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# Latino Immigrants and the Paradox of Health Care in America

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## Introduction to Immigrant Health

Mexican immigrants' health declines as they make the United States their home. While Hispanics maintain consistently lower rates of heart disease, hypertension, asthma, chronic bronchitis, and cancer, in comparison to non-Hispanic blacks and whites, their prevalence of diabetes and obesity, increasingly chronic diseases of the poor in the United States, rise after crossing the border (Livingston, *et. al.* 2008). Now, many researchers are concluding, "becoming an American can be bad for your health" (Tavernise 2013).

### By the Numbers

- **33.7 million** Hispanics of Mexican origin in the United States (**11% of population**)
- They comprise **64% of the Hispanic population** in the United States (Gonzalez-Barrera and Lopez 2013)

### Immigrants

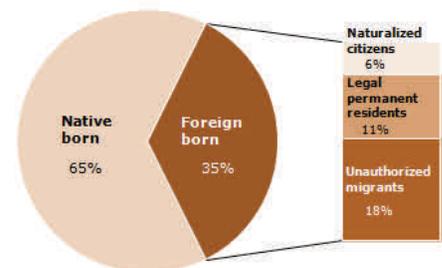
- **40 million** immigrants living in United States, **11.1 million unauthorized**
- **55%** of unauthorized from Mexico

The Mexican immigrant male's life expectancy is three years longer than that of his Mexican friend born in the United States, and the second generation is not living as long as their parents, even though they may have more money. This difference is being attributed largely to culturally American behaviors such as smoking, drinking, big meals, and sedentary lifestyles. Additionally, foods like ham and bread, which traditionally were not sweetened, are in the United States, diminishing inclinations towards healthier foods such as the cactus and beans common in Mexican diets. More than this, fast food, once a sign of success, is a cheap staple for poor, busy, working families. This population is particularly susceptible to "super-size" options, victim to their illusions of being more economical. Camilo Garza, a 34-year-old third-generation plumber and maintenance worker, says, "I'd love to

have my wife at home taking care of the kids and making sure they eat right, but I can't afford to...It costs money to live in the land of the free. It means both parents have to work." Of his kitchen table, he says, "It's a decoration...a place where we set groceries before sticking them in the refrigerator" (Tavernise 2013).

The most unfortunate part is that, as Robert O. Valdez, professor of family and community medicine and economics at the University of New Mexico,

Nativity and Legal Status of Mexican-Origin Population in the U.S., 2011 (%)



explains, "All the things we tell people to do from a clinical perspective today—a lot of fiber and less meat—were exactly the lifestyle habits that immigrants were normally keeping." Worse, according to Joseph B. McCormick, "The U.S. culture has crept across the border." Nearly 40 percent of the rural Mexican diet consists of packaged food. Valdez says, "People are no longer growing what they are eating. They are increasingly going to the market, and that market is changing." Another question, yet to be answered, is whether the surge in diabetes and obesity among Latinos, rates now double those of non-Hispanic whites, is simply a reflection of assimilation into American culture, or attributable to either a higher genetic propensity for the disease or their socioeconomic status. Only time will tell, as Latino families become more upwardly mobile and established in the United States (Tavernise 2013).

## Health Intro, *Cont.*

But even that upward mobility is debatable. Legal residents have a much better chance of moving up than their undocumented counterparts, whose incomes, for the most part, do not increase the longer they live in the United States. Instead, they are stuck with median incomes well below those of their U.S.-born counterparts (\$36,000

compared to \$50,000) (Passel and Cohn 2009).

Chronic disease requires regular care. This research brief seeks to investigate, understand, and critique the ability of Latinos to participate in the United States healthcare system, with special focus on the way the Affordable Care Act is shaping said participation.

## Affordable Care Act: An Introduction

The Affordable Care Act is the healthcare reform law enacted in March of 2010 under President Obama’s administration. It addresses issues related to insurance coverage and the healthcare system (APHA 2012).

### Changes to Insurance Coverage

#### Number of People Covered

- In states that adopted the expansion of Medicaid, just about everyone under 65 and earning below 133% of the federal poverty level is eligible.
- Insurance marketplaces created by each state enable more individuals who were previously uninsured and small businesses who did not ensure their employees to get insurance at competitive prices.
- Insurers can no longer discriminate based on pre-existing conditions.
- Children are allowed to remain on their parents’ plans until they are 26.
- Nearly all Americans are required to hold health insurance or pay a penalty based on their income level.

#### Increased Benefits and Protections

- Every plan offered through the exchanges is required to have a minimum set of benefits.
- A pre-determined set of preventative services are free to the individual, regardless of plan, including special additional services for women and children.
- Rate restrictions prohibit the charging of higher premiums based on gender or health status.
- Annual and lifetime caps cannot be placed on essential benefits.
- Competing insurers must provide summaries of their benefits and coverage to foster easy comparison by consumers.

