UNDOCUMENTED IMMIGRATION AND SOUTHERN ARIZONA'S HEALTHCARE SYSTEM:

A CASE STUDY ON THE IMPACT OF UNDOCUMENTED IMMIGRATION ON THE U.S. HEALTH SERVICES SYSTEM AND RELATED POLICY IMPLICATIONS

By

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ABSTRACT

Undocumented immigration is a serious policy issue directly affecting states along the US-Mexico border, and as healthcare costs increase, health systems in border communities are strained. The issues surrounding undocumented immigration and healthcare include the financial costs incurred by the healthcare providers, consequences specific to Arizona, medical implications for the population, and questions regarding the potential costs and benefits of including undocumented immigrants in a system of healthcare coverage. After reviewing the available literature, interviews were conducted with healthcare providers throughout Southern Arizona, which exposed a different view of the financial and human costs borne by both the providers and the population. This new perspective requires a holistic policy approach to balance the competing needs of financial sustainability for providers and fair access to care for those unable to afford medical services. Further research is necessary to expand upon the results of the interviews with healthcare providers, but it is clear that the issue must be reframed to fully capture the costs and benefits involved as undocumented immigrants access the US healthcare system.

INTRODUCTION

The cost of undocumented immigration within the United States (US) is a contentious issue across many different governmental systems, including education, security, and healthcare. Undocumented immigration has an undeniable affect on America's healthcare system, and as healthcare reform has come under the spotlight over the last year as a critical policy issue, undocumented immigration has been similarly scrutinized. Civic and political engagement groups are becoming increasingly polar as

the various proposals of healthcare reform, particularly regarding universal healthcare coverage, are discussed, with much of the controversy surrounding the right to healthcare. The undocumented population has been the scapegoat for the argument against universal healthcare coverage, with continued debates regarding the rights and status of this population in relation to the costs it incurs on the healthcare system. The concept of universal healthcare coverage is often criticized as it relates to the provision of healthcare services for the undocumented population, though there has been limited analysis regarding the real costs and savings such a program would have in relation to the systems strained by undocumented immigration. Although this issue fuels much of the debate about healthcare reform, few have recognized the complexities that must be dealt with as we analyze the relationship between undocumented immigrants and our healthcare system- the social, economical, and ethical considerations that must be discussed.

To more fully understand the policy implications that the growing population of undocumented immigrants has for our healthcare system, it is crucial that we focus on several key aspects of the relationship between the undocumented population and our health services system. What impact does undocumented immigration have on the US healthcare system and how might a policy of universal healthcare coverage that includes undocumented immigrants alter this impact? What are the local costs of undocumented immigration for healthcare systems near the international border and how are these costs being addressed? What are the legal, financial, and ethical implications of the unique impact of undocumented immigration on our healthcare systems?

These central questions must be addressed as strategies to contain the costs created by undocumented immigration are considered, especially with the recent discussion regarding healthcare reform. As undocumented immigrants continue to flow into the United States, our state and local systems are strained by the financial and social

burdens that multiply as the federal government struggles to secure our borders. To focus our discussion of the costs related to undocumented immigration and healthcare systems, we will consider the healthcare crisis in Southern Arizona that has resulted from the unabated flow of undocumented immigrants into the region. Issues within Southern Arizona's healthcare system are exacerbated by the tens of thousands of undocumented immigrants traveling through and residing within the state. As the costs of undocumented immigration permeate all aspects of Southern Arizona's healthcare systems, we will use this target area and its population of undocumented immigrants as our context for examining potential state and national solutions for easing the financial strain on hospitals struggling to provide care for those unable to offer payment for rendered services.

To analyze the relationship between proposed healthcare reform and the undocumented population, we will first examine the problem of undocumented immigration at a national level, along with the effects on the federal healthcare system. This will include a discussion of existing precedent regarding healthcare standards for undocumented immigrants. Healthcare providers have certain duties and obligations to all people, regardless of citizenship, and we must understand the legal and financial implications of current practices to move to an analysis of the proposed universal coverage reforms. We will then analyze these practices within context of Arizona as a border-state struggling to sustain its healthcare system. Once an understanding of the contextual information is acquired, we will consider the possible implications of a potential universal healthcare plan, since specific legislation has yet to pass through Congress. This will allow us to analyze the policy implications of the growing population of undocumented immigrants and the costs borne by border-states such as Arizona.

After a thorough review of the existing literature and data, I will conduct interviews with various stakeholders in the situation- healthcare practitioners, policy analysts, community leaders- in an effort to grasp the breadth and depth of the impact undocumented immigrants are having on Southern Arizona's healthcare system. As the responses of the interviews are evaluated, I will analyze the policy implications of the issue and the potential benefit of offering insurance coverage to undocumented immigrants. Finally, I will make a proposal regarding the effectiveness of current policy as we attempt to contain costs incurred by the undocumented population while still maintaining our legal and ethical integrity.

LITERATURE REVIEW

The relationship between undocumented immigration and healthcare resources is complex and far-reaching, with many contributing factors and possible consequences. In order to have the appropriate foundation to conduct the case study on the strain undocumented immigration places on Southern Arizona's healthcare system, we must turn to the literature to establish the context with which to analyze the local problem. We will first examine undocumented immigration as a national problem, then turning our attention to its effects on the national healthcare system and the legislation that has set precedent regarding healthcare provisions for undocumented immigrants. After surveying the medical implications current standards have on the undocumented population as a whole and the implied costs, we will examine the same problems in context of the state of Arizona, concluding with an assessment of possible universal healthcare proposals.

Undocumented Immigration: National Estimates

Undocumented immigration is a significant national problem that has largely remained unaddressed in recent years. Although this has limited salience for those living

away from the international border with Mexico, we cannot deny the presence of this population of undocumented people. In the literature and in our discussion, undocumented immigrants include all foreign-born people within the US who either entered the county without legal permission or remained in the country beyond the date specified upon entry (Hoefer, Rytina and Baker 2009)

As of 2008, it is estimated that 11.9 million undocumented immigrants reside within the US, making up an estimated 4% of the total population (Passel and Cohn, Trends in Unauthorized Immigration: Undocumented Inflow Now Trails Legal Inflow 2008). This population accounts for both those entering the US and those who have resided within this country for decades, however, this is a continuing issue, as approximately 300,000-500,000 undocumented immigrants enter the US each year (Kullgren 2003). The majority of these immigrants are from Mexico, making states near the international border with Mexico more vulnerable to the influx of undocumented immigrants; of the estimated 11.9 million undocumented immigrants in the US, about 7 million are from Mexico (Passel and Cohn, Trends in Unauthorized Immigration: Undocumented Inflow Now Trails Legal Inflow 2008).

Undocumented immigration is a complex issue that extends beyond immigration policy; the issue of identifying and penalizing adult immigrants is complicated by the fact that many have children with US citizenship. Since citizenship is acquired upon birth in the US and many undocumented women have children once in this country, it is estimated that 73% of children with undocumented parents actually have US citizenship themselves. These children represent 6.8% of all children enrolled in elementary and secondary schools within the US (Passel and Cohn, A Portrait of Unauthorized Immigrants in the United States 2009). As such, any kind of immigration policy targeting undocumented immigrants within the US will have a significant impact on many US systems, from education to healthcare. Although national debates regarding immigration

usually turn to arguments of crime, privilege, and citizenship, this policy issue complicates many aspects of our federal, state, and local governments.

Beyond our educational systems, undocumented immigration propagates the systemic problem of poverty, which can then lead to crime and additional life struggles involving job retention and health. The poverty rate for undocumented adults and children is double that of US citizens, and more than half of undocumented immigrants lack health insurance, which contributes to the vulnerability of this population (Berk, et al. 2000). As undocumented immigrants strain US systems, they also risk their own health and well-being, making the status quo a negative situation for all stakeholders.

Undocumented immigration is not a problem that will be solved without complex policy and systemic change. Undocumented immigrants provide inexpensive labor that is critical for certain industries; employers in labor-intensive industries such as agriculture and apparel are heavily dependent on the flow of undocumented immigration to bolster the labor supply, as the undocumented population makes up approximately 5% of workers within the US (Passel, Capps and Fix, Undocumented Immigrants: Facts and Figures 2004). Employers also have more power over undocumented workers due to intimidation and the threat of being apprehended by immigration officials. As Hispanics, undocumented workers have a higher chance of workplace fatalities, yet are unlikely to report or be treated for workplace injuries (National Council of La Raza 2008). This adds to the motivation of employers to hire undocumented workers, as their overhead costs for employee compensation, health insurance coverage, etc. are decreased as this vulnerable population is exploited.

