

***What does the 2010 U.S. Health Care Reform Mean
for Securing Immigrant Health in North America?***

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Introduction:

Long before NAFTA, North America relied heavily on temporary (migrant and immigrant) labor from the Global South. Since the failure of US immigration reform in 2005-2006, both the U.S. and Canada have increasingly expanded temporary labor programs to meet agricultural and low skilled worker needs; globally, the "permanently temporary" worker is an increasingly observable phenomena from North America to Dubai. Arguably, because migrants and immigrants are not citizens, the nation state is not responsible for meeting their legal, health and human service or advocacy needs. Yet in an increasingly globalized world, South-to-North labor mobility and immigration and migration patterns mean that a significant number of individuals from the global South (Africa, Latin America, most of Asia) live outside their home nation. This situation begs the question - who is responsible for ensuring the labor, health and human rights of these global workers? The immigration, labor and health care regimes of the industrialized West uniquely determine access to jobs and health and human services for citizen throughout the world.

Thirteen percent of the US population is foreign born (39 million; approximately 11 million of those are undocumented). Being a US citizen does not guarantee access to health care and approximately 45 million are uninsured. Even in the E.U. and Canada, where universal health care exists and immigration policies are theoretically more open and inclusive, migrants and immigrants with and without status experience high rates of labor abuses and low rates of health and human service utilization. In general, when migrants and immigrants face labor abuses and/or social welfare issues, States provide little support, instead relying on inclusive neo-liberal approaches that promote the capacity of civil society actors to meet legal/labor, health and human service and political advocacy needs for immigrants, migrants and their families.

Meanwhile, the introduction of new US health care legislation in March 2010 - The Patient Protection and Affordable Care Act (PPACA) - raises the question: *What does Health Care Reform mean for the health of immigrants and migrants in the US?* The answer

to this question is complicated, particularly as 25 lawsuits challenging various aspects of the policy are making their way through the US court system. As the American debate about universal health care continues, the economic and human health costs of limited or no access to employment and public programs for citizens, immigrants, and migrants alike is undeniably negative. Shortfalls in public health budgets and employer roll-backs in health benefits combine with policy mandates to reduce and/or deny services based on immigration status. Public health centers respond by increasingly partnering with civil society organizations and actors (community-based, non-profit, activists) to meet social service gaps, often by providing services to immigrants and migrants on a "don't ask, don't tell" basis. Despite the ongoing failure of immigration and health care policy reform and the relatively robust nature of civil society response to the issue, very little research has investigated health and immigration policy convergence in North America; nor has research effectively considered the role of non-state actors (i.e. civil society) in the policy process or in responding to the social service and health needs of the (im)migrants that make up a large portion of the US (and North American) labor force.

This paper builds on recent research to further understand pros and cons of civil society participation (innovations?) in immigrant health policy-making and service provision. At the practical level, understanding policy convergence and local responses to migrant and immigrant health needs is necessary for developing realistic and informed migrant and immigrant health and labor policy and programs at the transnational, national and local levels. Theoretically, the paper contributes to recent debates about the impact of globalization (neoliberal policy) on policy convergence and -the role of global civil society in shaping local, national and transnational policy and social service provision in the Americas.

Research design and methodology

This paper analyzes the impact of the 2010 PPACA on immigrant health in the US: How has the 2010 PPACA increased access to health care for immigrants? Does the 2010 PPACA favor some types of immigrants over others? How have US States and local actors responded at the policy and program levels? What policy and program mechanisms are mobilized by civil society organizations in response to the PPACA?

I take a mixed methods approach, including qualitative methods (participant observation, in-depth semi-structured interviews, archival research, policy analysis), combined with a case-study approach, to compare data across a range of knowledge domains. In-depth interviews were conducted in each locale with: (a) health policy-makers; (b) community-based organizations; and (c) transnational organizations (foundations, development agencies and international NGO's). Participant observation took place at numerous key events, including applied health forums, conferences, health policy planning meetings and civil society events. Finally, an historical comparative analysis of archival data, health policy documents, conference and workshop proceedings and organizational literature (including brochures, websites, annual reports, and internal documents) was conducted. Data from inter-views, participant observation and archival documents were triangulated to verify patterns and explanations for the positive and negative ways that civil society action impacts tri/bi/national policy development.

The problem of 'securing' immigrant health: Policy mandates and local responses

As discussed above, the problem of securing immigrant health is deeply tied to forces of globalization and neoliberal economic policies that promote increased reliance on 'cheap' and highly mobile immigrant/migrant labor. Without a doubt, recent changes in Canadian and US Visa laws indicate both countries are increasingly relying on opening up flows of cheap labor from the South.