#### Decreased Cost

- Subsidies and tax credits will be available to eligible individuals to allow them to afford coverage.
- At least 80—85% of premiums must be spent directly on healthcare as opposed to other overhead costs or as profits. If this does not occur, insurers must refund enrollees.
- Any increase in premium costs above 10% must be publicly justified and approved by either the state or federal government.
- Medicare recipients who reach the prescription coverage “donut hole” will receive rebates while the government works to eradicate the donut hole.

# Changes to the Healthcare System

## Improved Quality and Efficiency

- Encouragement of providers to work together in Accountable Care Organizations to coordinate care, improve its quality, and reduce cost by offering them Medicare incentives.
- Organization of Medicaid to encourage implementation of medical home models that coordinate care and integrate community-based services.
- Development of metrics to evaluate quality of Medicaid and Medicare providers.
- Medicare payments determined by quality metrics rather than strictly on the number of patients served. In particular, reimbursement will be decreased for mistake-driven care such as hospital-acquired infections and readmissions.
- Special efforts will be made to ensure the coordination of care for people eligible for both Medicare and Medicaid, generally the sickest and most expensive patients.

## Better Infrastructure

- Medicaid primary care provider reimbursements increased to match Medicare provider payments.
- 10% bonus given for Medicaid primary care services and to general surgeons who operate in underserved communities.
- National Health Service Corps funding to assist in loan repayment for doctors committed to serving underserved.
- Prevention & Public Health Fund (PPHF) for graduate and post-graduate training of people who want to work in public health and preventative medicine.

## Focus on Prevention and Public Health

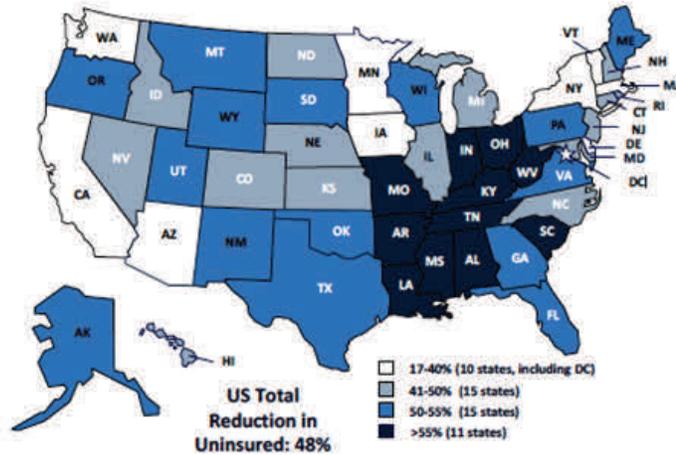
- PPHF funding for prevention efforts on state and local levels to maximize public health work as well as prevention research.
- Community Transformation Grants offered through PPHF funds to support community-level efforts aimed at addressing chronic conditions through prevention.
- Funding allocated for public education and outreach campaigns on issues such as nutrition and exercise, smoking and tobacco, and oral health.
- Community health needs assessments must be performed by tax-exempt hospitals and public health stakeholders kept abreast of the process.
- Chain restaurants and vending machines are required to provide nutritional information of their products.



## Eligibility

- Must be a citizen or legal resident.
- Can choose between bronze, silver, gold, and platinum level plans, which cover 60%, 70%, 80%, and 90% of healthcare expenses respectively.
- Those who make less than 400% of the federal poverty level are eligible for subsidies, set at the costs of a silver plan.

### Reduction in Number of Uninsured Under ACA with All States Expanding Medicaid, 2022



Note: Includes effects of the Medicaid expansion and other provisions in the ACA.  
Source: Urban Institute estimates prepared for the Kaiser Commission on Medicaid and the Uninsured, October 2012.

## Medicaid Expansion: The Debate

Part of the Affordable Care Act, as President Obama wrote it, includes an expansion of Medicaid to include all people with incomes under 133% of the federal poverty level, closing the differences in eligibility across states. With this expansion, about half of America's uninsured population would become newly eligible for Medicaid. Because the unemployed in every state are eligible for Medicaid, this expansion specifically addresses the needs of the working poor. Beyond helping needy families for whom the subsidies will not be enough, the bottom line, which Obama's administration also encourages states to consider, is whether the cost of Medicaid expansion to the state will outweigh the cost to taxpayers of unpaid hospital bills from people who are uninsured and cannot afford care. The cost of this expansion will be offset by federal contributions which will cover 100% of costs until 2017, 95% until 2020, and 90% until 2022. Currently states are divided about half and half about the impact of Medicaid expansion (Obama Care 2013).

