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Transcribed Speech of Dr. Jose Pagan

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DR. PAGÁN: Thank you so much. It's great to be on the same stage with Northerners. I live in McAllen, Texas, which is about ten hours away from Dallas. So when I think about the North, Dallas is one of the places that I think about as being the North.

But today, I want to share with you a couple of stories. I picked the title of my presentation on purpose, making it bilingual because you're going to see in a second why I think this is an issue. [W]hen we talk about immigration and health care, really the main issues have to do with the Latino population in the U.S., especially the Mexican population.

So let me begin with a few arguments on why we should provide access to care— arguments that are made often. The first one—I'm going to talk about the second one in a second—but the first one you always hear: it's the right thing to do. You should provide coverage or access to care because it's just the right thing to do. I don't find it fully convincing, but it is a good reason. Then there are other folks [who] are going to say "well, it doesn't cost a whole lot," and I'm going to tell you a little bit about that in a second, which I think is also a good argument. But I'm going to focus the end of my discussion today with what I call "an enlightened self-interest" argument. The idea here is that providing access to care for immigrants makes you and me better off, especially in communities that are heavily impacted by this issue . . . .

So let me show you the first point I was going to make about why I picked that bilingual title. [Take] a look at this. [T]his is from the *Pew Hispanic Center*. And what you see here is that we had forty-four million Hispanics in the U.S. in 2006. [I]f you look at the foreign-born population, thirty-seven to thirty-eight million people, Hispanics are seventeen to eighteen million of those folks. So basically you see that it is a Hispanic issue compared to the other populations. Twelve percent of the U.S. population is foreign-born; 39% to 40% of Hispanics are actually foreign-born.

[T]he second point is [shown by] this wonderful table that, being an economist, I had to throw in. Basically, the table ranks [the foreign-born population in the U.S.] according to their country of origin. [W]hat you see in the table is that out of those seventeen million foreign-born Hispanics, eleven million are from Mexico and then [there is] everybody else. [T]he border patrol calls them "OTMs" or Other Than Mexicans. My point there is that [there is a dichotomy on this issue], especially in states like Texas and California.

[P]art of the point that I want to make is that immigration is not only an issue that is mostly connected to the Hispanic population and the Mexican population, but also it is very concentrated in certain states. The red states . . . are states that traditionally have a large foreign-born population. [T]he yellow states with the numbers tell you where people are moving to. [T]he story there is that many of these states, particularly the ones in the southern U.S., [are] . . . having to face a lot of challenges because they see these southern increases in the foreign-born population; for political reasons or for practical reasons, they perceive that to be a challenge or it may be an actual challenge. I don't know what the answer for that would be, but you get the point if you have been to South Carolina, North Carolina, and so on. I'm always amazed at the number of people whom I see speaking Spanish; you wouldn't see that ten years ago, so it's just amazing.

I'm going to tell you a little bit about cost. Basically the bottom line is people who come from abroad . . . come to work; they don't come to get health care. [T]hat's going to be the lesson from this. [Look] at the data from this study that came out in *Health Affairs* about two years ago that uses the Los Angeles Family and Neighborhood Survey data from 2000 [*Goldman and Smith*]. [They] calculate the health care utilization rates across groups. What you see is that the undocumented population, if you look at hospitalizations . . . [and] visits within the previous year, you see that utilization rates are much lower. For example, [physician] visits in the previous year were 2.14 for the undocumented population in L.A. compared to 4.18 for the native-born. So the point is that utilization rates are much lower for the undocumented and for the foreign-born.