The current trend in immigration policies of most major countries is to reduce permanent settlement of unskilled labour in favour of "re-forming" temporary migration visa programs. The core for implementing US, Mexican, and Canadian immigration and labour policy is visa programs that release a limited amount of *temporary* skilled labour visas, as well as a larger number of *temporary* unskilled visas. The effect is a two-tiered system that favours employer use of cheap, temporary, foreign labour. At the societal level, all three countries acknowledge that there is a need to reform existing temporary labour programs and policy in order to meet long-term demands for labour and prevent the abuse of workers. Yet at the political level, debates have focused on expanding and streamlining temporary visa programs in ways to make it easier for employers and the government to increase labour mobility and provide foreign workers with a fewer labour protections.

Additionally, all three countries have enacted post 9/11 border security policies that support increasing control of their borders (Crepeau & Nakache, 2006). While Canada has agreed to increase border security and harmonize visa requirements, it has not gone as far as the US and Mexico, both of which have effectively militarized their southern borders. Alongside the amplification of local policing resources dedicated to immigration enforcement in North America, are increasing numbers of high profile raids by Immigration Control and Enforcement (ICE) that target unauthorized (im)migrants (vs. employers). In the US, arrests of undocumented workers grew by 750% between 2002 and 2006; and there has been a trend toward large-scale immigration raids arresting between 99-1,200 workers at a time. These tactics have a humanitarian cost, resulting in the separation of children from parents, often for months at a time (Abraham, 2008). Canadian immigration officials have adopted the US ICE-raid strategy and increased raids targeting (im)migrants (vs. employers), as evidenced by actions at a number of workplaces in Southern Ontario, arresting and detaining approximately one hundred unauthorized workers in Spring and Summer 2009(No One Is Illegal, 2009).

Access to Health and Human Services for (Im)migrants in the US

In the US, lack of comprehensive immigration reform coupled with the 2010 health care reform has led to hundreds of anti-immigrant laws and policies passed by States, Counties and Cities. For example, according to the National Conference of State Legislators (NCSL) Immigrant Policy Project (NCSL, 2006; NCSL, 2008), "state legislators have introduced almost three times more bills in 2007 (1,562) than in 2006 (570) and the number of enactments from 2006 (84) has nearly tripled to 240 in 2007. Much of the legislation focused on restrictions in the areas of employment, health, identification, drivers and other licenses, law enforcement, public benefits, and human trafficking. As a result of the climate of fear produced by anti-immigrant policies, many immigrants have stopped shopping or going to church and have closed bank accounts (Constable, 2008; Southern Poverty Law Center, 2007; Southern Poverty Law Center, 2009), and may also limit use of social and health services (Field Costich, 2001-2002). According to a 2010 report from COFEM, 85% of immigrants live in mixed-status households; new identification requirements will mean that eligible members of immigrant status-discordant families may avoid seeking preventative care. Another result is increasing internal migration away from anti-immigrant areas (such as Oklahoma and

Arizona) to more immigrant friendly regions in the US (Archibold, 2008; Pinkerton, 2008).

According to numerous studies (Health Initiative of the Americas, 2011; Hinojosa-Ojeda & Cruz-Takash, 2010; Kaiser Commission on Medicaid and the Uninsured, 2011; Waxman & Cox, 2009)immigrants in the US use health care services much (55%) less than native-born Americans. Per capita health expenditures averages \$1,139 for immigrant vs. \$2,564 for non-immigrants and 30% of immigrants used no health care at all in the course of a year. Even immigrants with health insurance used 52% less health care than non-immigrants... and Latino immigrants who did use health services had the lowest expenditures - \$962 per person versus \$1,870 pp for US born Latinos and \$3,117 for US-born whites. It is ironic that many immigrants actually subsidize health care for the rest of us and at the same time, the future economic success of the US depends on having a health immigrant workforce.

It is no surprise that debates about immigrant use of public health care show the conflict between the goal of providing care, and enforcement-based immigration policies that deny access to care (Field Costich 2002). In Mexico, the US, and Canada, access to health and human services for (im)migrant workers is viewed by public health and civil society actors as a human and labour right (all three nations have signed international documents supporting protection of the human rights of migrants (Crepeau and Nakache 2006)), but policy implementation and enforcement at the local level is difficult, particularly in southern Mexico and along the US-Mexico border. As a result, the vast majority of health and human service providers in each country enact a "don't ask, don't tell" policy by ignoring existing statutory barriers to health care for undocumented (im)migrants. The discordance between public health practices and immigration policy opens up space for local-level innovation; such innovative practices are observed at the political and technical levels of the policy assessment framework.