## Reflections on the Act from Local Experts



**Beth Wrobel**

**CEO of HealthLinc**

**Community Health Center**

HealthLinc is a network of six federally-funded health clinics serving the uninsured and under-insured in northern Indiana. It is run on an integrated care model which includes medical, dental, behavioral health, and optometry. Beth Wrobel predicts that 50% of her 20,000 patients will qualify for one of the services in the new insurance health plans. This, she emphasizes, is extremely important. "From our patients' perspective, they can get coverage through us, primary care, within our four walls, but if anything else happens outside of that... [Memorial and St. Joseph's] are good with charity care, but there's a limit." Many fear that if they go to the hospital they will lose their house or any savings that they have. Furthermore, she reminds those resisting having to pay for health insurance that the combination of fines and just one visit to the emergency room could easily equal the price of the yearly premium (Politically Speaking 2013).



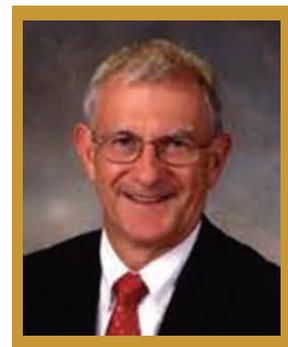
**Al Gutierrez**

**CEO of Saint Joseph  
Regional Medical Center**

St. Joseph Regional Medical Center, in addition to running its hospital, operates Sister Maura Brannick, a health center in South Bend which only accepts patients who are below 150% of the federal poverty level and ineligible for Medicare and Medicaid. As a result, it serves much of South Bend's Latino population. Al Gutierrez provides a few economic and structural insights on the Affordable Care Act. First, he asserts, the Supreme Court ruling giving states the option to expand Medicaid was the "first leg that fell off of the economics of the Affordable Care Act." Additionally, he reminds people, the program prescribed by the Act is only intended to increase coverage from 88% to 93%. Perhaps considered a stepping stone to universal coverage, it is not that as written. Finally, he comments, the majority of the healthcare budget is spent on intensive care units and the last months of life. Other countries have a much more "rational understanding of end-of-life choices," preferring "death with dignity" to "heroics."

Based on Gutierrez's comments, one cannot help but wonder if a prioritization of health conditions that insurance covers, with preventative care completely covered and risky procedures and life-prolonging measures largely unsubsidized by insurance companies, would lead to a significantly healthier people by allowing resources to be focused on the most efficient forms of healthcare. This debate, however, is bound to raise controversy over questions of human freedom. Because, for better or for worse, the United States is a country of heroics, at least for those who can afford them (Politically Speaking 2013).

Beacon Health System oversees both Elkhart General and Memorial Hospitals, whose bilingual diabetes management program has been particularly important for diabetic Latinos in the South Bend area. Philip Newbold explains the ways in which the Affordable Care Act is changing the country's philosophy on healthcare. Medicare, created forty-seven years ago, institutionalized a reactive model of care: the government springs into action once someone is sick. However, the new insurance plans offered through the state exchanges provide most preventative care services at no cost to the individual. In terms of doctors, their salaries will no longer be derived from fees for services rendered but instead episodes of care. The new system wants to "put doctors and hospitals financially at risk if a patient doesn't show up at their next appointment, or bounces back into the ER on a readmission." In this sense, responsibility for outcomes is both increasing on the part of the individual patient, with incentives for being preventative, but also being shared with the network of doctors providing care. The hope is that this system will encourage doctors to devise new healthcare delivery systems that lead to higher levels of patient compliance and a healthier America (Politically Speaking 2013).



**Philip A. Newbold**

**CEO of Beacon  
Health System**

## The Latino Enrollment Struggle

The biggest barrier to enrollment of eligible Latinos in the state exchanges is development of the local infrastructure to help them navigate the complex process, both linguistically and culturally. “The ACA provides funding for ‘navigators’ who are supposed to walk people through the enrollment process—which is likely to be akin to filling out a tax return in terms of complexity. Language barriers will add to that complexity for many eligible people” (Gold 2013). However, Hispanic community organizations, unlike health centers, are not eligible for the federal funds.

Even worse, community organizations agree that the federal government’s outreach to Latinos is not culturally-informed. “‘They’re doing an online campaign, and a lot of the Latinos we serve don’t have access to online services,’ [Angela McDonough, a program manager at the National Council of La Raza,] explains. The translation of the Obamacare Web site, [www.cuidadodesalud.gov](http://www.cuidadodesalud.gov), is ‘not culturally competent,’ she adds, ‘and some of the videos are still in English’” (Gold 2013).

Though the test-run of the basic principles of the Affordable Care Act, implemented by Mitt Romney in Massachusetts, was largely successful, “Hispanics were still the most likely to be uninsured” (Gold 2013). The success that was achieved is attributed to work on the local level by dedicated Hispanic organizations and health centers (Gold 2013).