This need is fed directly by the economic instability many immigrants face; with the North American Free Trade Agreement, competition with American companies forced many Mexican companies out of business (Living on the Edge: The Effect of Federal Immigration Policy on Cochise County 2004 2004). As reliable employment

became scarce in Mexico, undocumented immigration became a viable alternative, especially with the promise of American employment, despite the conditions. This, along with our industries' reliance on undocumented immigration, complicates this policy issue, as it is unlikely that employers will willingly give up these employees, despite the costs society must bear in relation to maintaining the status quo of the annual influx of undocumented workers.

Undocumented Immigrants and the Healthcare System

Undocumented immigrants represent a significant part of our population and affect many different governmental and social systems, however, a primary concern for both citizens and non-citizens is healthcare. Healthcare is not a right in the US, and all people are expected to pay for their care, enroll in social programs that will subsidize their care, or risk being turned away for treatment. This norm applies to all those accessing the US healthcare system, both citizens, legal immigrants, and undocumented immigrants. The only legal requirement for healthcare providers refers to emergency care. As a standard set by Congress in 1986, hospitals are required to provide emergency care as needed to stabilize the patient or to transport the patient to the nearest facility with the necessary equipment, regardless of the patient's ability to pay (Overview: EMTALA 2009)

Although undocumented immigrants are allowed access to emergency care, this population is barred from access to federal and state programs that provide healthcare resources beyond emergency Medicaid. Immigrants who legally reside within the US are excluded from non-emergency Medicaid coverage for five years from the time of their arrival, whereas undocumented immigrants are indefinitely excluded from these Medicaid programs, increasing the barriers of accessing necessary preventative and primary care. While Medicaid won't provide benefits directly to undocumented immigrants, it will reimburse hospitals and healthcare providers for the provision of

emergency care to all people, despite nationality, as long as the person in need of services meets the low income qualifications as set forth by Medicaid (Brooks 1997). Both documented and undocumented immigrants do qualify for emergency Medicaid, which includes only:

> "the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could result in: (A) placing the patient's health in serious jeopardy; (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part." (DuBard and Massing 2007)

Emergency Medicaid expenditures can generally be categorized as related to pregnancy, sudden-onset medical problems, or chronic disease complications; though the majority of these expenses are used for childbirth related costs, the use of emergency Medicaid by the elderly and disabled is increasing (DuBard and Massing 2007). The provision of services such as dialysis and chemotherapy are not considered emergency services and are not covered by Emergency Medicaid, despite the importance of these treatments (Scheer 2003).

Beyond emergency medical needs, there are major barriers to access to preventative, primary, and secondary healthcare. Undocumented immigrants face language and cultural barriers that, along with financial obstacles and negative stigmas, dissuade the population from seeking assistance. Those without health insurance lack the financial resources to pay out of pocket for medical screenings and routine exams; even those with health insurance face issues navigating the system and choose to avoid medical care rather than work with insurance companies for authorization and reimbursement of funds (Guttmucher 1984). Access to the American healthcare system is clearly restricted for undocumented immigrants, yet this population is having an incredible effect on the overall

system; even as legislation has been put into place to more specifically delineate what is required of providers to limit costs, undocumented immigrants strain the system, which puts both this population and the American public at risk.

Undocumented Immigration and Healthcare: Legislation

Proposed and enacted legislation relating to the provision of healthcare for undocumented immigrants has varied in recent decades, though any proposition for healthcare reform or for the expansion of preventative care for this population has been defeated and the status quo of allowing this population to access only emergency care has prevailed.

The Hill Burton Act of 1946 was passed to improve hospitals across the nation through grant and funding opportunities for hospitals to expand and modernize their facilities. As part of the Hill Burton Act, hospitals receiving funding were required to provide uncompensated care to a certain segment of the local population for twenty years after funding began. In 1975, this was extended, mandating that facilities receiving assistance from the federal government through the Hill Burton Act through grants and loans had to provide a certain level of uncompensated care in perpetuity (About Hill Burton Free Care Program, Titles IV & XVI n.d.). Eligibility for uncompensated care has been adjusted over the decades, but criteria are related to the federal poverty level and the consumer price index for medical care. Since there are over 6,800 Hill Burton mandated hospitals in the nation, this provided some level of care to undocumented immigrants until the population expanded beyond what hospitals could provide and other federal laws restricted available care (About Hill Burton Free Care Program, Titles IV & XVI n.d.).

Congress passed the Emergency Medical Treatment and Labor Act (EMTALA) in 1986 to ensure that all people have access to appropriate medical resources in the case of an emergency, despite the patient's ability to pay; technically, publicly funded hospitals

are required to provide "stabilizing treatment" for those in need of emergency medical care (Overview: EMTALA 2009). EMTALA was enacted to ensure a minimum level of care for all people (though this had no bearing on the decisions of private hospitals) and to discourage "patient dumping," a term referring to a hospital's decision to unnecessarily transport a patient to another facility based on the patient's inability to pay. EMTALA only applies to emergencies in which there exists a life threatening condition or a pregnant patient is in "active labor;" beyond this, hospitals have no obligation to patients with the inability to pay (Scheer 2003).

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was passed to reform government sponsored services, such as welfare, to increase accountability and cut cost. The PRWORA significantly restricted the availability of publicly provided services to undocumented immigrants, excluding them from all non-emergency federal programs (Medicare, Medicaid, State Children's Health Insurance Program) (Costich 2001-2002). The PRWORA allows for the provision of emergency medical services and general public health measures to prevent the spread of communicable diseases through immunizations and treatment of contracted infectious disease (Kullgren 2003). Beyond these emergency services though, the PRWORA prohibits the state from funding any public benefits for undocumented immigrants (Scheer 2003). Thus, the financial and social costs of providing preventative and primary healthcare for undocumented immigrants lay heavily with healthcare providers. Before the PRWORA, hospitals had to seek reimbursement for the emergency care rendered from the county, however, the enactment of the PRWORA made the reimbursement process a federal issue and essentially eliminated any county responsibility in the situation (Scheer 2003). In forcing hospitals to turn to the extensive federal bureaucracies, reimbursement issues were further complicated for medical providers,

creating costs that had to be absorbed by the hospitals or passed along to medical consumers.

Before the PRWORA, Proposition 187 in California was on the ballot in 1994 and is perhaps the best example of the consequences of a piece of legislation directly targeting undocumented immigration. Proposition 187 denied all public services beyond the provision of emergency medical care, including social services and education, to undocumented immigrants and mandated that public agencies had to report any known or suspected undocumented immigrants to the authorities (Tolbert and Hero 1996). This was an aggressive measure to alienate the undocumented population in hopes of discouraging residency in the state; there were many debates about this proposition in relation to human rights and welfare. Proposition 187 eventually met legal challenges that left the proposition unable to be enforced, but it still caused undocumented immigrants to avoid seeking healthcare and accessing any public health initiatives, forgoing vaccines and free clinics due to the risks of being identified as an undocumented person (Costich 2001-2002). This caused an increase in catastrophic illnesses, the development of chronic disease, and in the number of children going unvaccinated within the undocumented population, threatening that population and those in contact with these vulnerable people (Costich 2001-2002). Even though Proposition 187 remained unenforced due to legal stipulations, the fallout of this type of legislation is clear and it serves as an example of the negative externalities that directed policies can have when vulnerable populations are alienated.

Since the provisions set forth in the PRWORA, several pieces of legislation have been introduced that would provide compensation to hospitals for administering preventative and primary care to the undocumented population. Pieces of legislation such as the Federal Responsibility for Immigrant Health Act of 2002 (FRIHA), which would have provided preventative care, prenatal care, and treatment of communicable

diseases to the undocumented population, have never made it out of Congress due to fundamental disagreements about the status and rights of undocumented immigrants (Scheer 2003). As such, undocumented immigrants are currently restricted to access to only emergency care, which has significant consequences for that population.

Medical Implications

Preventing undocumented immigrants from accessing primary care and restricting their healthcare access to emergency care has serious human costs for this population, and by default, the nation. Officials are recognizing a potential public health crisis as the population of undocumented immigrants continues to grow without access to care, increasing the likelihood of the spread of communicable disease, compromised health, and the development of extensive chronic conditions (Costich 2001-2002). Since both undocumented immigrants are less likely to seek preventative and primary care and these programs are wholly lacking for this population in some areas, when medical treatment becomes an absolute necessity for these people, they face grave medical conditions. There are higher rates of late- and end-stage diseases, such as cervical cancer and renal disease, and conditions that are preventable with routine screening, such as hypertension, diabetes, and hearing loss, are more prevalent in the undocumented population (Guttmucher 1984). These conditions are unnecessarily jeopardizing the well-being of the undocumented immigrants, and as diseases are treated at later stages when medical intervention is more expensive, we see a significant increase in medical cost that usually defaults to local, state, and federal systems when the ailing, unsupported, undocumented person cannot pay.

