 44] states reported declines in Medicaid enrollment due to the documentation requirement, with the majority of these states attributing the decreases to delays or losses of Medicaid coverage for those who appeared to be eligible citizens"); Robert Pear, *Medicaid Hurdles for Immigrants May Hurt Others*, N.Y. TIMES, Apr. 16, 2006, at A1 [hereinafter *Medicaid Hurdles for Immigrants*].

164. See SHIN ET AL., *supra* note 163, at 4 (finding that the documentation requirements will "eliminate Medicaid coverage for between 2.2 and 6.7 percent of Medicaid-enrolled

These negative effects are particularly troublesome in light of the fact that the law does not seem to be serving its purpose. Its main purpose was to generate cost savings by preventing fraud, but there was never any widespread evidence of fraud, and data shows that the cost of enforcement has far outweighed any savings.¹⁶⁵ Denying access for prevention and treatment of nonemergency conditions costs more in the long run, because healthcare problems are allowed to worsen to the point that more expensive treatment, likely in the emergency room, is ultimately required. For example, chronic conditions such as asthma, diabetes, and blood pressure are cheaper to treat earlier, rather than waiting until the moment an emergency develops.¹⁶⁶ Prenatal care is also dramatically cheaper than the cost of hospitalization and other services necessary for children born with preventable disabilities and serious health conditions.¹⁶⁷ Ironically, the picture presented by restrictionists about the significant cost of emergency care for unauthorized immigrants supports arguments in favor of expanded access to preventative health care.

C. Undermining Notions of Choice and Blameworthiness

As noted above, critics have challenged restrictionists' claims that benefit exclusions protect us by exposing flaws in the deterrence and distributive justice arguments. As the link between healthcare restrictions and deterrence or distributive justice goals become more tenuous, the punitive character of these exclusions grows. This trend makes claims of moral culpability and blameworthiness much more important in justifying such restrictions, and many pro-access advocates vigorously challenge these claims.

Pro-access advocates essentially make three key arguments. The first highlights the disconnect between the rhetoric used to justify immigrant exclusions and the actual linedrawing done in these laws. While the

pediatric and adult patients," and "translate into an immediate financial loss of between [twenty-eight] and [eighty-five] million [dollars] in Medicaid revenues" that lead to service and staffing reductions).

165. See Ross, *supra* note 163 (several recent reports and studies have confirmed what many providers and health advocates predicted: heightened citizenship requirements cost the public more money to enforce than they save by preventing ineligible immigrants from fraudulently stealing benefits).

166. See Costich, *supra* note 20, 1059-62.

167. See, e.g., *id.* at 1061 (noting that the Second Circuit upheld a law denying prenatal care to undocumented immigrant women despite evidence by the N.Y. State Dep't of Health that the costs of furnishing prenatal care for the more than 13,000 annual births to undocumented pregnant women in New York would be almost completely recouped by the savings from the decrease in initial postnatal hospitalizations, let alone the vast savings from not having to pay to treat lifetime health problems likely to result from denial of prenatal care).

political and popular rhetoric focuses on unauthorized immigrants, especially those from Mexico and Central America who cross the border illegally, federal law also excludes many legal immigrants and immigrants whose status may be uncertain for legitimate reasons. While society and immigration law may label people who become public charges as “undesirable,” this is clearly not an act deserving of moral approbation in light of the gaps in our current healthcare financing system and lack of options for affordable health insurance.

One of the most visible and common examples of this is the fight to eliminate the current five-year waiting period for Medicaid benefits for children and pregnant women who are legal immigrants and to expand State Children Health Insurance Program (“SCHIP”) eligibility for immigrant children.¹⁶⁸ Exclusions of legal immigrant children presents perhaps the strongest examples of how immigrant-specific barriers harm those who are completely vulnerable and innocent, and thus cannot be justified on retributive grounds. At one point, exclusions that would have harmed persons with disabilities and dependents on public benefits (receiving Supplemental Security Income (“SSI”)) were also considered controversial because they were viewed as unfairly penalizing law-abiding immigrants for circumstances beyond their control.¹⁶⁹ In that case, however, advocates were able to successfully resist original PRWORA provisions that would have eliminated SSI payments to legally permanent residents altogether.¹⁷⁰

Immigration rights’ groups make a more general argument. Despite the rhetorical and political trend toward criminalizing unauthorized immigrants, advocates argue that an immigrant’s status as “illegal” should not necessarily be considered an act deserving of punishment as would a person’s violation of a criminal law.¹⁷¹ The dominant paradigm for

168. See, e.g., National Council of La Raza, *supra* note 82 (challenging federal exclusion and five-year waiting period for legal immigrants from public health benefits); Press Release, Hillary Rodham Clinton, Senators Clinton and Snowe Introduce Legislation to Expand Access to Healthcare for Legal Immigrant Children (Mar. 5, 2007) <http://clinton.senate.gov/news/statements/details.cfm?id=270120> (describing legislation to eliminate the five-year ban on access to health care benefits for legal immigrant children and pregnant women).

169. See Costich, *supra* note 20, at 1050-51 (“Under PRWORA, SSI payments to legal immigrants would have been terminated. The apparent motivation for this action was the perception that naturalized citizens were bringing their frail elderly parents to the U.S. so as to enroll them in government-sponsored benefits.”).

170. See *id.* (“A widespread expression of outrage at the harm done to these highly vulnerable persons led to the inclusion of less harsh provisions in the Balanced Budget Act of 1997. PRWORA was amended to allow immigrants to remain on SSI if they were receiving SSI on or before August 22, 1996, and remained otherwise eligible.”).