## California Paves the Way

With California the biggest state in the nation and Hispanics its largest population, the success in enrolling California Latinos in the health exchanges is critical to the success of the Affordable Care Act. Under the Act, 1.7 million Latinos will be newly eligible for Medi-Cal coverage, California’s expansion of Medicaid. Additionally, 1.2 million will be eligible for subsidies to buy insurance in the state’s marketplace, Covered California. Along with eligibility, Latinos are some of the Act’s biggest supporters. While nearly 50% of non-Hispanic whites in California oppose the Act, Latinos, who compose 50% of the state’s uninsured population, support it 2 to 1. Gabriel Sanchez, professor of political science at the University of New Mexico, “believes Hispanics will ‘remain much more enthusiastic about the law than the general population. Ultimately,’ he says, ‘a large number of Latinos will enroll and they’ll overwhelmingly like it’” (Castro 2013).

However, enrolling these Californians in their respective programs is no small feat. “‘Especially among the Latino community, this is something new for them,’ says Santiago Lucero, a spokesperson for Covered California. ‘For the first time in their lives, millions of Californians, millions of Latinos, will have access to affordable health care’” (Castro 2013). This means the insurance vocabulary will be new to them: “‘coinsurance, copayment. What is that? They don’t know that, so we need to explain step-by-step what that means and how the law will affect them’” (Castro 2013). With this in mind, California has allocated \$40 million from the federal government to 250 organizations assisting individuals in enrollment through the Covered California exchange (Castro 2013).

# Affordable Care Act Specific Limitations for Undocumented and Recently Immigrated

## The Insurance Issue

In response to the prospect of insuring undocumented immigrants, Steven Camarota, director of research at the Center for Immigration Studies, says, “The bottom line is you can’t give 11 million more people subsidized health insurance without incurring a whole lot of cost” (Abascal 2010). Others, however, do not hesitate to remind him that many undocumented immigrants pay taxes and contribute to Social Security without receiving any of the benefits. “I think it’s a fairness question,” says Adam Gurvitch, policy analyst at the National Immigration Law Center. “They contribute, but they don’t receive any benefits” (Abascal 2010).

As it stands, undocumented immigrants are excluded from all forms of insurance through the Affordable Care Act except in situations in which they enroll through an employer who does not carefully check immigration status. They are not eligible for the Act’s expanded Medicaid program, the low-income subsidies, or even the right to purchase insurance completely on their own through the exchanges (Zuckerman, *et. al.* 2011:1997). And yet, they are also still largely discriminated against in employer-provided insurance because of the industries they work in. Agricultural, construction, and service-industry employers are the least likely to provide their employees with insurance (Zuckerman, *et. al.* 2011:2002).

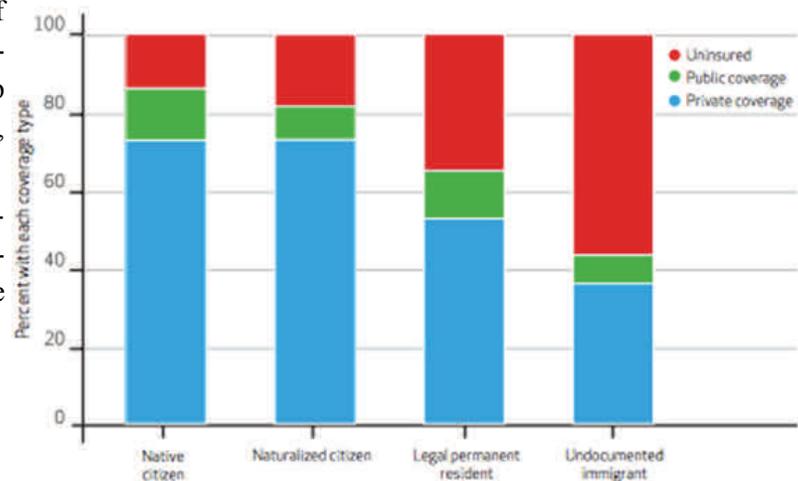
As a result, it is estimated that 61.5% of non-elderly undocumented immigrants will remain uninsured, comprising in some states up to 40% of the uninsured population (Wallace, *et. al.* 2013).

Further, as a result of the Welfare Reform Act of 1996, legal immigrants to the country are not eligible for public coverage for the first five years of their legal residency.

## Potential Solutions

There are a few compelling solutions which have been proposed to address the needs of undocumented immigrants. The first directly relates to expanded insurance provision. This works through a single-payer system, which provides healthcare to state residents irrespective of immigration status, and is being tried in Vermont. It may also work through requiring employers to provide coverage to their workers, as seen in Hawaii. The latter would particularly favor undocumented immigrants due to their high rate of participation in the work force: 94% for unauthorized men ages 18-64 in relation to 83% for U.S. born men in the same age range (Passel and Cohn 2009). Another option being debated is focusing available budget funds on providing a few high-yield services to the uninsured free or at low-cost. Others argue that the government needs to maintain its financial support of quality, cost-effective safety net programs (Wallace, *et. al.*). Finally, another option of interest is organizing insurance programs transnationally, that is, for Latino immigrants, providing coverage for primary care in the United States and high-cost services such as surgery in Mexico. This more effectively allows for cost sharing and mutual responsibility.