It is estimated that as of 2006, 40% of undocumented immigrants had never visited a physician for an annual exam and 23% had never visited a physician at all (Goldman, Smith and Sood 2006). These statistics are evidence of the lack of primary and preventative care that leads to higher occurrences of severe medical problems within

the undocumented population and the substantial related cost. Perhaps one of the most costly subgroups of the undocumented population, pregnant women have become the focus of increasing concern, as these undocumented expectant mothers are more likely to develop expensive medical problems without proper pre- and post-natal care. Programs offering this care are generally unavailable to undocumented expectant mothers; for example, those lacking Social Security numbers are disqualified from seeking assistance from the supplementary feeding program supported by WIC, or the USDA's Women, Infants, and Children program (Guttmucher 1984). As healthcare resources for pre- and post-natal care remain lacking, a correlation is seen to those experiencing healthcare problems; one in six undocumented female immigrants has been hospitalized for childbirth or pregnancy related condition (Goldman, Smith and Sood 2006). These women access the healthcare system at the point of emergency medical services, typically bypassing prenatal or preventative care due to sociocultural barriers and lack of health insurance, endangering the health of the woman and her child.

It is argued that undocumented immigrants arrive in the US with an unduly high proportion of otherwise preventable illnesses, and due to their continued lack of healthcare, this population in general experiences lower levels of personal health and welfare. Beyond the negative physical, mental, and financial costs to the individual, this can have negative implications for society. As undocumented immigrants avoid preventative care, including vaccinations and routine screenings, concern has been raised about the possibility of the extensive spread of communicable diseases, especially due to the nature of the industries in which many undocumented immigrants find employment-agriculture and food production (Kullgren 2003). As this population is blocked from accessing care, they are instead given access to industries that have the potential to quickly and dangerously spread disease throughout the nation. For example, although designed to stem healthcare costs borne by society due to the needs of undocumented

immigrants, there was substantial concern over the public health consequences of Proposition 187. If undocumented immigrants are unwilling to seek needed healthcare due to potential legal backlash, physicians fear both that women will refrain from obtaining prenatal care and those carrying infectious diseases will incite an epidemic among populations lacking healthcare resources (Gavagan and Brodyaga 1998). Any sort of epidemic will have terrible medical implications for those who fall ill, and even for those who escape the physical effects, as all will bear the financial burden of managing a state or national healthcare crisis.

Further, studies suggest that creating more stringent regulations to restrict healthcare access for undocumented immigrants will not dissuade people from entering the US illegally. Limiting access will only increase the health disparities of this population; specifically, policies to restrict care have been identified as potentially causing significant harm to children, often US citizens, with parents who entered the country illegally (Berk, et al. 2000). Putting these children at risk only makes them more vulnerable to medical conditions as adults, further propagating the development of severe medical conditions, again increasing cost. Restricting care for undocumented immigrants is a serious public health concern, undermining the well-being of the population and of the healthcare system as a whole.

Estimated National Costs

The structure of the US healthcare system causes the undocumented population to incur substantial healthcare costs that are then transferred to society as a whole. Undocumented immigrants account for one in six of the uninsured population nationally, and as such, incur higher healthcare expenditures when compared to their insured counterparts (Passel and Cohn, A Portrait of Unauthorized Immigrants in the United States 2009). Undocumented immigrants cost the US healthcare system approximately $6.5 billion dollars in 2000 with about $1 billion of that financed by public dollars,

amounts that have only increased over the last decade (Goldman, Smith and Sood 2006). Broken down into more manageable terms, it is estimated that the costs of publicly funded medical care in 2000 for each household in the country was about $843, with $11 of this amount spent to provide care for undocumented immigrants (Goldman, Smith and Sood 2006). Small steps have been taken to alleviate the healthcare system of the burdens of undocumented immigration, though what has been passed does not promote system sustainability, but only briefly lessens the burden of undocumented immigration. For example, in 2003, Congress authorized that $250 million dollars be allocated per year from 2005-2009 for hospitals providing uncompensated care to undocumented immigrants; however, this amount was to be spread across the nation, barely making any impact on specific health systems that are burdened in critical areas, such as border-states (Okie 2007).

To fully understand the root of these costs, it is necessary to examine overall consumption of healthcare resources by the undocumented population. It is estimated that approximately 3.2% of the US population are adult, undocumented immigrants; despite their representation in the population, undocumented immigrants account for only 1.5% of healthcare costs. Due to the stigmas and access barriers to healthcare, adult undocumented workers contribute more financially to the government as a whole than what they consume as a population (Okie 2007). This disparity is critical to recognize in the analysis of cost; this population is contributing to healthcare costs, yet undocumented people are also giving back to the system. Although the undocumented population is not consuming resources proportionately, the resources that these people do have access to are the most expensive; this revelation is crucial in the construct of future policies to address cost.

Most undocumented immigrants are deterred from seeking primary or preventative care, and only utilize healthcare resources during an emergency or for acute

illness. This is evident when comparing undocumented children to uninsured children; per capita healthcare cost for undocumented children is estimated to be 86% lower than the costs for uninsured children, however, expenditures for emergency care were three times higher for the undocumented children (Okie 2007). Emergency care is significantly more expensive than primary and preventative care, and it is in emergency care that costs balloon exponentially and the undocumented population strains the US healthcare system. Health expenditures for undocumented immigrants increased 28% between 2001 and 2004, with rapid cost elevation for the elderly and disabled, and this significant increase is indicative of the growing burden that this population is imposing on the healthcare system (DuBard and Massing 2007).

Undocumented Immigrants in Arizona

Undocumented immigration has been a national problem for decades, but in recent years, this issue has become disproportionately harrowing for Arizona. In 1994, the Border Patrol's Strategic Plan focused on stemming undocumented immigration through traditional urban areas, such as El Paso, San Diego, and other Texas and California cities, shifting the problem of undocumented immigration to Arizona's borders (Living on the Edge: The Effect of Federal Immigration Policy on Cochise County 2004 2004). As the smuggling corridors for undocumented immigrants shift to Arizona, Arizona's communities now bear a majority of the burden of undocumented immigration for the nation, especially in rural areas that are not the focus of the Border Patrol's operations (Orrenius 2001). Arizona's proximity to the Mexican border makes the state more vulnerable to the influx of undocumented immigrants, as it is estimated that more than half of all undocumented immigrants are of Mexican descent, indicating that states near the international border, like Arizona, are more likely to face the immigration problem (Arizona: Population and Labor Force Characteristics, 2000-2006 2008). Arizona's proximity to Mexico, along with federal policies that sacrifice the financial

well-being of Arizona's state and local systems, has left the state to face this crisis with limited resources, resulting in a burden that cannot be ignored for much longer.

Arizona consistently tops the list of states nationwide in the annual number of apprehensions of undocumented immigrants, which has a critical impact on all systems within the state, including education, security, and healthcare (Immigration Enforcement Actions: 2007 2008). Despite the astronomical numbers of undocumented immigrants being arrested, a large proportion of this population is able to bypass the immigration system and reside within the state. It is approximated that 40-49% of the foreign-born population in Arizona was undocumented in 2000 (Passel, Capps and Fix, Undocumented Immigrants: Facts and Figures 2004). More recently, as of 2008, Arizona was home to 560,000 unauthorized residents, which is a 70% increase since the year 2000; clearly, the intensity of this problem is growing (Hoefer, Rytina and Baker 2009). Undocumented immigrants account for 7-8% of Arizona's total population and over 10% of the state's workforce, which is significant when compared to the estimate that undocumented immigrants make up only 4.9% of the national workforce (Arizona: Population and Labor Force Characteristics, 2000-2006 2008). Cochise County, which is situated along the Southeast corner of Arizona, with several ports of entry into Mexico, is a prime example of the sheer magnitude of the issue of undocumented immigration. During 2003, the number of undocumented immigrants apprehended in Cochise County was greater than the number of county residents; the area is being overwhelmed by this policy issue (Living on the Edge: The Effect of Federal Immigration Policy on Cochise County 2004 2004).

The crisis of undocumented immigration in Arizona is undeniable. The state must address undocumented immigration in terms of financial burdens on healthcare, educational, and judicial systems, to identify a few, but the situation entails other costs as well. Undocumented immigration entails high human costs, as these people face

significant harms when crossing the Arizona desert, including dehydration, exposure, and possible death (Hastings 2000). According to the Pima County Medical Examiner's Office, the deaths of undocumented immigrants have increased exponentially over the last decade; in 1999, there were six deaths of undocumented people within the Tucson sector, where as 2007 saw 237 deaths (Green 2008). More undocumented immigrant deaths occur in Arizona's border counties than in New Mexico or El Paso County, and whether from heatstroke, exposure to cold, drowning, lightning strike, or violence, and these deaths take a toll on Arizona's counties (Sapkota and et al 2006). These incidences are critical evidence of the increasing problem of undocumented immigration in Southern Arizona; these numbers only give a hint of the real problem, as many who have perished in the desert have not been recovered.

