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From the Mayflower to Border Patrols: Who Deserves Access to Health Care in the United States?

An Introduction

*by Ruqaiijah Yearby**

Contentious at best, immigration reform debates have centered on the fairness of excluding undocumented immigrants from federal programs.¹ Framed in terms of recognizing the value of citizenship, the exclusion of undocumented immigrants grants citizens no additional benefits because the currency of citizenship itself buys little, particularly in terms of access to vital services, including health care.² While undocumented immigrants remain uninsured due to ineligibility for federal programs, including Medicare and Medicaid,³ citizens remain uninsured because they do not qualify for these federal programs or lack employer coverage. Going beyond the rhetoric of the debate, empirical studies show that in California, United States citizens are uninsured at the same rates as undocumented

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1. See Elizabeth M. Bruch, *Open or Closed: Balancing Border Policy with Human Rights*, 96 KY. L.J. 197, 197-212 (2008).

2. Linda Bosniak, *Citizenship Denationalized*, 7 IND. J. GLOBAL LEGAL STUD. 447, 456-464 (2000); T. Alexander Aleinikoff, *Citizenship Talk: A Revisionist Narrative*, 69 FORDHAM L. REV. 1689, 1692 (2001). See also Linda Bosniak, *Critical Reflections on 'Citizenship' as a Progressive Aspiration*, in TRANSFORMATIVE LABOUR LAW IN AN ERA OF GLOBALIZATION 339, 342-43 (Joanne Conaghan, Richard Michael Fischl & Karl Klare eds., Oxford Univ. Press 2002).

3. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub.L. 104-93, 110 Stat. 2260 (Aug. 22, 1996); Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, § 309(a), 1996 U.S.C.C.A.N. (110 Stat. 3009).

immigrants are insured—roughly 19%.⁴ Thus, the debate about excluding undocumented immigrants from the healthcare system fails to address the real problems of the healthcare system, which is lack of access to health care for those that contribute to the United States economy. In addition to focusing on the wrong issue, the current immigration reform debate fails to recognize the reality that, but for Native Americans, all United States citizens are immigrants or descendants of immigrants, whether voluntary or forced. In fact, a cursory review of United States history shows that, in spite of immigration policies, such as border patrols, that seek to prevent undocumented migration, the United States has been, and remains, a haven for immigrants who seek a better life.

Although explorers visited America as early as the 1500s, America was not colonized until 1607 and the first black slaves were brought to America in 1619.⁵ Symbolic of this full-scale immigration is the Mayflower and the arrival of the Pilgrims in 1620. This great migration of the English continued for forty years.⁶ During and following this period of migration, there were a number of different ethnic groups that migrated to the United States either as slaves or as free men. Many who came sought opportunities for economic prosperity or relief from religious persecution.⁷ The United States became known for its open borders with the dedication of the Statue of Liberty in 1886, which bears the famous inscription, “Give me your tired, your poor, Your huddled masses yearning to breathe free, The wretched refuse of your teeming shore. Send these, the homeless, tempest-tost to me, I lift my lamp beside the golden door!”⁸

Contrary to this endearing statement of welcome, the United States has intentionally closed its borders to those deemed “undesirable,” including the aforementioned huddled masses and homeless, particularly if they are public charges.⁹ This closure of United States borders has been largely symbolic as industries such as agriculture, child care, and health care have assisted unauthorized immigrants entrée into the United States work force,

4. E. Richard Brown, Dir., UCLA Ctr. for Health Policy Research, Panel Speech at the First Annual Beazley Symposium on Access to Health Care: Solving the Problem of Immigration and Health Care (February 8, 2008) (transcript published in the Summer 2008 Issue of *Annals of Health Law*).

5. ROGER DANIELS, *COMING TO AMERICA: A HISTORY OF IMMIGRATION AND ETHNICITY IN AMERICAN LIFE* 3-30, AND 62 (TABLE 3.1) (HarperCollins 2nd ed. 2002).