171. See, e.g., Park, *supra* note 153; Mahmouzdadeh, *supra* note 97; Sonal Ambegaokar, Health Policy Attorney, National Immigration Law Center, Address at the Loyola University Chicago School of Law Beazley Symposium on Access to Healthcare (Feb. 8, 2008).

immigration enforcement was initially a civil regulatory model, not criminal¹⁷² and immigration officials have repeatedly insisted that deportation proceedings and detention of undocumented immigrants are civil in nature, not criminal.¹⁷³

Moreover, external socioeconomic factors, as well as internal flaws in our immigration system, undermine the link between status and blameworthiness or moral culpability. Immigrants' rights groups highlight the nuances in status that exist due in large part to a broken administrative system that leaves many immigrants who want to or try to follow the law in immigration limbo.¹⁷⁴ They also highlight the economic disparity between the United States and Mexico and tight U.S. restrictions on the legal entry of workers, which create significant incentives for illegal immigration from Mexico.¹⁷⁵ The willingness of these immigrants to attempt crossing the border illegally and under increasingly dangerous conditions undermines the picture of "free choice." Rather, the hundreds of unauthorized immigrants that have died each year attempting to enter the United States suggest that immigrants view the decision to come to here as a choice about survival.¹⁷⁶

The third argument made by pro-access advocates highlights the severe health and collateral effects of benefit exclusions and heightened enforcement mechanisms. Limiting Medicaid benefits, which can only be used for medically necessary health care, has direct and significant health implications for immigrants who may be afraid to seek emergency care or

172. See Legomsky, *supra* note 83, at 469, 476 (describing how "the trend has been to import criminal justice norms into a domain built upon a theory of civil regulation" and that "[i]n the past [] civil "removal" proceedings were the principal mechanism for enforcing the immigration laws."). Nonetheless, many scholars have noted the trend of "criminalizing" immigration violations by criminalizing many immigration-related offenses and focusing attention on prosecuting these crimes. See generally *id.*; Miller, *supra* note 83; Stumpf, *supra* note 83

173. See Legomsky, *supra* note 83, at 475-76 ("For more than a century, however, the courts have uniformly insisted that deportation is not punishment and that, therefore, the criminal procedural safeguards do not apply in deportation proceedings." This insistence certainly seems due in part to the government's attempt to avoid certain protections that ordinarily attach to criminal detentions.).

174. See, e.g., National Immigration Law Center, *Groups Sue to Stop Excessive Citizenship Delays*, Dec. 4, 2007, <http://www.nilc.org/immlawpolicy/natzcitship/nc044.htm> [hereinafter *Groups Sue*].

175. See Howard F. Chang, *Cultural Communities in a Global Labor Market: Immigration Restrictions as Residential Segregation* (Univ. of Pa. Inst. for Law & Econ. Research Paper No. 05-14, presented at 2007 Univ. of Chi. Legal Forum), available at <http://ssrn.com/abstract=770484>. See also Kevin R. Johnson, *Open Borders?*, 51 UCLA L. REV. 193, 243 (2003) [hereinafter *Open Borders*] ("Military-style operations on the Southwest border have channeled immigrants into remote, desolate locations where thousands have died agonizing deaths from heat, cold, and thirst.").

176. See Howard F. Chang, *supra* note 175, at 96; *Open Borders*, *supra* note 175, at 243.

other care to which they are legally entitled. Even immigrants in detention centers are entitled to medically necessary care.¹⁷⁷ Forcing immigrants to undergo unnecessary physical suffering is an unfair punishment for a criminal law violation, let alone a civil one. The harsh effects of benefit restrictions result in large part from the retributive nature of these laws and the powerful reverberations this punitive message has at all healthcare access points for immigrants and Hispanic citizens.¹⁷⁸

It is clear that once immigration control is linked to health care access, fear of deportation will cause some immigrants to avoid seeking care. However, a more amorphous harm is the extent to which these policies embolden some healthcare actors to discriminate against immigrants and even Hispanic citizens in violation of civil rights laws.¹⁷⁹ Three examples of this were given at the beginning of this article: the hospital using security guards dressed in uniforms resembling U.S. Border Patrol agents, hospitals refusing to provide epidurals to non-English speaking women, and hospital officials questioning Hispanic patients immediately about their immigration status upon entering the hospital.¹⁸⁰ The first two were cited as civil rights violations by the U.S. Office of Civil Rights, while the third has not been expressly prohibited by federal law unless it would delay screening and treatment for an emergency medical condition.¹⁸¹

These kinds of acts designed to discourage immigrants from seeking health care are more likely to occur because the punitive message that strikes fear in immigrants also sends a message to the rest of society. This message devalues immigrants and paints them as criminals deserving of punishment, which encourages anti-immigrant, anti-Mexican sentiment that, in turn, leads to increased discrimination and profiling. It also heightens immigrants' vulnerability in society and contributes to the perception of immigrants as living as outlaws in hiding. As a result, immigrants are easier targets for discrimination as they fear the exposure necessary to fight against that discrimination. Thus, despite claims that "compassionate" exceptions are carved out in the law for certain immigrants, the punitive character of benefit restrictions generally overshadow these exceptions in spirit and in fact.

177. See *supra* Part I.

178. See Costich, *supra* note 20, at 1060 (describing the severe chilling effects on public health access for immigrants of California's Proposition 187, despite the fact that it was not enforced due to legal challenges).

179. See Orde F. Kittrie, *Federalism, Deportation, and Crime Victims Afraid to Call the Police*, 91 IOWA L. REV. 1449, 1450 (2006) ("The 'shadow population' of unauthorized aliens that Justice Brennan remarked upon in 1982 has remained vulnerable to abuse, exploitation, and callous neglect.").

180. See *supra* notes 11-13.

181. See *supra* notes 11-13.

V. EFFECTS OF HEALTH CARE DISCOURSE ON THE IMMIGRANT NARRATIVE

Proponents of benefit restrictions tell a story that clearly reinforces an “Us-Them” dichotomy and the dominant immigrant narrative in immigration discourse. Immigrants who are here illegally are viewed as having a parasitic and unhealthy relationship with the United States. They are viewed as criminals, who steal public money from vulnerable and morally deserving citizens and who consequently threaten citizens’ health and safety. Immigrants here legally are not as visible in this picture. They are usually lumped in with undocumented immigrants, probably because they are also viewed as welfare abusers who are violating the social contract that demands self-sufficiency and are threatening the availability of resources for citizens, who are viewed as having a stronger moral and legal claim to public benefits.