Annually, the costs of education, healthcare, and incarceration for undocumented people is estimated to cost Arizona taxpayers $1.3 billion, or more than $700 per native household, which creates a significant state deficit considering that undocumented immigrants contribute only $257 million in taxes each year (Martin and Mehlman n.d.). This immigration issue cost the four Arizonan counties along the international border over $24 million in fiscal year 1999, and this figure grows annually and is a significant drain on Arizona's local government resources (Salant, et al. 2003). Immigration problems have been targeted and reduced in California and Texas, but this was at the cost of Arizona's systems and sustainability; if left unaddressed, Arizona will continue to bear the burdens of undocumented immigration to the detriment of legal state residents.

Impacts on Arizona's Healthcare Systems

Arizona, as a border-state that is disproportionately impacted by immigration issues, is annually strained by the federal government's inability to secure the international border. Undocumented immigrants residing in and traveling through Arizona place significant burdens on the state's healthcare systems. As of 2002, it was

estimated that Arizona hospitals committed over $91 million dollars to the emergency care of undocumented immigrants; it is reasonable to assume that the majority of the cost was concentrated in counties near the border and the center of the immigration crisis (Scheer 2003). Especially troubling is the reimbursement rate for these costs by the federal government, which, for the same period, provided just over $650,000 in funding to cover the hospitals' expenses generated from providing care for undocumented immigrants (Scheer 2003). This leaves a significant deficit that hospitals must write off or cost-shift to the general population in order to recoup the losses.

In 2003, the Arizona Supreme Court required that the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid program) fund hospitals for treatment of undocumented immigrants far beyond the requirements of emergency care set forth by EMTALA (Scheer 2003). Although this would help alleviate the hospital's burdens in theory, statewide budgetary problems have deceased Medicaid funding, and thus, cut the ability of the state to appropriately reimburse hospitals. Additionally, Arizona's hospitals are left with the majority of the financial burden of caring for undocumented immigrants due to many loopholes in the standards of other federal agencies. For example, the federally funded Border Patrol can cost-shift the healthcare of undocumented immigrants to the providing hospital if agents transport the undocumented immigrant to the hospital before actually taking the person "in custody" (Scheer 2003). If the person receives care before "in custody," the cost is the responsibility of the hospital, whereas the Border Patrol is forced to offer reimbursement for taking a suspect "in custody" to a hospital for emergency care. Knowing this, agents can force the costs of providing healthcare to undocumented immigrants on the hospital, only contributing to the financial crisis of Arizona's healthcare system.

The four counties along the international border, Yuma, Pima, Santa Cruz, and Cochise, are the most heavily affected by undocumented immigration in the state. In a

2004 study of Cochise County, it was estimated that $589,475 was written off to provide care for undocumented immigrants between Southeast Arizona Medical Center in Douglas, Copper Queen Community Hospital in Bisbee, Sierra Vista Regional Health Center in Sierra Vista, Northern Cochise Community Hospital in Willcox, and Benson Hospital in Benson (Living on the Edge: The Effect of Federal Immigration Policy on Cochise County 2004 2004). These costs are substantial considering the small communities that each facility serves. Due to the population disbursement in Cochise County and the available medical resources, there is not a Level 1 trauma center in the county, which means that a consideration of costs in Cochise County must also include the medical evacuation costs of transporting patients to Tucson hospitals that have the specialists and equipment necessary to address the most severe trauma and injury cases. The costs of medical evacuation in Cochise County were estimated to be just under $2.5 million in 2004, and some organizations that incur these costs and participate in the transfer of undocumented immigrants estimate that they recover less than 5% of their cost (Living on the Edge: The Effect of Federal Immigration Policy on Cochise County 2004 2004). These costs undeniably burden the county, and as one of four counties along the border, we can expect the cumulative costs of providing healthcare to undocumented immigrants along the border to be significant.

A New Proposal: Universal Healthcare Coverage

The burden that undocumented immigration is placing on the healthcare system of both Arizona and the nation has been recognized as a key policy issue, though the appropriate measures to be taken remain unclear. As healthcare reform has been discussed nationally since the inauguration of President Obama, many have questioned the viability of a universal healthcare system in the US due to cost and our current healthcare structure of having services mainly provided by the private sector. A universal system would offer healthcare coverage to citizens, though the specifics of the proposals

have been vague up to this point; it is questionable as to whether such a plan would include immigrants, the extent to which it would subsidize healthcare costs, if there would be corresponding mandates for the population regarding enrollment in insurance plans, etc. (Nandi, Loue and Galea 2009). As such, the most effective way to analyze this possibility is to turn to other countries that offer universal healthcare coverage as a model for the potential consequences of this type of government funded plan.

Policies in which governments subsidize healthcare expenditures for citizens have been implemented in various countries, though the extent of government involvement is dependent on the individual country. In offering universal healthcare coverage, countries attempt to alleviate health disparities among different populations. A study in Canada, which offers healthcare coverage to its citizens, indicates that universal systems can be successful in achieving this; ensuring that all people have access to preventative and family physician care ameliorated the mortality disparities that were previously seen between different socioeconomic classes (Veugelers and Yip 2003). The implementation of a universal plan in Taiwan in the 1990's decreased barriers to healthcare access for those who had previously lacked insurance but failed to show any statistically significant affect on emergency room visits or overall healthcare consumption, which arguably would be a main motivation of such a system in the US (Shou-Hsia and Tung-Liang 1997). Across various nations with universal coverage plans, the countries with the highest levels of citizen satisfaction with their respective healthcare systems were those in which the government had higher levels of healthcare spending per capita (Blendon, et al. 1990). Clearly, universal coverage plans are worth considering as possible alternatives to market-ruled health systems as seen in the US, though there is much debate about the possible effectiveness of such a plan for those residing within the US.

Although this is a relatively new idea for the US, there are many who argue that universal coverage should include all residents of the US, including legal and

undocumented immigrants as a matter of human right. Supporters of universal coverage extending beyond US citizens argue that access to healthcare is a human right that should not be dependent on residency status, further referencing the need to provide preventative care and public health support to all populations to avoid epidemics and the development of costly medical conditions (Nandi, Loue and Galea 2009). Those opposed to including undocumented immigrants in a universal plan reference the population's violation of the law and lack of responsibility that citizens should feel towards this law-breaking demographic. Using Medicare as an example, some are concerned that offering universal coverage would increase healthcare consumption across all populations as is seen when the elderly age into Medicare, which would further strain already limited healthcare resources (Card, Dobkin and Maestas 2008). As these debates continue, the main issue that recurs throughout is cost, and how universal coverage, with and without coverage for undocumented immigrants, will theoretically alleviate the burdens on strained healthcare systems, though there has been limited discourse regarding the actual costs and potential savings of such a plan on state or local health systems.

Overall, the literature indicates that the problems surrounding undocumented immigration are at a critical juncture, with our healthcare system at its breaking point. As undocumented immigration inflicts billions of dollars of cost on the nation, Arizona is disproportionately burdened by this issue and cannot sustain the current drain on its healthcare system, with significant financial and human costs. As universal health coverage is discussed as an option of healthcare reform, few have examined the real costs and benefits that such a plan would have in relation to the undocumented population on a local level; only in analyzing local projections of costs and savings can the impact of a universal plan be estimated in a realistic manner.

METHODS

In order to analyze the true costs of undocumented immigration to the Arizona healthcare system, healthcare professionals will be interviewed and their answers will be analyzed to gain perspective on the issues at a local level. Understanding the consequences of current policies and practices locally will be valuable to the consideration of different policy alternatives meant to address the issue of undocumented immigration and the healthcare system, along with the proposal of some type of universal health coverage plan. First, we will examine the study methods, followed by a description of the analysis that will be necessary to interpret the research results.

Study Methods

According to Berg, interviewing is defined as a conversation with purpose (Berg 2004). The interviews conducted in this case study of healthcare systems in Southern Arizona will be structured as semi-standardized interviews. Unlike standardized interviews, in which there is no deviation in the language of the questions, the order, or clarifying follow up questions, semi-standardized interviews will offer the opportunity to maintain a consistent set of questions with limited deviations while allowing the interviewer to ask clarifying questions and respond to answers (Berg 2004). Due to the sensitivity of the issue and the complexity revolving around undocumented immigrants and healthcare, it is critical that the interviewer be allowed to slightly adjust questions according to the responses of those being interviewed. Further, due to the unique expertise of each professional being interviewed, it will be necessary to have the ability to ask follow up questions and clarify certain points and opinions. However, to be able to compare responses, the more structured format of the semi-standardized interview is preferred to the unstructured nature of unstandardized interviews in which the interviewer has extensive freedom in the format of the interview, questions, and response reactions.

The semi-standardized interview functions on the assumption that the interviewer may need to probe outside of the question set. In interviewing various healthcare professionals, it will be possible to formulate the question set in familiar language, although the less structured nature of this type of interview will allow for some digression.