Innovation aside, given political pressures to control (and reform) the (im)migration process as well as limit social and health services to (im)migrant farmworkers, the burdens of service provision and immigration enforcement have shifted heavily to local and regional police, doctors, educators, employers, and community-based organizations (CBOs). The increasing involvement of regional and local Canadian, US, and Mexican civil society organizations in responding to (im)migrant

health and human rights issues is a product of the global trends toward inclusive neo-liberalism in which North American countries have "shifted away from federal government control to greater roles for sub-national governments and civil society actors" (Mahon & Macdonald, 2007).

US HC system reform? And (Im)migrant health

The 2010 PPACA signifies that the US could be moving toward a universal health care model similar to Canada and Mexico. Yet there are many barriers to the roll-out of the health care reform- largely due to approximately 25 lawsuits challenging the constitutionality of 'forcing' citizens to buy health care that are currently making their way through the US court system. Ultimately, the reform is intended to provide access to health care for the 45 million (15% of the population) without insurance - a significant portion of which (32%) are Latinos.

Who are the Uninsured? Of the 45 million uninsured, approximately 11 million are undocumented immigrants, equaling nearly 25% of the overall uninsured population (Hinojosa-Ojeda & Cruz-Takash, 2010). Latinos make up 32% of the uninsured, largely because many are employed in jobs that don't have benefits. A majority of undocumented immigrants are from Mexico (57%) and the majority of the remainder (24%) are from Latin America. The undocumented population is concentrated in California, Texas, Florida and New York (Waxman & Cox, 2009). Of the 7.5 million undocumented immigrants of Latino descent in the US, 25% live in California and 65% are from Mexico (Health Initiative of the Americas, 2011).

Undocumented immigrants often reside in the US for years. A 2011 Kaiser Foundation survey (Kaiser Commission on Medicaid and the Uninsured, 2011) indicated 60-65% of adult undocumented Latinos have lived in the US for more than five years, and most live in poverty with low rates of health insurance coverage. Undocumented immigrants do not use an excess of health services, rather the opposite. In LA county, undocumented immigrants are 12% of the population but represent only 6% of medical expenditures.

California in particular is affected as 10 million of the 38 million foreign-born people in the US live there; California's total population is 37% Latino and 26% are immigrants. Over 4 million Mexican immigrants live in California and 47% have no health insurance, 22% live in poverty (Hinojosa-Ojeda & Cruz-Takash, 2010).

Assessing Health Policy Reform

At the federal level, two health policies were passed prior to the 2010 PPACA that affect immigrant access to health care: the 1996 the Personal Responsibility and Work Opportunity Reconciliation Act (barred legal immigrants from Medicaid and SCHIP for 5 years after entry into the US, excluding emergency), and the 2005 Deficit Reduction Act, which required Medicaid providers obtain proof of citizenship.

The 2010 PPACA positively affects Latino Immigrants (in California) in 5 ways (2011 Health Initiative of the Americas Fact Sheet): 1) the law requires employers buy health insurance, extending it to (7.3 million) previously uninsured (Californian) individuals, many of whom are Latinos (undocumented immigrants are exempt); 2) State-based health insurance exchanges will offer subsidies to those w/incomes 133%-400% above poverty level and many Latinos immigrants will be newly eligible (undocumented are not eligible to purchase insurance through exchanges); 3) Medicaid will be expanded to cover more individuals below the poverty line - Latinos immigrants are more likely to live in poverty than native born, however recent immigrants face a 5 year waiting period and undocumented are not eligible; 4) the law provides \$11 billion annually over 5 years in funding to Community Health Centers where Latino immigrants and undocumented immigrants are more likely to seek care (33% of CHC users are Latino); and 5) Everyone, including Latinos will benefit from laws banning underwriting (banning insurance based on previous medical history).

A number of federally funded public health programs are still available to the undocumented, including Title V of the Social Security Act (Maternal and Child Health Services Block Grant) and Title X of the Public Health Service Act (Family Planning), as well as funding for Federally Qualified Health Centers, Health care for the Homeless, and Migrant Health Clinics that provide comprehensive primary care, including prenatal care, without regard to immigration status (Waxman & Cox, 2009).

Clearly some immigrants benefit and others do not, particularly the undocumented (the reform retains a complete ban on publicly-funded benefits for undocumented. Community Health Centers - despite their increased funding - will bear the brunt of the policies exclusionary mechanisms. In fact, expanded CHC capacity is the only real improvement marginalized migrants will see, and CHCs generally provide only primary (not acute or specialty)

care. Additionally, the reform carries an amendment (Hyde) that bans federal funding of abortion procedures, meaning lower income women of all immigration statuses will have fewer family planning options.