The dominant narrative also tells a story about “us” as American citizens. Essentially, the following picture is painted: the United States is acting out of necessity to preserve resources and protect the health and welfare of its citizens. To the extent immigrants suffer from our laws and policies, our policies are morally justified because we are endangered by the choice of unauthorized immigrants to stay in the United States. Finally, we actually treat immigrants, even unauthorized immigrants, with empathy and beneficence by creating certain exceptions granting them health care access in extremely vulnerable situations where they have no control, such as for emergency care, care for immigrants seeking asylum, or victims of domestic violence.

At one level, pro-access rhetoric seeks to challenge the dominant narrative by painting a very different picture of immigrants excluded from the U.S. healthcare system. However, a closer look shows that some of this rhetoric unintentionally reinforces the dominant picture of immigrants and refines the narrative of our motivations in ways that could potentially undermine the pro-access advocates’ rhetorical, political, and legal goals.

A. Immigrants: Iconic Victims or Vectors of Disease?

Essentially, through the pro-access discourse, critics attempt to challenge much of the dominant narrative by cultivating the picture of immigrants as a vulnerable group that, despite their many contributions to our economy, live in fear and under dangerous conditions. Immigrants are afraid to use a healthcare system perceived as a hostile, de facto agent of immigration authorities, even when they are legally entitled to care. Many of these immigrants represent innocent people falling through the gaps of a labyrinthine and backlogged immigration system and a so-called healthcare safety net with massive holes. Immigrants whose status is legal or uncertain, as well as immigrant and citizen children are among those

affected. Benefit restrictions coupled with heightened enforcement and data collection by hospital officials create a system in which many immigrants are being victimized through fear, racial profiling, and denial of care when they are most in need.

The ability to transform the dominant narrative, however, is constrained by arguments challenging benefit restrictions along distributive justice grounds. These arguments assert that, rather than protecting citizens, such restrictions harm citizens by erecting additional barriers to care, further straining our healthcare resources, and creating a public health danger. Denial of access for some groups can also harm the rest of society directly or indirectly. This line of rhetoric, especially the paradigm of health care as a public good, seems designed to create a picture of everyone (citizens and noncitizens) being interconnected in significant ways that challenge the “Us-Them” dichotomy. However, this narrative also can be seen as having serious negative effects, reinforcing part of the dominant paradigm used to justify benefit restrictions.

The most obvious rhetorical effect is that it can feed into the narrative of the dangerous immigrant who threatens citizens’ economic and physical security. This is probably clearest in the public health justification used to challenge benefit restrictions. Health and legal advocates, as well as law reviews, consistently begin with this fear-based argument: a fear of what will happen if we do not encourage access.¹⁸² Indeed, the few law review pieces that focus on healthcare restrictions for immigrants often begin with some dire warning that fuels this fear.¹⁸³ This is also present in claims about dwindling economic resources and the indirect financial consequences of denying immigrants’ care. People on both sides of the debate frequently discuss threats to our current healthcare resources, encouraging the public’s fear of growing use of emergency services by immigrants and other uninsured.¹⁸⁴ Both seem to use the public’s fear to shape policy; the difference, however, is that pro-access advocates offer a different solution to this crisis that requires expanded access to health care.

Playing into these fears of dwindling resources can unfortunately reinforce the “Us-Them” dichotomy by determining our treatment of immigrants based on what we want for ourselves—not based on ethical or moral norms about how they should be treated. This is reminiscent of the justifications first used to provide health care to slaves and then newly freed blacks. The first system of “managed care” was health care provided to

182. See generally Costich, *supra* note 20, at 1043; Park, *supra* note 153, at 569; Cindy Chang, *supra* note 65, at 1283-84.

183. See Costich, *supra* note 20, at 1043; Park, *supra* note 153, at 569; Cindy Chang, *supra* note 65, at 1283-84.

184. See *supra* Parts III & IV.

slaves by plantation owners to ensure their continued productivity.¹⁸⁵ Once free, blacks were still largely excluded from the healthcare system until physicians successfully argued that this created a public health danger to whites—especially in the area of communicable diseases.¹⁸⁶ In *Health Care Divided: Race and Healing a Nation*, David Barton Smith criticized this approach on several grounds, noting that this essentially reduced blacks merely to “vectors of disease” that needed to be cleansed and made safe for others.¹⁸⁷ This “vectors of disease” rationale is most visible in public health justifications that highlight the incidence of communicable diseases among immigrants and the risk posed by discouraging them from seeking care.¹⁸⁸

This image is also reflected in arguments for prenatal care for immigrants. The focus is on the citizen children who will eventually be born—again a morally and politically acceptable position in light of the vulnerability of citizen children who should not be punished for their parents’ bad acts. Thus the image of immigrant women’s bodies as vessels for delivering healthy citizens is the one used to justify greater access to care—the ends, healthy newborn citizens, justify the means, health care for noncitizens.

Finally, this dehumanizing image pervades criticism of heightened documentation requirements, which focuses on how these policies hurt citizens. Consider the titles of reports and articles criticizing new citizenship documentation requirements: “Medicaid Hurdles for Immigrants May Hurt Others”¹⁸⁹ or “Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New State Data Show: Rule Mostly Hurts U.S. Citizen Children, Not Undocumented Immigrants.”¹⁹⁰ These titles implicitly acknowledge that harming undocumented immigrants, and even Hispanic citizens, might be acceptable to some, but emphasizing harm to non-Hispanic citizens might cause enough public outrage to force legislators to reconsider these requirements. The soundness of immigration-related initiatives is measured using a cost-benefit analysis of the harm to citizens, not to immigrants.

To understand the danger of the unintended effect of the pro-access narrative, consider how some restrictionists have adapted and used the image of immigrants as vectors of disease.¹⁹¹ Popular media commentators

185. SMITH, *supra* note 113, at 11-12.

186. *See id.* at 21-24.