Interviews will be conducted both on the phone and in-person; preference will be given to in-person interviews at the office of the professional being interviewed to ensure that the interviewee is comfortable and all verbal and nonverbal cues can be recorded for later interpretation by the interviewer. In order to gain local knowledge and expertise regarding undocumented immigration and healthcare systems, the following professionals will be interviewed:

- Larry Aldrich, President and CEO, University Physicians Healthcare
- Tara Sklar, Director of Access and Community Health, Carondelet Health Network
- Marie Wurth, Vice President and Public Relations and Human Resource Officer, Sierra Vista Regional Heath Center
- Mimi Joyal, RN MS, ER/OR Coordinator, Copper Queen Community Hospital
- Tony Struck, Interim CFO, Yuma Regional Medical Center
  Sheri Hanson, Director of Patient Accounts, Yuma Regional Medical Center
  Todd Hirte, Director of Managed Care/Budgeting, Yuma Regional Medical Center

These healthcare experts will be asked the following set of standardized questions, though some digressions will be made dependent on interviewee responses and reactions:

- How does your organization handle the costs of uncompensated care for undocumented immigrants?
- What are the financial costs realized due to the provision of services for undocumented immigrants?

- Are there any social costs due to the consumption of medical resources by populations unable to compensate providers for their services?
- Beyond financial costs, does your organization experience any specific consequences of being a healthcare provider in Southern Arizona?
- How does your practice handle charity care?
- Would you expect any costs or savings for your organization as a result of undocumented immigrants receiving some type of insurance coverage?
- Do you feel there are other issues beyond cost and compensation that are relevant to the discussion regarding undocumented immigration and the health services system?

Analysis

The responses to these essential, scripted questions will be recorded, along with any probing questions and applicable feedback. As a qualitative study, the answers will then be analyzed individually and in relation to the group as a whole. This will allow us to draw conclusions about the actual impact undocumented immigration is having on the healthcare system of Southern Arizona, along with the potential costs and benefits of a proposed universal coverage plan. The answers will also be compared to analyze whether there are any widespread schools of thought that seem to be accessed by healthcare professionals that may contribute to any answers or biases, giving some context to the results of the interviews.

RESULTS

Interviews were conducted in-person with Mrs. Joyal, Mrs. Wurth, and Mr. Aldrich, and on the phone with Ms. Sklar and the executive team from YRMC. The scripted questions were asked, though the responses from the interviewee typically extended far beyond the question's scope. Mrs. Joyal and Mrs. Wurth were interviewed February 19, 2010; Ms. Sklar was interviewed March 17, 2010; Mr. Aldrich, Mr. Struck,

Ms. Hanson, and Mr. Hirte were interviewed April 21, 2010. We will consider the results of each interview individually.

Mimi Joyal, RN MS, ER/OR Coordinator, Copper Queen Community Hospital

Mrs. Joyal first described the facilities at Copper Queen Community Hospital, located in Bisbee, Arizona. Copper Queen Community Hospital (CQCH) has four emergency room beds and four “fast-track beds,” which are lounge chairs for people in need of emergency care but stable enough to allow critical cases to occupy the emergency room beds. According to Mrs. Joyal, CQCH most always has at least one undocumented immigrant in its care, though this is likely an understatement as undocumented immigrants seeking non-emergency care typically receive services without strict verification of their documentation status.

Mrs. Joyal described the community divisions that result from the strong presence of undocumented migrants within the healthcare system. Residents of Cochise County have complained when undocumented immigrants receive treatment in the emergency room beds while residents receive treatment in the “fast-track” area; these objections were based purely on the principle that residents should take priority over those whose documentation status has not been verified. This creates community tensions that are evident at CQCH, yet are unavoidable as healthcare professionals are obligated to triage patients based on medical necessity without thought to citizenship status.

There are also palpable tensions between the healthcare staff and the Border Patrol. When an undocumented immigrant is brought in to the emergency room, a Border Patrol officer must monitor the patient at all times, basically sitting bedside for the officer’s entire shift. Many officers take a sterile approach to the situation and attempt to fulfill their duties in a way that can impede in the administration of medical care, which can create tensions between the officers and staff. These tensions are

noticeably heightened by the contrast in attitudes and interactions between the medical staff and the undocumented immigrants themselves. Undocumented immigrants on the whole are described as being thankful for the care they receive and generally respectful of the role of the medical staff and processes of the hospitals, in contrast to some officers who were described as haughty, cold, and even uncooperative with medical staff.

Mrs. Joyal explained the many routes in which an undocumented migrant can end up at CQCH. Some who are ill and traveling illegally throughout the area flag down Border Patrol officers to be taken to a medical facility en route to a detention center. Mrs. Joyal acknowledged that some undocumented immigrants may access care through the hospital using borrowed AHCCCS (Arizona's Medicaid program) cards or IDs, but this is difficult to identify as a trend. A more pressing issue is those who need emergency care. Though motor vehicle accidents are widely publicized as a leading cause of undocumented immigrants needing emergency care, Mrs. Joyal described the healthcare crisis undocumented immigrants face in Arizona in a different light. Many undocumented immigrants must climb and drop over a 15-foot wall to enter the United States, and in Douglas, along a targeted section of fence noted for undocumented traffic, and 15-foot pit is in place on the US side, so people crossing the fence in that area essentially drop 30 feet. This results in serious orthopedic injuries, which Mrs. Joyal described as the most prevalent medical problem seen at CQCH. She also described situations in which undocumented immigrants are brought in from heat exposure, exhaustion, and a number of injuries expected from crossing the harsh desert.

Most explicitly, Mrs. Joyal described a rarely discussed epidemic of joint deformities occurring as people continue to cross into this country illegally. Due to the gravity of the orthopedic injuries seen at CQCH, most of the bone breaks must be set surgically. As this is a non-emergency procedure in most cases, and many times surgery must wait until swelling decreases, follow up surgery is not offered in the United States.

Rather, undocumented immigrants have their breaks set temporarily and are given medical instructions to seek follow-up care in Mexico. Oftentimes, Mrs. Joyal will encounter repeat border crossers who come into the emergency room with new injuries, and upon examination, she finds that their old wounds/breaks have not healed properly, leaving the patient with open wounds and severe joint deformities. The patients often blame the medical practitioners in the US for their ailments, accusing medical staff of not fixing their wounds the first time around. From these interactions, Mrs. Joyal said that it is not clear where the miscommunication on the necessary medical follow-up happens. It may be that follow-up instructions are given in English and not followed by patients who speak only Spanish. The medical follow-up notes are given to Border Patrol when the patient is released into their care, so there is also a chance that the medical instructions are not being given properly or at all upon the patient's return to a detention center/Mexico.

Mrs. Joyal questioned where the responsibility for the patient lies and described a complex dynamic in the views of medical practitioners. On one hand, a patient is injured; on the other, there is an advantage to the medical cases coming into Southern Arizona's emergency rooms. University Medical Center in Tucson has one of the best training centers for hand surgeons in the country due to the high number of "gloving" cases, where undocumented immigrants essentially lose all the skin on their hands and forearms as they jump over the fence, which requires hand surgery to repair. The disproportionate prevalence of these cases in Southern Arizona is described as a serious advantage for our medical schools, which adds another layer of complexity to the effects on the healthcare system.

There is also the issue of the healthcare cases that confront the Ports of Entry along the border. Mrs. Joyal explained that the agency responsible for stopping the flow of undocumented immigration into our country is also known outside of this county as an

access point for people who need immediate medical care. If a Mexican national requires immediate medical care, they can be taken to the Port of Entry on the international border and transported by ambulance to an American hospital for care. This right is protected under the provision of “compassionate entry”. In Cochise County, the patient is most often taken to the hospital in either Bisbee or Douglas. This is abused, explained Mrs. Joyal, as some people feign illness to gain entry into the United States when other methods of entry fail; young children are often involved as authorities are less likely to seriously question a family with a potentially gravely ill child. Whether or not the patient has a real medical condition, they are discharged from the hospital under the premise that they will return to their country of origin, though often this is a free pass to be picked up by family members or friends in the US. These people are let into the US on humanitarian grounds with a family member and then discharged even though the Border Patrol is not present (and will not be called by the hospital as immigration enforcement is outside of the mission and abilities of the hospital).

Further, Mrs. Joyal stated that many patients found in the CQCH emergency rooms come for a variety of care that often goes unnoticed for the public. Douglas and Bisbee have only emergency labor delivery services; Mrs. Joyal estimated that about half of the cases they are forced to deliver out of medical necessity in their facilities are to undocumented mothers. Further, she testified to the fact that some people, though a limited number, do cross into the US specifically for medical care. For example, in Mexican facilities, there is often an expectation that procedures and treatment need to be paid for upfront, and if the patient cannot finance their needs, they are turned away. Since US hospitals operate under a different ethical code that commands treatment for emergencies despite citizenship or ability to pay, some patients in need of dialysis or other treatments for chronic conditions seek care in the US to save their lives. Still, the

majority of injuries Mrs. Joyal sees on a day-to-day basis are fall and wire injuries stemming from crossing the border fence.