6. *Id.* 24-29, 30-52.

7. *Id.* at 121-237.

8. A line from the poem, “The New Colossus,” by the nineteenth-century American poet Emma Lazarus. “The New Colossus,” describing the Statue of Liberty, appears on a plaque at the base of the statue.

9. See Bruch, *supra* note 1, at 197-212; DANIELS, *supra* note 5, at 265-284; Kevin R. Johnson, *Race Matters: Immigration Law and Policy Scholarship, Law in the Ivory Tower, and the Legal Indifference of the Race Critique*, 2000 U. ILL. L. REV. 525, 525-535 (2000).

while limiting their access to housing, health care, and other life-sustaining services.¹⁰ Nowhere is this conundrum more apparent than in the healthcare industry. As a result of staffing shortages, healthcare entities have assisted the immigration of numerous foreign-born healthcare workers, while at the same time limiting access to health care for other foreign-born immigrants.¹¹ Admittedly, the immigrants providing care and those immigrants seeking care are typically from different countries. The pertinent point is that both are noncitizens who contribute to the United States economy but are treated differently, because one class is considered “desirable,” e.g. the healthcare workers, and the other “undesirable,” e.g. the unskilled laborers. However, this is an artificial construct—both contribute to the United States economy by providing necessary services. In fact, the “undesirable” immigrants pay taxes using tax identification numbers provided by the IRS.¹² This disparate treatment of desirable and undesirable immigrants is not novel.¹³

Once the United States was formed, Congress restricted immigration by establishing a two-year residency requirement before one could qualify for citizenship.¹⁴ In 1795, five years after the original law imposing residency requirements, Congress increased the wait to five years.¹⁵ In 1798, Congress passed the Naturalization Act and the Alien Act. The Naturalization Act increased the residency requirement to fourteen years, while the Alien Act authorized the President to arrest and deport any alien considered dangerous.¹⁶ Both of these laws were supposedly enacted to curtail the political activities of immigrants, who were critical of the government, particularly those from France.¹⁷ Even though these laws were

10. See Bruch, *supra* note 1, at 210-11; DANIELS, *supra* note 4, at 243-247 and 307-309. See generally Sara R. Halle, *Proposing a Long-Term Solution to a Three-Part American Mess: U.S. Agriculture, Illegal Labor, and Harvest Mechanization*, 12 DRAKE J. AGRIC. L. 359 (2007).

11. See Beth Lyon, *Tipping the Balance: Why Courts Should Look to International and Foreign Law on Unauthorized Immigrant Worker Rights*, 29 U. PA. J. INT’L ECON. L. 169, 171-200 (2007).

12. Nina Bernstein, *Tax Returns Rise for Immigrants in U.S. Illegally*, N.Y. TIMES, Apr. 16, 2007, at B1.

13. DANIELS, *supra* note 5, at 265-284.

14. U.S. Citizenship & Immigration Servs., *Historical Immigration and Naturalization Legislation*, <http://www.uscis.gov/portal/site/uscis> (follow “Education & Resources” hyperlink; then follow “Immigration Legal History” hyperlink) (last visited Apr. 7, 2008) [hereinafter U.S. Citizenship & Immigration Servs.].

15. *Id.*

16. *Id.*

17. C. WILLIAM MICHAELS, *NO GREATER THREAT: AMERICA AFTER SEPTEMBER 11 AND THE RISE OF A NATIONAL SECURITY STATE* 16 (Algora Publishing 2002) (“The Acts [Alien and Naturalization Acts] were a reaction to the “XYZ” affair, an alleged attempt by French agents to affect negotiations between the United States and France designed to avert a war crisis.”).

either repealed or allowed to expire, the treatment of immigrant unskilled laborers as second-class citizens is an oft repeated theme throughout the history of the United States.¹⁸