Type Of Insurance, By Immigration Status, 1999–2007



# The Latino Safety Net

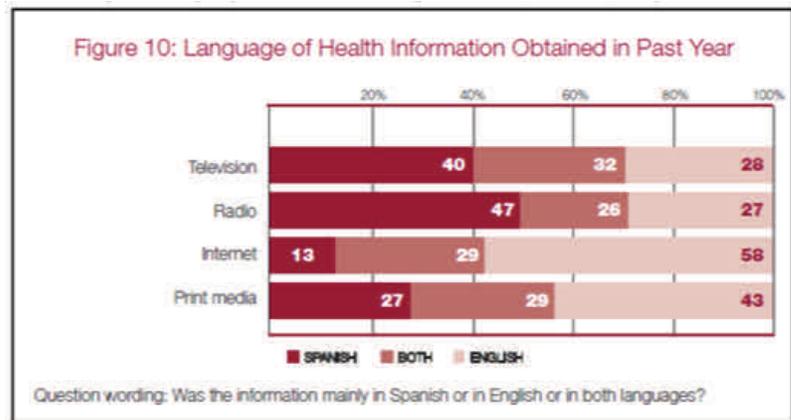
Traditionally, for people without insurance there have been two options. The first, and preferred, is to receive preventative healthcare from federally-, state-, or privately-funded clinics providing care blind to immigration status. Second, for more serious, emergency matters, every emergency room in the country is required by federal law to treat everyone who walks through their doors, even if they cannot pay.

As a result of the Affordable Care Act, however, an already patchy safety net has been rubbed thinner. The federal government's \$20 billion fund to reimburse hospitals for emergency care was cut in half, following the rationality that fewer people would be uninsured with the exchanges, and the \$12.5 billion fund for clinics Obama proposed to take care of the remaining uninsured population was cut by Congress.

## Must Capitalize on Networks

### Importance of Radio and Other Media

Effectively disseminating healthcare information into the Latino community extends far beyond the doctor's consultation room. The media through television, radio, newspapers, and the internet is proving a vital source of free healthcare information to the Latino population. Research shows that while 71% of Hispanic adults received information about health/care from a medical professional in the past year, 83% of Latinos received this information from one of the branches of the media and 70% from social networks. While 79% acted on the information they got from the media, 57% say this information prompted them to ask a medical professional further questions. Linguistically appropriate media programming is especially important for Latinos whose primary language is Spanish (Livingston, *et. al.* 2008).



Dame tu Mano is Elkhart General Hospital's Latino healthcare outreach program. In addition to operating a Help Line in Spanish, the program cooperates with two local radio stations to provide healthcare programming that is both educational and offers listeners an opportunity to call in with questions. They occur each day at 9 am on 1460 AM, la Mejor, and in South Bend at 10:20 am on the local Latino station, Sabor Latino, 93.5 FM. They discuss a topic of health for five minutes, after which questions are fielded from their help line (Montiel 2009).

## Must Provide Culturally and Linguistically Sensitive Care



**Alivio Medical Center**  
An Active Presence for a Strong Community



“If I can’t get through the door, I’ll have to use the window. And if I can’t get through the window, I guess I’ll have to blow the roof off the place.”

Carmen Velasquez established Project Alivio in the mid-1980s in response to the lack of healthcare available to the Latino community in Chicago, opening her first clinic in 1989. At that time, 40% of her patients had no insurance, and another 20% only had coverage for hospitalizations. Since then, she has expanded her force to a network of three bilingual, bicultural medical centers targeting nine communities in the Chicago area, in addition to three clinics in schools. “Alivio continues to meet the primary health care needs of over 20,000 Spanish speaking, predominantly Mexican immigrants who fall through the cracks of our health care system” through “high-quality, culturally sensitive, comprehensive medical care for those whose income, lack of health coverage or other social and economic vulnerabilities limit their ability to access mainstream medical care” (Alivio 2008).



## Must Coordinate Efforts and Be Innovative

“Even as the nation moves forward with the Affordable Care Act reforms, many low-income people—those already covered, those gaining coverage, and the twenty-plus million projected to remain uninsured—will continue to use safety-net providers for their care. These providers are located where the low-income populations live, and they have expertise in meeting their needs” (Felland, *et. al.* 2011).