Ultimately, even though Latinos make up 32% of the uninsured (largest uninsured ethnic group in the US) the reform will increase coverage for only 60% in that group. According to the HIA "long stay documents Latino Immigrant families with low incomes will be better off, many other within the Latino community will be excluded. The law may serve to exacerbate health disparities by immigration status, potentially undermining the many ways in which the law can otherwise benefit California's Latino community." "The exclusion of some legal immigrants and all undocumented immigrants from reform creates a class system in health care based largely on immigration status" - of the 23 million people who would remain uninsured by 2019, 33% would be undocumented (im)migrants " (Hinojosa-Ojeda & Cruz-Takash, 2010).

Conclusions

Even though a "significant pathway to coverage for undocumented is state-level reform and state-only funded programs and services, as well as the private market...[there exists] little support for including undocumented immigrants in state health care reform..." (Sanchez & et, 2011). The burden of filling gaps in care will continue to fall on governments and organizations at the state and local level as they try to maintain programs in a time of drastic cuts to social and health service budgets.

In particular, the following actors and innovations will be increasingly important for meeting immigrant health care needs in the US and North America:

- Multi-national and multi-sector Health Initiatives (Health Initiative of the Americas)
- Mexican consulate programs ("Ventanillas de Salud", and place-of-origin immigrant and migrant health programs)
- Private "multi-national" Health Insurance Exchanges (foreign born and immigrants historically pay more out of pocket)
- Medical Professionals required to be 'health literate' with immigrant/migrant health programs in all three (CA-US-MX) health care systems
- Role of Labor Unions in fighting for immigrant labor rights

Ultimately 'socioeconomic factors and employment do a better job explaining long term access (Or lack of access) to health insurance. It is education, income and place-of-employment that matter, not place of birth- except for the undocumented.

Summary Table: Im(migrant) Access to Health Care: Policies, Programs and Services Pre and Post 2010 PPACA		
	Pre-PPACA	Post-PPACA
Number and type of uninsured	<ul style="list-style-type: none"> •45 million uninsured (Includes 11 million undocumented) •Latinos make up 32% of the uninsured (COFEM) 	<ul style="list-style-type: none"> • Undocumented are excluded • Increase coverage for 60% of uninsured Latinos; • 23 million would remain uninsured by 2019; 33% would be undocumented
Immigration Policy	<ul style="list-style-type: none"> •Lack of comprehensive immigration reform in all 3 North American Countries; left to each state to regulate • "...there remains only one road to greater [health care] access for [undocumented]: comprehensive immigration reform." (Sanchez et al 2011) 	
Health Policy		
Federal level	<ul style="list-style-type: none"> • 1996 Personal Responsibility and Work Opportunity Reconciliation Act (legal immigrants barred from Medicaid - and in 1997 SCHIP - for 5 years excluding emergency) • 2005 Deficit Reduction Act required Medicaid agencies obtain proof of citizenship; implement-ted in 2006 	<ul style="list-style-type: none"> •Undocumented are denied • Limited access to some Federal Programs remains for undocumented (funded via States): Title V of the Social Security Act (Maternal and Child Health Services Block Grant); Title X of the Public Health Service Act (Family Planning); Federally Qualified Health Centers, Health care for the Homeless, and Migrant Health Clinics; Emergency Medicaid; SCHIP
State level	<ul style="list-style-type: none"> • States pass laws both restricting/improving access: • Prop 187 in 	<ul style="list-style-type: none"> • "...a significant pathway to coverage for undocumented is state-level reform and state-only funded

	California (1994) • Prop 200 (2004) and SB 1070 in Arizona (2010)	programs and services, as well as private market..." • "Little support for including undocumented immigrants in state health care reform..." (Sanchez et al 2011)
Health Services		
Immigrant/Migrant access to HC Insurance and Services	<ul style="list-style-type: none"> •Sanctuary Cities •Don't' ask Don't tell public service provision • Community Health Centers, Migrant Clinics •Private Health Insurance 	<ul style="list-style-type: none"> •Increasing reliance on "Pre-PPACA" services & providers at State and local levels
(Increasing reliance on) External/private sector to meet needs of undocumented		
<ul style="list-style-type: none"> •Multi-national and multi-sectoral Health Initiatives (Health Initiative of the Americas) •Mexican consulate programs ("Ventanillas de Salud", and place-of-origin immigrant and migrant health programs) •Private "multi-national" Health Insurance Exchanges (foreign born and immigrants historically pay more out of pocket) •Medical Professionals required to be 'health literate' with immigrant/migrant health programs in all three (CA-US-MX) health care systems •Ultimately 'socioeconomic factors and employment do a better job explaining long term access (Or lack of access) to health insurance. It is education, income and place-of-employment that matter, not place of birth- except for the undocumented. • Role of Labor Unions 		

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