In 1862, as the nation was battling with its history of the forced migration of African slaves, Congress passed the first laws restricting immigration of the Chinese.¹⁹ Twenty years later, the infamous Chinese Exclusion Act was enacted as a means to close the border between China and the United States and to “protect” the economy by regulating access to cheap labor.²⁰ The Chinese Exclusion Act suspended immigration of laborers for ten years, permitted Chinese laborers to remain in the country after an absence, provided for deportation of Chinese illegally in the United States, barred Chinese from naturalization, and limited entry of Chinese to tourists.²¹ The significance of this act was that it was the first time that the United States required permission to enter the country and in doing so singled out one ethnic group, the Chinese.²² Although the United States repealed this law sixty-one years later, the sentiment that gave rise to ethnic-based immigration laws remains.

Similar to immigration policy in the late 1800’s and early 1900’s, the current immigration debate and policy centers on one ethnic group, Mexicans. As it did in enacting the Chinese Exclusion Act, the United States has focused on closing the borders between Mexico and the United States to “protect the economy by regulating access to cheap labor.”²³ In both cases, the Chinese and Mexican immigrants were initially encouraged by the United States government to immigrate due to labor shortages in industries such as mining and agriculture.²⁴ Thus, although the Chinese and Mexicans contributed to the United States economy through their labor and taxation, they were intentionally denied equal access to the benefits of their labor. Therefore, in a sense these immigrants subsidize the lives of United States citizens. Recipients of this subsidy, United States citizens, cannot now declare that immigrants who contribute to the United States economy do not deserve the same access to services as themselves, particularly when it comes to health care.

Often ignored, issues concerning immigration and health care have remained the same from the Mayflower to present day border patrols:

18. See generally Johnson, *supra* note 10.

19. U.S. Citizenship & Immigration Servs., *supra* note 16 (Act of February 19, 1862 (12 Statutes at Large 340)).

20. ANDREW GYORY, CLOSING THE GATE: RACE, POLITICS, AND THE CHINESE EXCLUSION ACT 5 (UNC Press 1998)

21. U.S. Citizenship & Immigration Servs., *supra* note 16.

22. DANIELS, *supra* note 5, at 311.

23. See generally Bruch, *supra* note 1.

24. DANIELS, *supra* note 5, at 243-247 and 309-327.

restriction of access to health care and prevention of communicable diseases. Beginning in the 1880's, Congress' solution to the problem was to simply restrict immigration of public charges that needed assistance for vital services such as health care and segregate United States citizens from the "risk" of disease by preventing entry of immigrants with contagion.²⁵ These policies remain in place; nevertheless, restrictions on access to health care have not prevented immigrants from obtaining some form of health care in the United States and contagion still spreads as Americans travel to foreign countries. Hence, although immigration and health care have been an issue for over four hundred years, the federal government has failed to develop and implement an effective policy to address these issues.

The key to addressing the problem is to face the reality that undocumented immigrants will continue to enter the United States and to develop policies to regulate equal access to health care. This Symposium on Immigration and Access to Health Care represents one of the first of many steps in this process to fix the United States immigration policy on health care. The purpose of this interdisciplinary conference was to identify key issues affecting immigration and health care and to develop solutions to the problems. The three main issues discussed during the Symposium were: (1) addressing the barriers immigrants face when trying to access health care; (2) changing the misguided perceptions concerning restricting immigrants' access to health care; and (3) providing solutions to rectify the problem of immigrants' lack of access to health care. Whether through articles or presentations, each participant provided a new perspective by which to address the issue of Immigration and Health Care.