Ascension Health is the nation’s largest nonprofit healthcare system, consisting of seventy hospitals. The organization emphasizes the importance of collaboration amongst healthcare providers to ensure maximum quality and cost effectiveness in provision of safety net services at low or no cost. Much of the success of their work relies on operating within coalitions of safety-net providers and community health organizations. One of the major initiatives they support is the development of information technology systems common across providers, enabling a physician attempting to treat a patient to view a written record, the narrative, of his health story. This is critical for under-insured people whose engagement with the healthcare system is irregular and scattered. Some systems additionally have the ability to check eligibility for public programs and enable emergency doctors to refer patients who visit the emergency room to appropriate primary care homes for continuance of and more proactive preventative care. This is particularly important not just when chronic disease is involved but also when physical conditions are co-presenting with mental health problems, which are significantly more prevalent amongst lower-income populations. Additionally, many safety net providers offer mental and dental care and prescription drugs. Another collective effort in many Ascension cities is creation of a central safety net pharmacy which collects all of the drugs donated and subsidized by various groups into one organized location, helping to ensure low-income patients continuity of prescriptions instead of being subject to the whims of drug availability. Finally, yet another initiative includes partnering with specialists directly and indirectly through hospitals to secure access to necessary doctors for this population. Through cooperation and communication, they aim to ensure an even distribution of charity care among hospitals, so no one bears a disproportional share of the temporal and financial burden. All of these innovative solutions are extremely important, because they increase the quality of care the under-insured population receives and reduce its cost, allowing more people to receive what they need (Felland, *et. al.* 2011).

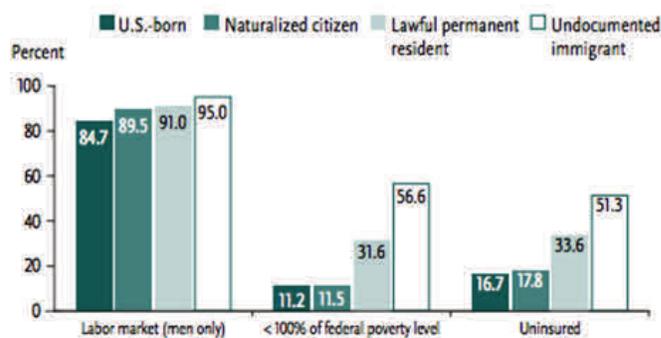
# Role of Latinos in the Labor Force

## Undocumented Immigrants: Essential Participants in the Labor Market

As of 2008, 8.3 million undocumented immigrants worked in the United States, representing 5.4% of the labor force. While this statistic may seem inconsequential, it is impressive given undocumented immigrants represent only 3.7% of the population (Wallace, *et. al.* 2013). In states such as Arizona, California, and Nevada, they compose upwards of 10% of the state’s labor force. Nationally, undocumented immigrants comprise 25% of workers in agriculture; 19% in building, grounds-keeping, and maintenance; 17% in construction; and 12% in food preparation and serving (Passel and Cohn 2009). 95% of unauthorized men are working, and therefore paying taxes, as opposed to 91% of legal immigrant men and 84.7% of U.S. born men (Wallace, *et. al.* 2013). Interestingly, statistics show the opposite effect in the female population. Only 58% of undocumented female immigrants contribute to the work force, in comparison to 66% of legal immigrants and 73% of U.S. born women (Passel and Cohn 2009). This effect is likely due largely to the unregistered nature of work categories, such as house cleaning and childcare, which many undocumented women participate in.

Despite their high participation in the labor force, the average household median income for undocumented immigrants is \$36,000, just above 150% of the federal poverty level for a family of four (Passel and Cohn 2009). In fact, another study indicates that 56.6% of undocumented immigrants live under the federal poverty line (Wallace et al 2009). Furthermore, with 47% of undocumented households consisting of a couple with children, it is clear not only that many such families are struggling to make ends meet but that, if they were eligible to participate in the state exchanges set up by the Affordable Care Act, they would be eligible for significant tax credits that would reduce the price of their monthly premiums (healthcare.gov).

**EXHIBIT 1. LABOR FORCE PARTICIPATION RATES, POVERTY RATES, AND UNINSURANCE RATES, CALIFORNIA RESIDENTS AGES 18 TO 64, BY CITIZENSHIP AND IMMIGRATION STATUS (UNADJUSTED), 2009**



Source: California Health Interview Survey, 2009.

## Latinos: Vital to the Future

Perhaps even more important than the current role they play in the work force, Hispanics are projected by the Bureau of Labor Statistics to account for three-quarters of growth in workers between 2010 and 2020. This is due to two primary factors. First, the Hispanic population is growing as a result of continued immigration and higher rates of birth, but at the same time, the non-Hispanic white participation in the labor force is slowing due to the aging of the baby boomer generation. Ultimately, the Hispanic share of the labor force is anticipated to grow from 14.8% to 18.6%, with Hispanics adding 7.7 million workers to the labor force and non-Hispanic whites decreasing by 1.6 million.

The challenge, however, is that not all workers are the same. While migrant work occupies a large portion of the Hispanic population, non-farm jobs are projected to increase by 19.7 million, with the largest numbers of jobs in health care and social assistance, followed by professional and business services. A college degree will become more valued. While most of the new jobs will not require higher education, the importance of low-skilled jobs will decrease because the most rapid growth will be occurring in fields requiring advanced degrees, decreasing the average worker's chances at upward mobility (Kochhar 2012).