If you look at it in terms of per capita spending then you are going to see the same story, and I'm not going to go over the details in that large table. But the point again is because they use less health care, they therefore spend less on health care. [O]ne of the things that they did in that study is they also took the data they had on L.A. on expenditures and utilization, and they basically tried to make some sense of it at the national level. So . . . you see that we spent $469 billion in 2000 on the non-elderly adult population, (the working-age population), and you see that the amount spent on the undocumented population is a very small number. So I tried to put it into something easier to see. [I]f you look at the foreign-born population, they're 13% of the population, but they only spend about 8.5% of cost. They represent only 8.5% of cost. [I]f you look at the undocumented population, they are 3.2% of the population, and they spend 1.5% of cost. So this is interesting math that I think is [pertinent] in some ways because I'm going to link it to Marguerite [Angelari]'s presentation in a second.

[W]e spent $89 billion in 2000 providing care to non-elderly adults. We have 105 million households in the U.S. [That] comes up to $843.00 per

household. So, if you take the amount that is spent, the cost that is basically provided by the public sector—if you think about it as a tax, you're spending [about] $56.00. Out of that $843.00 cost per household, $56.00 is for the foreign-born and $11.00 goes to undocumented. So that buys a couple of drinks. That's my point—$11.00. [T]hat's [approximately] how much it costs you to deal with the undocumented population in the U.S. and to provide coverage from the public sector. Now, having said that, obviously the problem, given the discussion and the maps that I showed you before, a lot of this is a problem more in certain states or certain communities that have basically have borne the brunt of immigration.

This is data from the California Health Interview Survey. Basically [it] shows the same thing except it focuses on the Mexican population compared to whites; you [essentially] see the same patterns—lower utilization rates and so on. So, the lessons here are that the healthcare system burden from immigrants, in my opinion, is very low, but some communities are impacted more than others.

[W]hat I want to do now is to quickly move into the issue of how many of these communities are actually impacted; [this is] to show you how different policy solutions will have different consequences on these communities. My point of view on this is that you don't need to convince the uninsured . . . . You need to convince the insured; you need to convince the insured that [they] are going to have to bear the cost of doing this. [The uninsured] are already convinced that they need access to care.

I want to take a look at this question. Should we provide health care access to immigrants and everyone else through health insurance coverage? How are certain communities impacted by this problem? How can we go about it? Because what I think you're going to see in a second is that the different proposals out there to provide access to care will have different impacts on you and me. Hopefully, I am assuming that most of you are insured even if you live in the North.

I'm going to tell you quickly about who the uninsured are. They are basically working families that, in most cases, just don't make enough money to be able to purchase a policy at the prices that are put out there. It's heavily Latino, noncitizens . . . . The foreign-born actually represent a large share of [the noncitizens] and a high proportion of them are uninsured, which has direct consequences for health.

Here's a map of the U.S. There are no recent "cool" maps that you can get on this, but [here] you see that the dark areas are in the Southwest and Florida and you see it there in Chicago, too. [T]his is basically a map showing what the percentage of the total county population is foreign-born. This is not the same map. This is a map of the percentage of the [county's] total population that doesn't have health insurance coverage. My point is that the dark areas look about the same in both maps. So when you talk

about covering the uninsured and when you talk about helping the foreign-born population . . . there's an overlap on the population that we're talking about, so a lot of it is concentrated in the Southwest.

[W]hat I want to talk about now is a little bit about how communities are impacted by this. The Institute of Medicine came out with a series of reports on this topic. [It] came out with a series of reports on the problem of the uninsured and it's fascinating because it says that a federal solution is needed. [T]hey came out with this in early 2003, and basically . . . that hasn't happened. But I think the argument is pretty interesting. [W]hat they say is that if you have providers that make less money, it has . . . ripple effects on the local economy where you may need increases in public and private spending to provide public health services. You have more financial instability of providers and you have more uncompensated care, which ultimately impacts health.

So given those effects, when the "Governator" talks about providing access to care in California, he is talking about a 10% tax or 10% higher premiums that we will pay [to provide additional coverage]. That's basically the price side of it.