187. *See id.*

188. *See supra* Part IV.

189. *Medicaid Hurdles for Immigrants*, *supra* note 163.

190. Ross, *supra* note 163, at 1.

191. Costich, *supra* note 20, at 1058 (“U.S. immigration policy has traditionally associated immigrants with ‘germs,’ and any discussion that touches on this topic must be carefully constructed to avoid fostering the xenophobia that appears to animate immigration

like Lou Dobbs, who hosts the nightly newscast “Lou Dobbs Tonight” on the cable television station CNN, fuel a fear of immigrants that in turn generates support for harsher immigration initiatives.¹⁹² Lou Dobbs has used his CNN program to help make immigration one of the most discussed issues of the 2008 campaign, resulting in others labeling him as “the most influential spokesperson for the anti-immigration movement,” and accusing him of being “a fearmonger who vilifies immigrants and promotes xenophobia.”¹⁹³ In fact, Dobbs recently appeared on the radio show Democracy Now to answer these accusations.¹⁹⁴ Lou Dobbs’ motives and methods were challenged by examining one of his shows where he discussed communicable diseases among unauthorized immigrants, such as tuberculosis, leprosy, and malaria.¹⁹⁵ One of Dobbs’ guests grossly misstated the numbers of the actual incidence of leprosy¹⁹⁶ and then Dobbs claimed these numbers were linked to “two basic influences: unscreened illegal immigrants coming into this country primarily from South Asia, and better reporting.”¹⁹⁷ Indeed, one of the guests on Dobbs’ show was supposedly a medical attorney who described undocumented immigrants as “deadly time bombs, because of the diseases they bring into the country.”¹⁹⁸

B. Fortifying Citizenship Boundaries and Potential Illegality

As discussed in Part IV, immigrants’ rights groups challenge the use of immigration “status” as a moral or sound legal basis for determining benefits eligibility in several respects. They call attention to the fact that many immigrants’ status may be uncertain for a number of legitimate reasons, especially for those who come here legally and whose status is

legislation in other areas.”).

192. See Fact-Checking Dobbs, *supra* note 137 (referencing a website column that described how CNN anchor Lou Dobbs “may be the most important person in the 2008 presidential election aside from the candidates themselves” and that “[t]he bundle of concerns that Dobbs and his audience have about globalization, trade, diminished American sovereignty and immigration will be ignored by politicians at their own peril.”).

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.*

197. See Fact-Checking Dobbs, *supra* note 137 (quoting to a clip of another interview of Lou Dobbs by 60 Minutes, also questioning the use of his statistics and inaccurate facts in his immigration discussion. In fact, when these statistics were first questioned, Dobbs insisted that his staff had verified the numbers and repeated them on his show).

198. See *id.* (It was later discovered that some of the qualifications and background of this guest were suspect. However, she had previously made public statements using extreme racist generalizations about Mexican men’s criminal tendencies and sanity that should have caused a reasonable person to check her background more closely in advance of the show).

later questioned.¹⁹⁹ Even those who come illegally and fleeing persecution are may be in limbo until a formal determination of status can be made.²⁰⁰ Thus, moral stigma should not automatically attach to “nonlegal” status, especially for the purpose of restricting important health services. They also highlight the social factors and economic disparity that can “encourage” illegal immigration and undermine the dominant picture of immigrants as simply making a legal and moral choice to leave or stay.²⁰¹

While laudable, both of these approaches can also backfire and have unintended deleterious effects. Arguing that immigration status should be irrelevant as a normative principle because of socioeconomic and systemic factors that undermine immigrants’ choice and blameworthiness can also feed into fears about immigrants as parasitic and threats to our healthcare resources. While many people will sincerely claim sympathy for immigrants’ plight in the abstract, the moment they are viewed as potential public charges coming here to compete with citizens for scarce resources, the fear and mistrust created under the dominant narrative is triggered.

Second, emphasizing the fluidity and ambiguity of immigrants’ status may lead to greater suspicion of all immigrants and strengthen ideological linedrawing between citizens and noncitizens. Rather than generating sympathy or a more accepting profile for immigrants as more deserving of societal benefits, emphasizing this immigration limbo can create a picture of immigrants who are perpetually in danger of becoming “illegal” or violating the social contract not to become a public charge. In other words, fluidity can simply feed into present fears about immigrants’ as potential criminals or untrustworthy. This fortifies the line drawn between citizen and immigrant—with immigrant constantly being labeled as “other,” “unknown,” and “foreign.” Indeed, this is already evidenced through legislative narrowing of benefits for immigrants whose status is uncertain.

Finally, focusing on the nuances of immigrants’ status, even in order to challenge the current restrictions, may validate the decision to use immigration status as a measure of who deserves nonemergency health care. By engaging in a debate about the nuances of this status and about why legal immigrants should be treated better than those of uncertain or unauthorized status, pro-access advocates are at least facially accepting the terms of the debate established by restrictionists that insist on linking immigrants’ moral and legal rights to immigration status.

199. See *infra* Part IV.C.

200. See *Groups Sue*, *supra* note 174.

201. JASON ACKLESON, IMMIGRATION POLICY: IN FOCUS, FENCING IN FAILURE: EFFECTIVE BORDER CONTROL IS NOT ACHIEVED BY BUILDING MORE FENCES 5 (April 2005), <http://www.immigrationpolicy.org/images/File/infocus/Fencing%20in%20Failure.pdf>.