Marie Wurth, Vice President and Public Relations and Human Resource Officer, Sierra Vista Regional Heath Center

Mrs. Wurth discussed the effects undocumented immigration has on Sierra Vista Regional Health Center (SVRHC), the largest hospital in Cochise County. She estimated that the hospital expends $250,000 annually on the care of recognized undocumented immigrants. SVRHC, as a community hospital, cannot refuse to treat people in need of medical care, even if there is not a guarantee that the hospital will be reimbursed for the necessary procedures. This means that there is some level of people "dumping" undocumented immigrants at the hospital for medical conditions, since treatment will be provided. If this occurs, the hospital works with the consulate to help people return to their native county; SVRHC allows patients access to a translator at all times of the day to improve the level of care that can be provided. SVRHC then uses their compassion programs and charity care to render services and the resources necessary, from clothing to transportation, to have the patient return home. It is difficult to estimate the true cost of providing this care, however, as the hospital does not ask for documentation of citizenship status; even if there are suspicions that a patient might lack proper documentation, the hospital is not a reporting facility and with strict confidentiality standards, will not call Border Patrol.

SVRHC does not experience significant losses due to the provision of care for undocumented immigrants specifically; the financial strain the hospital faces is a problem of the underinsured and uninsured in general, documented and undocumented, who are unable to pay for the medical services rendered at SVRHC. As far as the costs associated with undocumented immigrants, the hospital does received limited reimbursement from

the government, and the costs are somewhat restrained by the fact that SVRHC does not have a Level I Trauma center. Without this center for the most medically severe traumas, the patients with the greatest injuries, and often the greatest costs for care, are transported to Tucson hospitals, and SVRHC does not have to become involved with factoring the costs associated with those patients, beyond transport, into their budget. Losses that are experienced by the provision of care for people who cannot pay, both residents and immigrants, can be addressed by payment plans or simply written off as charity care.

Although undocumented immigration has a polarizing effect in the community, Mrs. Wurth emphasized the need for a comprehensive policy to address this problem to best accommodate the area. Despite the costs associated with the care of undocumented immigrants, the hospital also receives about $250,000 for care provided to those who enter the country legally for medical services and then return to Mexico. This shows the potential advantage of providing care to those outside our country if there were a system that allowed people to enter the US, receive the needed care and provide payment, and then return to their native country. Further, Mrs. Wurth acknowledged the economic impacts of undocumented immigration on the local construction, agricultural, and hotel industries; the costs that the hospital incurs from providing care to undocumented immigrants is part of a large, complex situation that has both benefits and costs for Cochise County.

Mrs. Wurth identified the main financial issue that SVRHC faces as the general provision of care for those lacking the resources to pay, regardless of demographic. With upcoming regulations that will mandate the use of electronic medical records, at the estimated cost of $11 million, and that may limit hospital reimbursement rates based on overall patient satisfaction surveys, the hospital faces serious difficulties in providing the highest level of care in a financially viable manner. Mrs. Wurth discussed that if the hospital cannot cost-shift enough to cover expenses, without government

reimbursements, the level of care provided by hospitals will fall short of community expectations. The industry faces issues in providing care to rural areas, a problem especially prevalent in Cochise County, and in finding the resources to implement new care strategies and regulations. Overall, the main issue Mrs. Wurth identified was not the effect of undocumented immigration on SVRHC, but the combination of an epidemic problem of people not being able to afford care and decreased support from governmental institutions that leave the hospitals to make tough decisions about how to provide care.

Tara Sklar, Director of Access and Community Health, Carondelet Health Network

Tara Sklar explained the difficulties that Carondelet Health Network is facing with respect to undocumented immigration. Carondelet Health Network is the largest Catholic, nonprofit healthcare system in Southern Arizona. Ms. Sklar described the problem plaguing Carondelet as universal for healthcare providers in Southern Arizona, though hospitals in closer proximity to the border, such as Holy Cross hospital in Santa Cruz County, have higher incidences of providing care for undocumented immigrants, particularly in obstetrics. She emphasized that the hospitals in the Carondelet Network are not reporting agencies and thus not responsible for verifying documentation of any patients or reporting undocumented immigrants to the authorities. However, a recently passed Arizona law, HB 2008, now requires any employee of the state who administers federal benefits to immediately report undocumented immigrants to the proper authorities or face criminal action as of September 2009. Ms. Sklar described the issue that this bill has created in healthcare facilities, since employees who would typically be involved in the continuum of care for undocumented patients are now required to report their illegal status to the authorities. For example, though the hospital is not a reporting agency and will not take part in the disclosure of a patient's immigration status, an involved DES

worker who discovers that a patient is in the US illegally must report the patient, regardless of confidentiality and the norms of nondisclosure in the healthcare setting.

Ms. Sklar described the fallout of legislation like HB 2008, which has a detrimental effect on the provision of healthcare services for needy populations. Many people are not accessing care in hospitals or community health systems out of fear of being reported, which may align with the short-term goal of limiting the benefits to undocumented immigrants, but there are questionable long-term effects as people do not access primary care but wait until more advanced and expensive emergency care is the only option. Some are circumventing the restrictions of HB 2008; many DES workers do not explicitly ask the patients about their status, so some patients have realized that as long as they do not disclose their immigration status, they will not be reported. However, many people wait until emergency care is necessary while trying to navigate potential Medicaid benefits and sliding scale payment options, leading to care that is more expensive and that often results in the hospital applying for reimbursement from the government. Hospitals do receive limited reimbursement from Section 1011 of the Medicare Modernization Act, which provides federal funds to help hospitals offset the costs of providing care for undocumented immigrants. Still, hospitals end up absorbing costs from care provided in the most expensive setting, the emergency room, for conditions that may have been prevented if people, regardless of immigration status, had access to primary care.

Ms. Sklar also described the cost issues that currently plague Carondelet Health Network. She explained that undocumented immigration is not a significant financial burden on healthcare providers compared to the costs incurred in providing for the general population of uninsured, poverty ridden groups that often access care in hospitals as a last resort. She spoke to the fact that while undocumented immigrants are targeted in the media and in debates as creating significant financial burdens for healthcare centers,

this argument usually reverts to racist generalizations rather than the reality that the costs are generally related to poverty and an inability to pay for care, regardless of race or immigration status. The hospitals also face reimbursement issues, as poor patients are often unable to pay and even governmental programs have delayed payments that are less than requested by the facility. This leads to the greater issue of providing care without shifting costs to patients able to afford care. In order to address this, Carondelet Health Network does offer twelve step payment plans to recoup some of the cost and allow patients to take responsibility for their care. Providers at Carondelet also work with the patient to access any insurance benefits or county programs such as PCAP, the Pima Community Access Plan, which helps people access primary care at a discounted rate before serious conditions develop. If there is not any way for the hospital to recover costs from the patient or other programs, the cost of care is written off as charity care.

Larry Aldrich, President and CEO, University Physicians Healthcare

Larry Aldrich is President and CEO of University Physicians Healthcare (UPH), which is a nonprofit corporation that is the largest physician's group in Arizona. Mr. Aldrich estimated that a minimum of 5% of the patients served by UPH are undocumented, though like other area hospitals, the issue of the uninsured in general outweighs the costs of providing care for undocumented immigrants. Although it is not the mission of UPH to serve the uninsured, physicians in the network often find themselves rendering care for those who lack insurance and are unable to pay for services.

Mandatory reporting does not restrict UPH, and the providers in the network do not disclose the immigration status of their patients to the authorities. The hospitals do incur costs for caring for the uninsured, though the billing departments offer self-pay schedules for those who are only capable of paying discounted rates for care. If

payments cannot be collected, the care provided can be written off as charity care, which is a cost that is built into the bad debt in the budgeting process. UPH providers also access Section 1011 to receive federal funds for the provision of care for undocumented immigrants. If a patient seeks non-emergency care and cannot afford the services at UPH, the providers often refer the patient to healthcare providers whose missions involve providing lower cost care to needy populations, such as Kino Community Hospital.

Mr. Aldrich discussed reimbursement concerns as a primary issue for UPH, for care provided to the uninsured, both documented and undocumented. For example, managed care programs such as PCAP (Pima Community Access Plan) give some financial relief to the hospitals by enabling patients to offer at least a minimal level of payment, yet low reimbursement rates can be a significant issue for UPH. The hospitals may receive as little as seven cents on the dollar for the provision of care, but this extremely low reimbursement rate disqualifies the hospital from deeming this charity care and seeking reimbursement from government entities.