Proponents of immigration reform often assert that undocumented immigrants should be prevented from entering the United States, arguing that they deplete already limited resources such as health care and spread serious contagion and communicable diseases. To address this "threat" of resource depletion and the spread of hazardous contagion, the United States has erected several barriers to accessing health care for immigrants. These barriers include: lack of health care coverage; lack of accessible health care providers; and lack of culturally and linguistically competent physicians. Sonal Ambegaokar, the Health Policy Attorney for the National Immigration Law Center, critically reviewed these barriers in her presentation and noted that the government has failed to offer a coherent policy governing immigration and health care. While the federal government has issued general macro level prohibitions on providing access to health care to immigrants under federal programs, these

25. The Immigration Act of 1882 prevented immigration of public charges and the Immigration Act of 1891 further restricted the entry of immigrants with certain contagious diseases. See U.S. Citizenship & Immigration Servs., *supra* note 16.

exclusions remain unrealistic on the micro level, as states are required under federal law to provide emergency care to all individuals, but receive little federal funding for the care provided.²⁶

The federal government has enacted blanket prohibitions based in part on the perception that restricting access to health care for immigrants will decrease the number of “undesirable” immigrants entering the United States, effectively a crude form of immigration reform. Thus, the question raised is whether these perspectives are correct. According to Dr. José Pagán, Director of the Institute for Population Health Policy at the University of Texas-Pan American, immigrants do not migrate to the United States for health care; rather, they are searching for a better life. Although immigrants are labeled by some people as “free riders,” the majority are not. According to Dr. Pagan, immigrants come here to work, not to gain access to health care. This assertion is supported by numerous empirical studies that show that immigrants utilize less health care than citizens.²⁷ This utilization covers hospital visits and per capita spending. Consequently, the perception that undocumented immigrants drain limited healthcare resources is patently false, and thus barriers to accessing health care should be removed.

Professor Brietta Clark’s article, *The Immigrant Health Care Narrative: The Real Story*, suggests that the dominant narrative of immigrants in our country directly influences policies, particularly concerning health care access. These images, stereotypes, and discourse create a narrative that reinforces fear and mistrust of immigrants, which affects the formation of these policies. Unfortunately, as Professor Clark reveals, this narrative can be unintentionally invoked by those who are in favor of extending health care access to immigrants, thereby counteracting their goals.

The narratives perpetuated by groups on both sides of the immigrant access issue also have a significant impact on the immigrant elderly. According to Professor Marguerite Angelari in her article, *Access to Health Care for Elderly Immigrants*, the aging of the immigrant population mirrors the aging of the citizen population. Foreclosing access to Medicare for immigrants will only serve to tax an already under-funded system of safety-net providers, such as hospitals and physicians who rely on Medicaid payments. Furthermore, the incentive for immigrants to pay into the Medicare program will be eliminated if they have no hope of ever reaping its benefits. Thus, immigration health care policy also needs to address this inevitable issue.

26. See Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. § 1395dd (2000 & Supp. IV 2004).

27. José A. Pagán, Dir., Inst. for Population Health Pol’y, Dept. of Econ. & Fin., Univ. of Texas-Pan American, Panel Speech at the First Annual Beazley Symposium on Access to Health Care: Solving the Problem of Immigration and Health Care (February 8, 2008) (transcript published in the Summer 2008 Issue of *Annals of Health Law*).

Additionally, the perceived distinction between immigrant and citizen is meaningless in the fight against the spread of communicable diseases. Dr. Sana Loue's article, *Immigrant Access to Health Care and Public Health: An International Perspective*, firmly dispels the antiquated notion that immigration reform is the best means by which to address the spread of communicable diseases. Dr. Loue eloquently and correctly notes that by continuing to view this problem nationally, one fails to address a more critical issue of the spread of communicable diseases and other public health concerns by citizens who travel outside the United States. Disease knows no borders and cares not for citizenship. Dr. Loue directs us to expand the focus of this issue beyond nationalistic terms to focus on how this issue affects the public's health internationally. The United States should adopt this international perspective to adequately address the problems associated with the spread of communicable diseases.