C. Collateral Effects of Healthcare Restrictions: The “Alien Citizen”

Although pro-access arguments may have limited success in challenging the dominant profile of immigrants, it appears to be more successful in challenging the narrative about “us” and our motivations for enacting such policies. As noted earlier, the dominant narrative paints U.S. citizens as rational and beneficent.²⁰² However, critics challenge the dominant narrative about our motivations for restricting health care access. They have undermined the claim that such restrictions really protect us by exposing flaws in the deterrence and distributive justice arguments, revealing a motive which looks primarily retributive or punitive in nature. They challenge the story of moral culpability that we use to justify such punitive actions and highlight the especially important health, financial, and psychological harms such restrictions create. Finally, they show that the empathy apparently reflected in legislative exemptions providing health care in certain instances is not always borne out in practice. In fact, many advocates go further to characterize laws that exclude certain categories of immigrants as “unduly punitive, mean-spirited and at times racist.”²⁰³ Some of the more visible and outspoken proponents of such legislation have also been accused of intentionally racializing the debate and fueling irrational fear to garner support.²⁰⁴

To the extent we are willing to enact benefit restrictions on immigrants that endanger citizens’ health care and increase health care costs, distributive justice arguments look like pretext for acts that are primarily, if not exclusively, punitive in nature. The most ardent proponents who justify benefit restrictions in the name of protecting “us” against “them” seem willing to sacrifice “us” in order to punish “them.”²⁰⁵ Policies that harm a certain group of people based on problematic and unsubstantiated assumptions about their moral and legal status, and at one’s own expense, reflect precisely the kind of discrimination that is supposed to be prohibited.

Consequently, the collateral effects of many of these policies on citizens within certain ethnic groups reinforce claims that discriminatory motives

202. See discussion *supra* Part III.C.

203. See, e.g., National Council of La Raza, *supra* note 82 (quoting Janet Murguia, NCLR President and CEO, “No one is against security or enforcing the law. But it is an affront to all . . . that House Republicans are proposing laws that are strictly punitive, unduly restrictive, and a waste of taxpayer money. The House Republicans have overreached and are playing with people’s lives for political gain.”).

204. See *id.*

205. One recurring example of this given by those challenging benefit restrictions generally is the passage of Proposition 187 in California, which was ultimately struck down. E.g., TANYA BRODER, NAT’L IMMIGRATION LAW CTR., MOST STATE PROPOSALS TO RESTRICT BENEFITS FOR IMMIGRANTS FAILED IN 2005: MEASURES TARGETING IMMIGRANTS PROMISED FOR NEXT YEAR (Nov. 21, 2005), http://www.nilc.org/immspbs/sf_benefits/2005_anti-imm_proposals_article_112105.pdf.

are present. As Leti Volpp describes in her review of Mae Ngai's *Impossible Subjects*:

Presumptive illegality has not only shaped the experiences of those branded as 'illegal aliens.' Ngai traces how the presence of large illegal populations in certain communities has contributed to the construction of Asian and Latino communities in general as illegitimate, criminal, and unassimilable. These communities are peopled by what Ngai calls 'alien citizens,' persons who enjoy the formal status of citizenship as an immigration matter, but lack citizenship as a matter of identity.²⁰⁶

Immigrant rights' groups and healthcare advocates have described a general hostility and narrowing of access affecting not only legal immigrants and immigrants of uncertain status, but also Hispanic citizens.²⁰⁷ They are all grouped together as "perceived illegal immigrants" who threaten our economic and social stability.²⁰⁸ In the healthcare discourse, concerns about undocumented immigrants and benefits often turns into concerns about uninsured Latinos, used in a way that seems to implicitly assume illegal or questionable status.²⁰⁹ One stark example of this is the concern by restrictionists about "anchor babies" and policies proposed to deny them health care or make care more difficult to access.²¹⁰ These babies are labeled "alien citizens," because their citizenship (and healthcare coverage) is considered to be stolen; they are not treated as full fledged members of U.S. society.²¹¹

Again, while pro-access advocates highlight legitimate and serious concerns underlying the motives and effects of benefit restrictions, this approach also has its pitfalls. While this may accurately describe some restrictionists, it is very difficult to ascribe this intent to society as a whole. It is difficult to measure the degree to which racial animus or bias subconsciously influences popular opinion and causes people to give more weight to the intuitively appealing claim that restricting health care access for immigrants will preserve resources for citizens.²¹²

206. See Volpp, *supra* note 73, at 1597 (partially citing NGAI, *supra* note 73, at 2).

207. See Johnson, *supra* note 35 at 1534-35 (describing how some providers who use ethnic profiling to question the immigration status of anyone Hispanic).

208. *Id.*

209. See generally *Political Ticker*, *supra* note 101.

210. See, e.g., Posting of A. Rosario to <http://politicalticker.blogs.cnn.com/2007/09/17/clinton-health-plan-has-no-answers-for-undocumented-immigrants/> (Sept. 17, 2007, 21:40 EST) (complaining about "anchor babies").

211. See generally *Political Ticker*, *supra* note 101.

212. See Johnson, *supra* note 35, at 1536 ("In some instances, political efforts to limit benefits to noncitizens had little more than symbolic meaning, thereby suggesting that deeper more subtle social forces, including possibly racism and ethnocentrism, are at work. Proposition 187 may be properly viewed in this light.").

Moreover, while it may be impossible to establish a direct link between benefit restrictions and immigration deterrence, such laws may have an important expressive value that indirectly affects immigration. The most obvious claim made is that such laws communicate an important message of intolerance for illegal immigration. Making life difficult for immigrants here in every way signals less tolerance for unauthorized immigration that may actually discourage some people from coming or overstaying visas. Indeed we see such rhetoric in an article cited on the Center for Immigration Studies website, entitled “*The Undocumented Hesitate to Enter a Less-Alluring U.S.*”²¹³ The article describes how stepped-up enforcement against undocumented workers and growing intolerance of illegal immigration is causing some immigrants to tell others not to come.²¹⁴

Another example of significant expressive value is the internal communications between the state and federal governments.²¹⁵ State leaders are disadvantaged with respect to immigration reform because of federalism limits on states’ abilities to regulate in this area, yet they feel that they bear the brunt of the federal government’s failure to stop illegal immigration. Much of the political rhetoric and action surrounding immigrant health care is really about who should pay for that care (i.e. the federal government, state and local governments, or hospitals), about public shaming of the federal government for its failure to enact meaningful immigration or healthcare reform, and the federal government’s attempt to appease state concerns.