Thus, decreasing disparities in education is essential for recent immigrant families in order to prepare them to assume the available jobs. Otherwise, immigration will decrease, Hispanic participation in the labor force will decrease, and a diminishing population will be left to fill the needs of a growing market.

### Spotlight: Dayton, Ohio

In post-Great Recession America, many Midwestern cities are ailing. People have moved away, leaving empty jobs and empty homes. However, Dayton, Ohio, like others, is realizing the growth and energy that immigrants can bring, rejuvenating its city. “We want to get back to the entrepreneurial spirit that immigrants bring,” said Richard Herman” who “advises cities on ideas for development based on immigration” (Midwestern Cities 2013).

Officials in Dayton “say their goal is to invite legal immigrants. But they make no effort to pursue residents without legal status, if they are otherwise law-abiding.” The mayor believes the worst 4000 immigrant families could do is occupy and fix up 4000 empty houses. “So how do we facilitate their success?” (Midwestern Cities 2013).

More than agreeing to co-exist, mutually subsisting off each other, leaders in Dayton wish to invest in their immigrants, enabling them to participate and contribute to their community. They have arranged for interpreters in important public offices, added culturally and linguistically diverse books to their libraries, created English classes, and sent their teachers back to school to learn other languages. In addition, they have cooperated with a local public university to ensure that skilled professionals, such as doctors and engineers, obtain the proper licensure to continue their work in the United States.



While some have criticized Dayton for being a “sanctuary city” that ignores immigration law, others hope cities like Dayton will provide “impetus to Congressional efforts to overhaul an immigration system that many say is broken” (Midwestern Cities 2013). Many agree this conversation starts with opening up ways to achieve legality. In the meantime, a serious discussion must occur regarding the right to health care for people who are being openly recruited to rejuvenate American cities. On a functional level, they must be healthy to work, but they are also actively contributing to taxes and deserve, by virtue of the mutuality created, to be ensured some level of quality of life (Midwestern Cities 2013).

## The Immigration Debate

### A Hard-Earned Right or “Amnesty for Outlaws”

One of the biggest challenges undocumented immigrants express is the difficulty of moving transnationally. They make it to the United States, work, and infrequently return to their homes and families because of the difficulty and expense of crossing the border back into the United States. “So many people back there depend on those of us who are here,” says Ms. Martinez, a thirty-year-old Nicaraguan woman working in a Houston hair salon. “It would be such a help if we could work in peace and go back sometimes to see our children.” Three of her four remain in Nicaragua. Most undocumented immigrants simply want a “a solution that allows them to overcome their greatest vulnerabilities,” explains Oscar Chacon, executive director of the National Alliance of Latin American and Caribbean Communities. Another Houstonian, Elena Sandoval, recalls missing her father’s funeral, which took place in El Salvador. “I can’t tell you how hard it is to leave your family,’ [she] said with a sigh. ‘ If only I could have permission to move about freely,’ she added. ‘Citizenship would just be a blessing we would pray for.’” Others demand a little more, and rightly so. Ms. Espinal, a Honduran woman who has worked in construction for over a decade, explains, “We have been working hard for our families and paying taxes all these years and we never lived off the government. Why shouldn’t we be able to vote someday?” Instead, this year her husband faced deportation and escaped only with the assistance of immigrant groups who fought for his freedom (Illegal Immigrants 2013).

The bill which passed in the Senate but became trapped in the House proposed a thirteen-year pathway to naturalization for 11.7 million undocumented immigrants. Obama held fast to his position that offering immigrants anything else “would create a disenfranchised underclass.” The country’s dependence on immigrants is not disappearing anytime in the near future, so to offer immigrants anything other than legal status is to enslave a people and justify it by calling them criminals.

The real systemic challenge of all of this is that while many moderate Republicans could be convinced based on this argument to consider comprehensive immigration reform, the party itself knows that after fighting immigrant issues for so long, legalization would create an entirely new and powerful population of Democratic voters (Illegal Immigrants 2013).



# Individual Independence or Collective Interdependence

## Opening Up the Affordable Care Act to Immigrants Might Just Save It

At its core, the Affordable Care Act creates a system of generalized exchange whose success hinges on the participation not just of the poor and those with preconditions but of the young and healthy who will, comparatively, underuse care. This participation provides the pool of money that will fund the necessary care for everybody. A fee as low as \$95, however, allows those who do not want to participate to opt out, avoiding the possibility that they may spend more than they receive in healthcare services due to their relative healthiness.

Regardless of physical health, anyone is an accident away from a trip to the emergency room. Every hospital in the country is required by law to treat anyone who walks through its emergency room doors, absorbing the cost if the patient cannot pay. As a result, people know that if they forego coverage and something happens, they can rely on this safety net. The emerging question is that of a person's responsibility to his community.