As Dr. Jennifer Cutrer, the Executive Director of Public Affairs for Parkland Health & Hospital System, notes in her presentation, the issue of immigration is one of perspective: "Latinos did not cross the border, the border crossed them." Thus, the question of access should be considered from a sociologist's perspective, which her hospital, Parkland Health & Hospital System, has adopted. As a safety-net hospital, Parkland provides access to all different types of populations: insured, uninsured, citizens, and undocumented immigrants. Parkland provides access to health care to everyone not only because the law requires it,²⁸ but also because Parkland is committed to providing care to all regardless of ability to pay. This commitment is significant because on the micro level, the cost is a heavy burden on individual hospitals, even though on a macro level the cost is minimal to the federal government. But according to Dr. Cutrer, the commitment to provide care translates into an overall benefit to the community of having a healthy economy and workforce. Furthermore, if the United States would improve access to preventative care for immigrants, costs associated with emergency care would decrease and perhaps lessen the burden on individual hospitals and communities. Other hospitals in the Dallas area believe that access to health care for immigrants is linked to the political system. Mr. Robert Earley, Senior Vice President for JPS Health Network, submits that providing access to health care for immigrants is a political question. Because individuals are not willing to raise taxes, hospitals such as JPS Health Network need to make difficult

28. Title VI of the Civil Rights Act of 1964 requires hospitals to treat everyone the same regardless of race, while the Emergency Medical Treatment and Active Labor Act requires hospitals to provide care to those in emergency situations who are presented to the emergency room. See Civil Rights Act of 1964, 42 U.S.C.A. § 2000d (West 2003 and Supp. 2006) and the Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. § 1395dd (2000 & Supp. IV 2004).

choices when providing care based on residency and financial issues. Nevertheless, if one hospital fails to provide care, another hospital will have to bear the burden, such as Parkland Hospital in Dallas, Texas. However, macro solutions to the problem are still necessary.

Professor Janet Calvo advocates a macro solution to the problem of immigrant access in her article, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*. She argues that the federal government must provide access to immigrants and citizens. Moreover, this reform cannot be accomplished through the exclusion of immigrants from healthcare programs. When the federal government excludes immigrants from federal healthcare programs, barriers are also raised for citizens, who have a right to access. Limited access may fix present funding concerns; however, these limitations will leave the United States vulnerable to contagious diseases and outbreaks as citizens and immigrants without access to care are unable to receive treatment for contagious diseases, such as tuberculosis. In addition to increasing the risk of the spread of communicable diseases, the prohibitions waste limited resources. Instead of focusing on providing health care, state agencies and hospitals spend time and administrative costs trying to weed-out human beings whose only crime is that they are undocumented.

According to Dr. E. Richard Brown, the founder and Director of the UCLA Center for Health Policy Research, the central issue of access to health care is not an issue of immigrant versus citizen. Rates show that among uninsured employees, 78% of the undocumented have no access to employment-based coverage insurance through their own or family members' employment compared to 73% for citizen employees.²⁹ Therefore, the problem is not that immigrants are depleting limited resources; the problem is that people who work do not receive health care and do not have enough money to pay for health insurance. Dr. Brown further asserts that limiting access to health care affects United States' citizens more than immigrants. The laws do not address this problem and actually exacerbate it because they put limits on providing access to immigrants who work just as hard as citizens. Therefore, his suggested solution is to provide employer-based health insurance for everyone, citizen and undocumented immigrants alike.

Regardless of where one stands on the issue of immigration, some data is beyond dispute: immigrants, both documented and undocumented, who contribute to the United States economy and subsidize United States citizens through wages and taxation do not receive the full range of benefits for their work that principles of equity would dictate. Health care should be one benefit. Providing access to health care would not erode citizen's

29. Brown, *supra* note 3.

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rights if, as this Symposium suggests, the government provides equal access to citizens and immigrants in measures equal to their contribution to the United States economy. One pervasive problem with current immigrant health care policy is that policymakers, healthcare workers and entities, and the general public believe that ignoring the issue will make it go away. Our history as a nation reminds us, however, that both immigration and health care have been vexing issues for this nation that have never been solved by simply ignoring the problem.