Finally, politicians use this narrative to communicate to the public generally that they care about the immigration issue. It seems to be a politically expedient way to address an issue that has stymied legislators. At the federal level, real immigration reform requires doing things that appear to be either impossible (e.g. securing the border to keep people from crossing illegally or creating a system capable of tracking and deporting everyone who overstays their visas) or too politically controversial (creating an amnesty or guest worker system that would facilitate a legal status for immigrants, primarily from Latin America). Benefit restrictions, on the other hand, can be accomplished simply with the stroke of a pen. Restricting public benefits for immigrants allows politicians to get political credit for

213. Marla Dickerson, *The Undocumented Hesitate to Enter a Less-Alluring U.S.*, L.A. TIMES, Dec. 26, 2007, <http://www.latimes.com/news/nationworld/world/la-fi-migrate26dec26,0,2042341,full.story>.

214. *Id.*

215. See, e.g., Johnson, *supra* note 35, at 1540-41.

trying to address illegal or undesirable immigration, while also addressing the domestic economic concerns.²¹⁶

While these considerations may not justify the effects of immigrant-specific restrictions, they do show that ascribing a particular motivation to such restrictions can be difficult and that in doing so, one risks alienating people who have genuine economic and health care concerns. Attaching these labels or motives to groups who view immigration status as a legitimate factor in linedrawing can also facilitate divisiveness between citizens and noncitizens that entrenches existing support for benefit restrictions and impedes momentum for broader healthcare reform.

VI. WHAT THE IMMIGRANT NARRATIVE TELLS US ABOUT OUR HEALTHCARE SYSTEM: THE MINER'S CANARY

The discourse surrounding immigrant health care has been primarily about the proper role of immigration status and its link to health policy decisions. It has centered around two critical questions: to what extent is health policy a legitimate or effective mechanism of immigration control, and to what extent do immigration status and immigration-related concerns serve or undermine important public policy concerns in allocating healthcare resources? This article has gone one step further to ask whether the immigrant health care narrative can or does influence health policy decisions.

Pro-access advocates' have attempted to construct a narrative that engenders empathy and minimizes the blaming and bias that encourages fear and mistrust of immigrants, which in turn fuels harsh immigration-related policies. They have also challenged the justification for benefit restrictions by describing health care as a public good for which benefit exclusions and heightened enforcement of eligibility hurts citizens and noncitizens alike. Nonetheless, immigration-related concerns continue to pervade health policy discourse and decision-making.

This begs the question—to what extent can the health policy concerns of pro-access advocates be meaningfully addressed by reconstructing the immigrant health care narrative?

Ironically, despite the preoccupation on both sides of the debate with this narrative, the answer is probably that changing this narrative will have very little effect on health care policies and on the lives of immigrants in our healthcare system. First, it is not clear that changing the immigrant health

216. See Costich, *supra* note 20, at 1048-49 (“In addition to ‘ending welfare as we know it,’ PRWORA had the goal of substantial reduction in the federal social service budget. In the context of public health, it is startling to learn that forty-four percent of the expected savings to the federal government from PRWORA would have resulted from cutting off services for post-enactment legal permanent residents.”).

narrative will result in the removal of immigration-based eligibility criteria or would necessarily bring about fairer or sounder health policy decisions. In fact, the rhetoric used to justify or challenge restrictions for immigrants is not that different from the rhetoric used to allocate resources among different groups of citizens. Indeed the nature of the restrictions and exceptions for immigrant health care largely mirror the same kind of barriers and linedrawing of citizens based on “moral desert,” a utilitarian, cost-benefit analysis, or some combination of both. Health care is not considered a human right to which everyone should have access. In fact, the federal government will only provide funding for certain categories of people, such as those who have contributed to the Social Security system long enough to be viewed as having a legitimate claim to benefits (Medicare coverage for the aged), those who have become particularly vulnerable and unable to care for themselves for reasons beyond their control (Medicare / Medicaid coverage for poor children and the disabled), the very poor parents of children and pregnant women because it is a cost-effective way to ensure healthy children (Medicaid/SCHIP), and people in need of care to deal with serious bodily harm and life-threatening illness or injury (such as laws requiring emergency care or funding dialysis treatment for those with end-stage renal disease).²¹⁷

Even if immigration-status was removed as an eligibility criterion, it would only potentially help immigrants who qualify under one of the designated eligibility categories, and even then, qualified immigrants still might not feel they can access care. We know this in part from data showing that immigrants forego care for themselves and their children, even when they are legally entitled to it.²¹⁸ Fears of becoming labeled a “public charge” or being deported have had a serious chilling effect that will not simply disappear with the elimination of immigration-based eligibility criteria. For example, even after the INS issued a policy stating that receipt of public benefits would not be used to label immigrants “public charges” subject to deportation, the fears and chilling effects persist.²¹⁹

Moreover, the elimination of status-based criteria would not guarantee access to care; it only removes one barrier among many affecting immigrants. Immigrants are vulnerable along a number of axes: delays in care and poor quality care are due to the intersection of immigration status, economics, ethnicity and race, as well as gender for women and transgender individuals. Immigration is certainly an added impediment to care, but it is not the only one.²²⁰ In fact, the racialization of certain types of immigrants,

217. See generally ABRAHAM, *supra* note 113; COHN, *supra* note 113.

218. See *supra* Part IV.B.

219. See OVERVIEW OF IMMIGRANT ELIGIBILITY, *supra* note 39, at 4.5-4.6.

220. See, e.g., Sam Roberts, *Immigrants in New York Better Off, Study Finds*, N.Y.

and the creation of a permanent class of “alien citizens” divorced from immigration status, reveals the entrenchment of discrimination that will not be easily eliminated by simply challenging the health policy-immigration link.