One of the major problems with the implementation of the Affordable Care Act is that it requires a different level of collectivism than that existent in the America designed by James Madison and Thomas Jefferson, "with their rabid hatred of the state" (Bellah 1998:622). Individualism, Tocqueville warned, "is the Achilles heel of the American experiment" (Habits 2007:xi). Richard Sennett concludes, "American society gradually does not merely erode the idea of cooperation but also eradicates the cultural tools or cultural know-how to enact cooperation" (Richman, *et. al.* 2012:9). Each citizen, "withdrawn into himself, is almost unaware of the fate of the rest. Mankind, for him, consists in his children and his personal friends" (Habits 2007:xi). The problem with this is that "under the ideological façade of individual freedom," we are becoming a society in which "wealth, ever more concentrated in a small minority, is the only access to real freedom" (Bellah 1998:623). Wealth allows one to operate autonomously, privileging a person not to have to rely on the collective systems of health care, public safety, and education, while the market "determine[s] the lives of everyone else" (Bellah 1998:623).

What the rich forget, however, is that the market that fills their pockets, providing them with agency, relies on the labor of a larger web of people to perpetuate it. "There is very little that Americans need that [they] can produce for [themselves] any more. [They] are dependent on the market not only for goods but for many kinds of services" (Bellah 1998:614). These goods and services exist vis-à-vis a network of uninsured Americans and recent immigrants who must be healthy to maintain that network. Many, however, are just receiving insurance coverage for the first time via the Affordable Care Act and others, because of their immigration status, are excluded from its provisions and therefore will remain uncovered.

Contrary to their upper-middle class, native-born peers, Mexican immigrants' "social interdependence" is "their bulwark against economic insecurity" (Richman, *et. al.* 2012:9). While many Americans suffered extensively as a result of losing their individual savings in the recession, "collectivist competencies appear to have helped keep many in the Mexican immigrant community afloat against all odds" (Richman, *et. al.* 2012:9). They rely on collective efforts to provide the collective agency necessary to secure their needs.

Interestingly, the best way to make the system set up by the Affordable Care Act solvent may be to enroll recent immigrants from Mexico, healthier than Americans and much more open to a collective system. This, however, would require a serious discussion of immigration and legal status, which the House proved this summer it is not ready to commence.

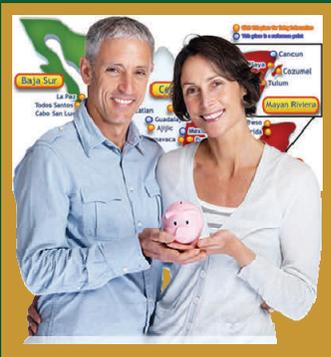
In order for the Affordable Care Act, or anything like it in the future, to work, we must have "some notion that we are in this thing together, that we need each other, that our precious and unique selves aren't going to make it all alone. That is a tradition singularly weak in our country, though Catholics and some high Protestants have tried to provide it. The trouble is, as Chesterton put it, in America even the Catholics are Protestants," individualist to the core (Bellah 1998:622).

# Transnational Healthcare

## Retiree Medicine

Despite the fact that undocumented and recent legal residents of the United States are neither eligible for Medicaid nor the insurance programs available through the Affordable Care Act, American citizens have had no problem capitalizing on the perks of the Mexican healthcare system. While research studies have shown that recent immigrants to the United States under-use healthcare, American citizens frequently fly to Mexico to receive emergency care.

In Mexico, a yearly fee of up to \$250 covers any and all health care a person needs: primary care, medicine, tests, surgery, dental, and even eye care. In the United States, add a zero to that number and count yourself lucky you escaped with such a small deductible. The Mexican plan, called IMSS, was founded in 1943 and is funded by a triumvirate of payroll deductions, employer contributions, and government funds. Therefore, like Social Security, it is designed to benefit people who have been contributing to it over the course of their lifetimes, not “bargain-hunting foreigners” (Hawley 2009). The reality, of course, is that the Americans with the agency to transplant to Mexico on occasion for care are not working but early retirees not yet eligible for Medicare in the United States. Further, they largely continue to pursue a regimen of preventative care in the United States, saving trips to Mexico for healthcare emergencies. Contrary to the plight of Mexican immigrants to the United States, obtaining residency visas as foreign retirees and then enrolling in IMSS has been a pain-free, simple matter. However, Javier Lopez Ortiz, IMSS director in San Miguel de Allende, says, ““If they started flooding down here for this, it wouldn’t be sustainable”” (Hawley 2009).



## Medical Tourism

### Spotlight: Mexicali

In Mexicali, just on the other side of the Californian border, 150,000 Americans came in 2011 for various types of healthcare, generating \$8 million for the city. The majority received dental, orthodontic, or ophthalmology care, as well as plastic surgery.

The city now has twelve hospitals and one hundred medical offices. Healthcare is its primary source of tourism, and an entire industry is developing around the 6-block radius containing the main healthcare district.

A medical lane has even been constructed at the border, allowing Americans with a doctor-issued pass to easily enter into Mexico (Medina 2012).



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