But the other side of it, that I think many people miss, is the quality of care. The reason why you would expect to see an impact, not only in price or cost, but also in quality of care to everyone (and by that I mean quality of care provided by the facilities) . . . goes like this: so you have a population here called the uninsured that demand lower quality; not that they demand a lower quality and quantity of care, but they use less quantity or quality of care. Thus, they restrict their consumption of health care. When you take that out of the system level at the local level, what you have then is the average quality in the community is going to go down. So, when you go to a facility in the local community, you're going to see quality falling, and I think the best way of seeing this is through a very simple example. Suppose we live in two cities, and in the first one we have an uninsured population that never uses charity care so they have to pay. They use the same facilities that you and I use. [Essentially], what you see is this quality spillover. They restrict the amount of health care that they buy. The average quality of health care in that community goes down. So, for example, where I come from, the best example that I can come up with has to do with pawn shops. We have the greatest pawn shops in the world in McAllen, Texas. Part of the reason is we have one of the highest poverty rates in the country and income levels are low and so you need services that cater towards that population. These businesses show up in the community and that's what happens also in terms of health care.

The other example is what happens if an insured population doesn't get charity care. We provide charity care so they can purchase whatever they want. Then you have the other extreme–a price effect, not a quality effect.

The reality is you end up having both in any community in the U.S. [T]his has important consequences on how we think about how to structure reform and that's what I want to end with. Here's a quick example on that. I have data from a study called the Community Tracking Study, which [tracks] sixty communities in the U.S. with very different uninsurance rates, and I [selected] ten communities with very low uninsurance rates, 6.8% of the people in those communities are uninsured, and ten communities with very high uninsurance rates, [where] 27% of the population in those communities is uninsured. Then I took the people who are insured in those cities to see how difficult or easy it is for them to access care. The only difference is that I have an insured person who happens to be in a different context—a high uninsurance community or a low uninsurance community. You can look at different indicators of access, satisfaction with the system and so on. For example, are you satisfied with your health care provider? And satisfaction rates for the insured are much higher in low uninsurance communities than in high uninsurance communities.

So my point is that you see this spillover effect from the uninsured to the insured population that it is important, and . . . this is another argument that you could use to say we need to do something about [the uninsured].

So let me finish with a couple of ideas here. What this means is that if we are trying to provide access to care to the uninsured, which a lot of them are foreign-born and so on, then there are many different ways of doing it. So, for example, you could do it by creating a parallel system, [such as] community health centers and that's going to work. That's going to take care of the problem but the spillover of that is very small. The spillover that I'm talking about is going to be very small. So even though you've solved the problem, at the same time, you're not getting this multiplier effect if you would do things like, just to give you an example, [giving] tax credits or vouchers for the uninsured. The reason for. . . vouchers or tax credits . . . is to allow people to access the same system that you and I can access. [Therefore], you're basically strengthening the healthcare system in places that [need] it. That's something that, when people talk about universal health care or increasing coverage to everyone, you have to be aware of because different proposals will have different spillover effects on you and me. [I]t's interesting that proposals to provide access to the foreign-born that are targeted to benefit everyone, are better than if you actually do it altruistically towards that population by setting up facilities for them.

What you're seeing in South Texas, for example and in many, many states, are specialty hospitals that are popping up everywhere . . . as a result of this problem. There are many proposals that you can go through. I listed a bunch here but that doesn't mean that I agree with all of them, but I'm going to tell you . . . what I think in terms of how to get around this

problem. I was telling you that this was a Latino issue but . . . basically the first one is shameless self promotion [because] basically Latinos happen to be underrepresented in health policy research, and I think there's a need for more voices from that community to get engaged in this. And that's not happening I think. [O]nly [about] 4% of people who are doing health services research are of Latino origin.

The second [problem] is that there are many interest groups that don't work within the system and have their own agendas. I won't go over that. But the [last] . . . [problem] is this belief that we're going to be able to solve the problem in one shot. I don't think that's very realistic; you have to solve it using an incremental approach. [M]any times the words that you pick are very loaded; if I use the term "voucher," for example, many people are turned off by it. We need to somehow figure out a way to come up with different words that are more palatable to folks. So let me finish with that then. Thank you.