Challenging the narrative offers only limited success because of the inherent limitations and structural defects of our existing healthcare system. By engaging restrictionists’ on their terms and under the existing health care paradigm, pro-access advocates can unwittingly reinforce the “Us-Them” dichotomy that pervades health policy decision-making. Linedrawing within this paradigm will always pit immigrants against citizens, just as it pits different groups of citizens against each other. One could argue that while linedrawing based on immigration status is unfair and unsound for many reasons, it is not atypical or unusually cruel in light of a healthcare system that routinely draws lines based on flawed or irrational assumptions about who is “most deserving,” while excluding millions of others in need through no fault of their own.²²¹

This is not to suggest that the dominant immigrant narrative does not influence health policy discourse in ways that harm immigrants. Nor should we trivialize the unique and compounded effects of these benefit restrictions on immigrants, especially those impacted in multiple ways, such as immigrants with disabilities. What this article argues, however, is that the immigrant health care narrative is only one factor influencing policy decisions and discrimination at access points. Reconstructing the immigrant narrative or story to argue for greater access for immigrants will offer only limited success and, in some ways, could actually backfire and undermine the goals of immigrants’ rights groups and public health advocates.

This reconstruction of the “immigrant health care narrative” and the discourse surrounding benefit restrictions is very useful, however, for refining our understanding of the problem and suggesting more creative approaches to reforming health policy:

[L]ike the miner’s canary that uses a call of distress to the miner of warn the hazardous atmosphere in the mine, the critiques people of color offer

TIMES, Dec. 2, 2007, at B40 (describing the role of race and class in immigration policies: “[t]he narrower socioeconomic gaps between immigrants and native-born Americans in New York may be one reason that the state has generally been more receptive to foreigners.”). See also *Policy on State and Local Immigration*, *supra* note 25 (“[t]he implications for Latinos are vast and these measures create mistrust, fear, discrimination, and intolerance in communities.”).

221. See, e.g., Richardson, *supra* note 1 (describing San Diego’s struggle to provide health care to unauthorized immigrants when it does not even have a public hospital dedicated to serving indigent citizens).

our institutions are warning signals to alert us to the presence of more systemic problems. Instead of relegating the voices of minorities to the complaint category and relegating it as race-specific, we must look at those critiques as a reflection of what is not working in our institutions.²²²

Lani Guinier and Gerald Torres use this metaphor of the canary in the mine to suggest one important benefit of critiquing our institutions from an “outsider’s” perspective:

The canary is a source of information for all who care about the atmosphere in the mines – and a source of motivation for changing the mines to make them safer. The canary serves both a diagnostic and an innovative function. It offers us more than a critique of the way social goods are distributed. What the canary lets us see are the hierarchical arrangements of power and privilege that have naturalized this unequal distribution.²²³

To this end, the immigrant healthcare narrative provides a particularly compelling example of how our healthcare system is structured in ways that are inconsistent with notions of equality and fairness. The problem at its root is not unique to immigrants. Immigrant-specific discourse or advocacy thus will not solve the fundamental problems of immigrant access to care and can serve to reinforce, rather than challenge, the fundamental defects of our health care system. Rather than simply fighting for more rights for immigrants within an inherently flawed and inequitable healthcare system, we should use the immigrant experience to fuel fundamental reform of the existing system to ensure better access for everyone.

Viewing the problems of our healthcare system through the immigrant lens also presents opportunities for crafting more creative solutions. In particular, it should encourage partnerships between citizens and noncitizens in building coalitions to advocate for comprehensive health reform. Immigrant communities have demonstrated a robust and powerful commitment to grassroots organizing and mobilization to protest actions considered anti-immigrant, despite the fact that these communities are typically politically, economically and socially vulnerable. Recall the massive protests and community mobilization seen all over the United States by immigrant communities in response to the Sensenbrenner bill in

222. See Luz E. Herrera, *Challenging a Tradition of Exclusion: The History of an Unheard Story at Harvard Law School*, 5 HARV. LATINO L. REV. 51, 51 (2002) (citing to Professors Lani Guinier & Gerald Torres, *The Miner’s Canary: Methodology and Critique*, The Nathan I. Huggins Lectures, Harvard University (Apr. 19, 1999) and LANI GUINIER & GERALD TORRES, *THE MINER’S CANARY* (Harvard Univ. Press 2002)).

223. GUINIER & TORRES, *supra* note 222, at 259 (Harvard Univ. Press 2002).

March 2006.²²⁴ In her recent book, *Suburban Sweatshops*, Professor Jennifer Gordon also describes examples of successful mobilization by unauthorized immigrants, particularly vulnerable to discrimination and labor violations, to fight for labor reforms.²²⁵

Citizens and noncitizens should also view each other as coalition partners in the fight for health reform because they suffer many of the same burdens and effects under the current healthcare system. Given the multiple axes along which immigrants suffer discrimination: age, gender, disability status, race—this leads to multiple opportunities for coalition building and lines of advocacy for reforming the healthcare system in ways that may or may not be immigrant-specific, but that will ultimately benefit immigrants as well.²²⁶ While immigrant-specific exclusions affecting children and people with disabilities have led to partnerships between these respective groups, gaps in the existing healthcare system that exclude immigrants and citizens should encourage partnerships and advocacy aimed at more fundamental reforms. Involving immigrant communities and advocacy groups in this broader health reform movement could generate the kind of momentum and political will needed to change the system.²²⁷

Professors Kevin Johnson and Jennifer Gordon gives examples of these kinds of partnerships in other contexts: women's and immigrants' groups fighting for relaxation in the requirements of immigration marriage fraud laws;²²⁸ these same groups partnering to achieve greater recognition of gender-based persecution for purposes of asylum;²²⁹ immigrants working with lesbian and gay organizations to repeal legal provisions interpreted to

224. See, e.g., Interview with Abel Nunez, Associate Director of Centro Romero, in Chi., IL on DEMOCRACY NOW!, *Over 100,000 March in Chicago to Protest Immigration Reform Bill in One of Biggest Pro-Immigrant Rallies in U.S. History*, transcript available at www.democracynow.org/2006/3/14/over_100_000_march_in_chicago; *Hispanics March in Milwaukee Against Immigration Bills*, CNN, Mar. 23, 2006, <http://www.cnn.com/2006/US/03/23/latino.march/index.html>; Frontera Norte-Sur, *U.S. Media Black Out Immigrant Protests*, IMMIGRANT SOLIDARITY NETWORK, Mar. 23, 2006, <http://www.immigrantsolidarity.org/cgi-bin/datacgi/database.cgi?file=Issues&report=SingleArticle&ArticleID=0480>

(describing protests in Chicago, Washington DC and Tampa).