In order to address the problems associated with providing care for undocumented immigrants and the general population of the uninsured, Mr. Aldrich mentioned a variety of potential solutions. We must bend the cost curve to address demand side healthcare strains. Mr. Aldrich also discussed the paradox of the healthcare system; we need people to adopt healthy habits to limit their use of the healthcare system to reduce cost, yet all incentives within the healthcare system support excess use of medical resources. Hospitals receive larger reimbursements with additional testing, so the culture of the medical field often errs to excessive testing and services, which increases cost for providing care to the uninsured. Mr. Aldrich also suggested that more care needs to be provided in an ambulatory or home setting to limit costs. In addition, governmental support for the charity care must be addressed; states often fall short of the ability to compensate hospitals since states cannot partake in deficit spending. However, Mr.

Aldrich also emphasized that the problem of providing care to undocumented immigrants must be tempered by the benefits of having these people in our system. Greater patient heterogeneity helps physicians and healthcare providers gain greater experience with a diverse population and varied problems, which ultimately helps the research missions of the hospitals. These potential advantages must be considered in the discussion of costs and benefits that will be necessary to resolve the cost vs. care dilemma faced by UPH.

Tony Struck, Interim CFO, Yuma Regional Medical Center, joint interview with:
Sheri Hanson, Director of Patient Accounts, Yuma Regional Medical Center
Todd Hirte, Director of Managed Care/Budgeting, Yuma Regional Medical Center

Mr. Struck, Ms. Hanson, and Mr. Hirte are on staff at Yuma Regional Medical Center (YRMC), which is a full-service, nonprofit acute care hospital. YRMC faces reimbursement issues similar to those experienced by other hospitals across Southern Arizona, and again, these issues involve the uninsured, both documented and undocumented. YRMC does contract with an outside company to facilitate the balancing of patient accounts, assisting patients who qualify for Medicaid and other subsidized programs identify applicable possibilities and fill out the paperwork. As this process occurs, patient accounts are put on 30-60 day holds; if there exist no applicable programs, care provided to those who are unable to pay is written off as charity care.

If the hospital knowingly provides care for an undocumented immigrant, YRMC seeks reimbursement through Section 1011, submitting collective claims quarterly. Though Section 1011 may help hospitals recoup some of the cost of providing care for the undocumented, there is significant payment delay that must be factored into the budget; for example, claims for care for these people provided between July 2009 and September 2009 were submitted in March 2010, with reimbursement expected in May 2010. The executives at YRMC estimate that the hospital's annual gross revenue falls

between $700 million - $850 million, and reimbursement from Section 1011 claims accounts for about $1 million of that total gross revenue.

YRMC is not a reporting agency and does not disclose the immigration status of its patients to authorities. Yuma was described as an area that experiences the flow of undocumented immigration, but undocumented immigrants are typically passing through and do not stay in the community. With an increased Border Patrol presence in the community, the hospital is treating less undocumented immigrants, so costs associated with this problem are decreasing for YRMC. Further, if Border Patrol brings in a patient in custody, the hospital can submit the claim for payment to the Border Patrol itself, which gives the hospital a better chance of recouping some of the cost associated with treating undocumented immigrants, though the success of this policy varies year to year.

Any losses that are incurred by the hospital are acknowledged and built into the budget. As executives construct the hospital budget each year, a certain figure is set aside for charity care, discounted services, and bad debt; the hospital's cost structure has allowed it to maintain profitability despite the issue of undocumented immigration. Further, to limit losses, elective procedures are not eligible to qualify as charity care, and those planning admission to the hospital typically must have a payment plan in order before care is provided; the losses associated with charity care and bad debt stem from the provision of emergency care.

Future financial concerns of the hospital involve the potential shift in reimbursement structures. The team at YRMC described Arizona as one of only three states that still has funds available through Section 1011, and due to issues with reauthorization of the legislation, the program will end once the funds are fully depleted. This means that YRMC will be unable to seek even limited compensation for much of the care provided to undocumented immigrants, and will instead need to assign the costs to charity care or bad debt. Further, healthcare reform's looming changes in reimbursement

rates for Medicare and Medicaid mean that any decrease in bad debt or charity care that may occur with more people having access to insurance will likely be offset by lower reimbursement rates for care covered by Medicare and Medicaid.

DISCUSSION

The interviews conducted with various healthcare professionals across Southern Arizona offered unique and valuable insight into the issue of undocumented immigration and the healthcare system. These results give important context to the literature on the topic of undocumented immigration and the healthcare system, and it is clear that discussions with those most directly impacted by the issue will be critical in working towards feasible solutions to this national problem. First, we will consider an interpretation of the results. Next, we will examine the overall findings of this endeavor, which will lead to policy implications, future areas of research, and finally a conclusion regarding the impact of undocumented immigration on the US health services system.

Interpretation of Results

Overall, healthcare providers acknowledge the impact undocumented immigration has on the healthcare system, but each professional interviewed described this issue as part of the overarching problem of providing care to people who lack insurance and the ability to pay, documented and undocumented. The financial strain experienced by healthcare providers is due to the large population of the uninsured who seek care only in emergencies, the most expensive setting in which to receive care, and while undocumented immigrants are a part of this population, undocumented immigrants are not the driving force of increasing costs and financials losses for healthcare systems.

Mrs. Joyal offered invaluable insight into the social costs undocumented immigration has on the healthcare system in Cochise County and the associated

community tensions. While it was acknowledged that undocumented immigrants should not be condoned or excused in their violation of the immigration law, the dynamic between the providers and the undocumented immigrant versus the dynamic between the providers and border authorities exposes the conflicting views about this issue. Undocumented immigrants impose costs on the hospitals, but it is critical that we do not forget that these immigrants are humans in need of compassion and assistance. The feelings of hostility that providers experience from the Border Patrol complicate the issue of undocumented immigration for people who may otherwise be willing to report the violation of the law. Further, significant social costs are borne by the population of undocumented immigrants severely or permanently injured by their experiences, and while the illegal efforts to enter the US cannot be condoned, Mrs. Joyal's experiences raise serious issues about creating humane policies that limit injuries and costs to the population violating the law.

The community tensions that arise out of perceptions of the kind of care residents versus undocumented immigrants receive are also important factors to consider in policy and practice related to this issue. These tensions must be examined, along with the seemingly contradicting policies prohibiting undocumented immigration while at the same time allowing compassionate entry into the country. The main message taken from Mrs. Joyal's interview was that this is a policy issue that has severe consequences for those involved, and the contradictions, tensions, financial losses, and perpetuation of the serious injuries resulting from poor governmental intervention must be addressed to prevent the epidemic of injuries, the human crisis occurring on the border every day.

Similarly, Mrs. Wurth emphasized the exaggerated way that the costs of providing care for undocumented immigrants are presented to slant the public's view on the issue and cause people to attribute significant financial strains on hospitals to a group that is only a very small portion of the problem. Community hospitals such as SVRHC

face serious questions of how to balance quality care with financial viability, yet it seems that this issue is not typically discussed and a significant portion of the blame is incorrectly placed on undocumented immigrants.

Ms. Sklar's interview shed a light on the various ways hospitals can recoup costs and the unintended consequences of legislation directed at addressing the impact undocumented immigration has on healthcare. The conflict of some providers in the continuum of care having to report the patient's immigration status to the authorities while the hospitals as a whole remain as non-reporting agencies seems to exacerbate the problem of people waiting to seek care only in times of emergency. This unintended consequence seems to be undermining the purpose of the legislation, and adds another layer of complexity to this already complicated issue.

Mr. Aldrich's insight into hospital administration exposed the incentive issues that work against the promotion of preventative care to limit excessive use of medical resources. This increases costs borne by healthcare providers and creates a greater need for emergency care. This applies to both documented and undocumented people and action must be taken if we are truly targeting uncompensated costs written off by the hospital. Further, Mr. Aldrich spoke to the difference in providing care for the uninsured and undocumented in a facility whose mission does not involve the provision of such care as compared to healthcare providers targeted towards these populations. What his descriptions exemplify is the widespread impact of undocumented immigration on all facilities, regardless of mission or cost structure.

Mr. Struck, Ms. Hanson, and Mr. Hirte offered important insight into the financial planning that must take place for facilities impacted by undocumented immigration. Again, they emphasized that undocumented immigration is a small portion of a much larger problem, and while YRMC has built the associated costs into their profitability structure, all facilities have major concerns about continuing to provide care to patients

who are unable to pay. Further, their experiences in holding Border Patrol liable for expenses incurred by immigrants in their custody demonstrates the interplay between healthcare providers and government entities, and the balancing strategies and negotiations that must occur to ensure that healthcare facilities absorb as a little of this cost as possible.