225. See generally GORDON, *supra* note 123.

226. Using intersectionality analysis to find shared interests that facilitate coalition building among different groups is certainly not a new idea and has been recognized and used in many other contexts. See, e.g., Herrera, *supra* note 222, at 51 (“[U]sing ‘political race’ to forge cross-racial coalitions can be effective tools in exposing and demolishing embedded hierarchies of privilege in American institutions which endanger everyone.”).

227. It is important, however, that such partnerships be formed out of mutual respect and shared goals for advocacy, and not simply out of a desire to harness the political power of one group to further another's purposes.

228. See Johnson, *supra* note 35, at 1554-58, 1574-75.

229. See *id.*

allow the exclusion of immigrants based on sexual orientation;²³⁰ and labor unions reaching out to include immigrants.²³¹ At first glance, this kind of partnering may not appear as likely in the fight for greater access to public benefits.²³² The examples provided by Professors Johnson and Gordon do not involve fighting for limited resources. They were fighting to reform the immigration process to ensure fair administration for groups marginalized in ways that violated our internal shifting norms about equality and fairness, to enhance labor protections, and to ensure that existing protections were being enforced for everyone. Any movement to increase economic entitlements or access to limited resources is going to be much more controversial and presents a greater challenge for immigrant communities.

Despite these challenges, there is a meaningful chance that such partnerships can be used to successfully advocate for healthcare reform. First, the fact that patients do not get money directly, but rather receive coverage for health care, is important because health care providers and benefit administrators provide a gate keeping function.²³³ They help to ensure that resources are only used for a legitimate medical need, which minimizes, even if it does not completely eliminate, mistrust arising out of fears about fraud and waste in the distribution of resources.²³⁴ Second, because health care access has obvious public health implications, people's interests are interconnected in ways that should encourage collaboration rather than competition, and does not require singling out any particular group. Third, health care providers are potentially powerful coalition partners in health reform efforts. Although examples of discrimination by healthcare providers were cited throughout this article, many providers believe they have a moral and ethical duty to treat all regardless of ability to pay or immigration status. They not only oppose immigrant-specific barriers, but have mobilized to fight for universal health care that would eliminate much, if not all of the problematic linedrawing currently used to distribute benefits. Moreover, they are also hurt economically by benefit exclusions that jeopardize federal and state funding for the services they feel a moral duty to provide.

230. *See id.*

231. *See generally* GORDON, *supra* note 123.

232. *See* Johnson, *supra* note 35, at 1555-56 (suggesting alliances to help reform immigration policy generally, including amnesty and guest worker programs).

233. Centers for Medicare & Medicaid Services, Medicaid Eligibility: Overview, http://www.cms.hhs.gov/MedicaidEligibility/01_Overview.asp#TopOfPage (last visited April 11, 2008).

234. *Id.*

Finally, while the current discourse focuses primarily on immigrants as patients in need of benefits, the medical system has viewed physicians and healthcare providers from other countries as an important part of the solution to dwindling resources and a growing need for culturally-appropriate care in underserved communities. For example, in California a bill was proposed to relax the requirements for physicians from Mexico willing to come here and work in underserved communities.²³⁵ In fact, one of the motivations underlying the bill was to increase healthcare access for California's Latino population.²³⁶ Such initiatives reveal a more complex and positive relationship between immigrants and the health care system than generally portrayed in the health care discourse.

VII. CONCLUSION

Our existing healthcare policies are influenced by the dominant narrative of immigrants and thus reinforce that dominant narrative in unfortunate ways. Immigrants, unauthorized and legal, immigrant children, and even communities labeled as "alien citizens" fall victim to policies designed to discourage immigrant health care access. In trying to challenge these policies, however, pro-access advocates are put in the regrettable position of unintentionally reinforcing some of the fear, mistrust, and assumptions about immigrants as a threat to the public fisc that help fuel these policies in the first place. While scholars and public health advocates try hard to structure their discourse in a careful and respectful manner, these effects are unavoidable as long as they engage restrictionists on their own terms and accept the current healthcare paradigm for allocating resources.

The immigrant health narrative is the canary in the mine that is warning us of danger if vulnerable groups continue to compete against each other for a greater piece of the pie rather than working together to challenge the status quo and eliminate inequities inherent in our current system. Fortunately, policymakers, advocates, and providers participating in this Symposium and the dominance of immigration goals over public health goals are important factors in illuminating the weaknesses of the commonly asserted justifications of restrictionists' claims. However, the immigrant's narrative in health care is particularly powerful in illuminating the fundamental problem in our healthcare system that must be addressed before any meaningful reform of immigrant access can take place. It

235. See, e.g., Assemb. 1045, 2001-2002 Sess. (Cal. 2001) (Mexico Physician Pilot Program designed to increase health care access to California's Latino population); Fitzhugh Mullan, *Affirmative Action, Cuban Style*, 351 NEW ENG. J. MED. 2680, 2680 (2004) (describing a program at the Latin American School of Medicine ("ELAM") in Havana, a school sponsored by the Cuban government and dedicated to training doctors to treat the poor of the Western hemisphere and Africa). See also Howard F. Chang, *supra* note 175, at 4 (arguing that "immigration barriers interfere with the free flow of labor internationally.").

236. See Assemb. 1045, 2001-2002 Sess. (Cal. 2001).

creates a discourse that will facilitate coalition building and advocacy to fight for meaningful and comprehensive healthcare reform that will benefit everyone. They are heeding the warning.