Together, these interviews exposed critical issues and themes in the relationship between undocumented immigrants and the healthcare system in Southern Arizona. The interview responses indicated that there is a serious misrepresentation of the issues surrounding undocumented immigration and the healthcare system. Media attention and national reports generally examine only the financial data when considering the issues faced by the healthcare systems, describing the issue in a cold, objective manner that ignores the human crisis. All of the healthcare providers interviewed emphasized the importance of healthcare facilities and of providers remaining as non-reporting entities to ensure that people are not afraid to seek needed medical care. When this issue is discussed nationally, people do not mention the injuries and negative impacts on the undocumented immigrants, which is a critical component of this complex policy problem. Those closer to the border who face these issues each day consider the costs and benefits of undocumented immigrants accessing our healthcare system with greater compassion than is typically expressed in the media. There seems to be an understanding of the true economic, social, and human costs of the situation near the international border, which gives healthcare providers a unique perspective as compared to those who fail to consider all aspects of the issue. Undocumented immigration undoubtedly strains the healthcare system, but not in the exaggerated manner often described, and the healthcare system is not the only entity enduring any burdens or negative consequences.

The healthcare providers generally explained the cost issues faced by their facilities as related to the large population of underinsured and uninsured; whether

documented or not, these people are unable to pay their medical bills. This does include many undocumented immigrants, but none of the providers identified this population as the driving cause of the cost crisis. The financial losses that are straining the system reflect a greater systemic issue that presents throughout the county. In Southern Arizona, however, it is easier to mark a population as the cause of all problems within local healthcare systems, despite evidence that shows that most hospitals are able to factor expected care of undocumented immigrants into budget and cost balancing systems, minimizing the undue burdens undocumented immigrants place on the system. Though extremely negative opinions are expressed and broadcast as representative of public opinion, the people nearest to the issue seem to lack this attitude and have a more understanding and holistic approach to dealing with the problems created for their healthcare facilities. The population of undocumented immigrants seems to be treated as a scapegoat for the healthcare crisis growing throughout Southern Arizona and the country, yet when the issue is pressed, it seems that undocumented immigrants have little net impact on the system and bear a significant amount of the costs, physically and otherwise, for attempting to enter the country illegally.

Overall Findings

A careful consideration of the literature available about undocumented immigration and healthcare, along with the research conducted to understand the actual impact of the population on healthcare providers, sheds an interesting light on this critical policy issue. Although we may not have answered the questions with which this project began, we can draw important conclusions from the data gathered and analyzed.

Undocumented immigration does have an impact on the US healthcare system, creating a financial burden for healthcare facilities that care for undocumented immigrants. The trends reported in national statistics and reports that are far removed from the situation seem to publish only part of the problem, giving a sterile, financial

summarization of a problem that is multifaceted with serious implications for the wellbeing of an entire population. The costs borne by healthcare providers along the international border do create a burden to some extent, though the facilities have factored the losses into their budgets effectively. The costs are addressed through limited reimbursement programs, flexible payment schedules, or are simply written off as charity care. The financial strain placed on the system by undocumented immigration is dwarfed by the costs incurred from providing care to the overall uninsured population, and this seems to be the primary concern for providers. While undocumented immigration is recognized as a problem, providers explain this issue realistically, recognizing the economic and human costs of the issue; the fact that those closest to the issue take a more compassionate stance speaks to the shift needed to reframe and portray this problem accurately, reflecting all relevant values.

The potential benefits of implementing a universal healthcare plan that includes undocumented immigrants are debatable, but this type of plan would arguably help hospitals offset costs. While most people are opposed to paying for benefits for this population, the data shows that undocumented immigrants do contribute to our social programs, indicating that a coverage plan would not necessarily be catering to a free-riding population. As undocumented immigrants are forced to delay medical treatment until emergency care is needed, we see higher costs for providers; though this can often be discounted as charity care for the hospital, in reality, there is a cost-shift effect that increases overall costs to all consumers. Any healthcare system that would extend insurance to a greater portion of the population would help facilities with what appears to be the actual financial strain most providers must address: caring for an uninsured population, regardless of immigration status, that is unable to pay for services and thus creates costs that must be absorbed by either the government or provider. While a coverage plan that included undocumented immigrants would be controversial and may

face staunch opposition, there seem to be real benefits that would decrease the strain on healthcare providers, increase access to primary and preventative care, and limit the human crisis that is occurring as people are injured and sickened as care is delayed due to documentation status.

Undocumented immigration does carry unique legal, financial, and ethical implications when considered with respect to the provision of healthcare. Legally, there is immense conflict and contradiction regarding the situation. Undocumented immigrants break the law and government employees who provide federal benefits are forced to report the violations, yet the legal requirements of patient confidentiality and the concept of compassionate entry have bearing on the provision of care to undocumented immigrants; it is not always clear what the legal system requires when providing that care. Financially, this policy problem is straining the system, and hospitals are forced to absorb the losses or cost shift to paying patients. While it seems that national reports overstate the impact of undocumented immigrants on the healthcare system, healthcare providers along the international border operate under the increasing burden of providing care to those who cannot afford the services. This leads into a string of ethical questions based on the financial and legal considerations of this issue. Several of the providers interviewed expressed ethical concerns about letting this problem continue unaddressed, as immigrants continue to be severely wounded without the ability to seek necessary follow-up care. There are ethical questions about how much providers' medical obligations bear on their legal obligations; physicians and nurses must provide care despite the patient's ability to pay, yet this is at the cost of their employer. There are also ethical questions that are beyond the scope of this research regarding our obligations to other people to ensure that a minimal level of medical care is provided to those in need and to what extent, if any, access to medical care is a right.

Policy Implications

After an extensive literature review and interviews with many people who have firsthand experience with the intersection of undocumented immigration and healthcare, several key policy implications become evident. Primarily, this revolves around the clear need for a more holistic policy approach to address this problem; the impact of undocumented immigration on the healthcare system is not strictly a financial or economic problem and cannot be viewed as such. The issue of undocumented immigrants accessing the US healthcare system must be reframed as we consider solutions so that policymakers have an accurate perception of all of the costs and benefits that result from this crisis, for people of all nations.

Policies designed to alleviate the burden undocumented immigration places on the healthcare system must address both overall reimbursement issues and the humanitarian crisis that is developing along the border. The general population of uninsured patients strains healthcare providers, so any policy designed to address this issue must include strategies for better reimbursement structures to ensure the financial viability of the system. Reinstating programs such as Section 1011 is crucial to enabling healthcare providers to continue to provide treatment for those in need while limiting the community cost of that provision of care.

Policy must also be created to ensure more accurate reporting and a more realistic discussion about the problem in a manner that includes those who face the issue every day. A participatory approach to management will ensure that people truly understand the costs and benefits associated with the high population of undocumented immigrants residing within the state while creating a context for candid and constructive conversation about how to balance the interests of all involved. We also need to design policies to emphasize the importance of primary and preventative care, again regardless of documentation status, to cut overall costs and avoid unnecessary losses from the

emergency room when injuries may have been addressed in a much less aggressive manner. Policies implemented to address the issue must take a realistic, combined look at the costs and benefits to ensure that the roots of the problem are adequately addressed.

Future Areas of Research

This analysis leaves open many areas for future research. Since this project began, healthcare reform has been enacted, though universal coverage was not included in the legislation. There are numerous questions about how the new healthcare legislation will affect the costs borne by the healthcare system due to the provision of care for the uninsured, and significant research is required to determine the effectiveness and efficiency of such a policy. Once the impact on citizens is determined, there are related questions regarding the costs and benefits of potentially including undocumented immigrants in some sort of scheme so that hospitals are not forced to absorb the cost of providing care.

Specific statistics regarding the care provided to undocumented immigrants are limited, since many undocumented immigrants secure care without disclosing their immigration status, which means that any losses associated with this care are attributed to the general population of the uninsured as opposed to undocumented immigration. Future research will need to note this and take a more comprehensive approach to examine this problem; the issue of undocumented immigration and the healthcare system cannot be examined outside of the context of the costs associated with the uninsured.

Although there were overall themes found in the interview responses, future studies regarding the human cost would be valuable to the conversation about how to solve these policy issues. When undocumented immigration is discussed, the issues raised by Mrs. Joyal, the day-to-day consequences of failed policy, are often omitted, despite the importance of this type of insight. Data related to injuries and the social costs must be collected, examined, and discussed if comprehensive policy is to be created.

Future areas of research must include data relating to the various impacts undocumented immigrants accessing healthcare have on a community to determine how to best alleviate cost while maintaining professional integrity.

Conclusion

Overall, while further research is necessary, we can conclude that undocumented immigration is a critical yet misunderstood problem facing the municipalities, states, and federal government. The problem needs to be reframed to include all aspects of the issue, and it is an absolute necessity that those along the border are advised and considered in light of the issue. The question of universal healthcare coverage may not be as relevant since healthcare reform has passed, but it does raise unique ethical and legal obligations regarding the issue. Although hospitals along the border do seem to be managing the losses incurred effectively, there is a need for a new management approach that compensates these providers while limiting the physical and social costs to immigrants and our communities. In the end, all people, despite immigration status, seem to deserve at least some consideration of medical need regardless of cost. However, in reality, undocumented immigrants seem to be a scapegoat, incorrectly characterized as burdens on the healthcare system despite their needs, and in failing to take a full account of costs and benefits, we fail to find effective policy that will address this growing issue.

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