

**SUSTAINING A HOUSE OF CARDS: THE HEALTH CARE OF  
UNDOCUMENTED MEXICAN IMMIGRANTS IN THE UNITED STATES**

By

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## ABSTRACT

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Undocumented immigrants in the United States (and arguably elsewhere) live in a precarious situation, lacking both the benefits of legitimacy due to their immigration status (legal exclusion) and the security of having labor rights, such as adequate working conditions, working hours, and pay (economic exclusion). The Patient Protection and Affordable Care Act, which passed on March 23, 2010, became yet another policy following the historical trend of restricting and limiting the health care of undocumented immigrants in the United States. In this thesis, I utilize a biopolitical framework to understand why the United States continues to restrict health care access to this population. I focus my analysis on undocumented Mexican immigrants because they are often blamed for the increasing costs of health care. I assess current perceptions and misconceptions of undocumented Mexican immigrants' use of health care. I examine how ambiguity in the United States' medical culture and tension from "bare minimum" health care manifests in the challenges undocumented Mexican immigrants and their health care providers face in Lawrence, Kansas. I argue that the United States should rethink fee-for-service health care with regard to undocumented immigrants because they cannot afford to participate. By not acknowledging this problem, the United States continues to control undocumented immigrants' bodies, keeping them subjugated through economic and legal exclusion.

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# CHAPTER 1

## Introduction

Pa' una ciudad del norte  
Yo me fui a trabajar  
Mi vida la dejé  
Entre Ceuta y Gibraltar  
Soy una raya en el mar  
Fantasma en la ciudad  
Mi vida va prohibida  
Dice la autoridad

Solo voy con mi pena  
Sola va mi condena  
Correr es mi destino  
Por no llevar papel  
Perdido en el corazon  
De la grande Babylon  
Me dicen el clandestino  
Yo soy el quiebra ley

Manu Chao, "Clandestino"

In the fall of 2008, I volunteered for a local nonprofit organization in Lawrence, Kansas, teaching English to Spanish-speaking immigrants. During my time there, I met a young man named Carlos. He was a 22-year-old undocumented immigrant from Mexico, working in construction. One evening, he came into class limping. I looked down at his foot, curious, but did not say anything because it was not bandaged. At the end of the class, I gave in to my curiosity and asked him what was wrong with his foot. He simply smiled and said it was probably broken. I smiled back, puzzled. After all, if my foot had been broken, I thought, I would not have had such a pleasant expression on my face.

Nevertheless, I pressed on, asking how it had happened. He said that it had happened during work, when a brick fell on his foot. It was swollen and might be broken. I asked if he had gone to doctor or hospital. Shaking his head, he replied, "No es bastante malo." *Not bad enough*. In my ignorance of the situation, I felt that the man simply had not cared enough about his own health, or perhaps, his not bandaged foot was a telltale sign of *machismo*, and with that, I let the conversation end.

Two years later, the United States was in the midst of health care reform.

Arguably a long time coming, health care reform had been a major issue since the early 20<sup>th</sup> century. Before that time, the federal government had continued to leave matters of health to state and local governments, and according to Starr (1984:240), “the general rule at those levels was to leave as much to private and voluntary actions as possible.” As such, the United States was not likely to mandate health insurance to the entire population (Starr 1984:240). By the end of 2009, the American public was fed up with the existing health care in the country. Not only was the government already dealing with pressure to reform immigration laws, as the public was greatly concerned with the increase in undocumented immigration and drug trafficking from Mexico, but it was also attempting to address the skyrocketing costs of health care and the vast number of uninsured. They demanded changes, and politicians answered.

Not surprisingly, undocumented immigrants, especially Mexicans, were at the top of the “who to blame” list for the high costs of health care. Under this pressure from both the public and other government officials, President Obama adamantly assured everyone that the reforms he proposed to make health care more universal “would not apply to those who are here illegally” (CBSNews Transcript 2009). I, however, did not feel so assured, not because I feared undocumented immigrants would somehow infiltrate U.S. health care. Instead, I was frustrated that the government openly targeted and denied health care to a specific population.

True to his word, when the Patient Protection and Affordable Care Act, passed on March 23, 2010, undocumented immigrants were entirely left out, except in mentioning that they would be denied participation. The act includes health-related provisions that will take place in the course of the following four years, including legislation that

mandates “everyone” buy health insurance and that expands Medicaid coverage to include those living at 133% federal poverty level. Ultimately, this act aims to insure 32 million people who are currently uninsured. Even so, millions of people will be left uninsured for various reasons, such as those who choose not to purchase insurance and pay a fine instead. Douglas Elmendorf, Director of the Congressional Budget Office (CBO), explains the particular case of undocumented immigrants:

Under current law, CBO projects that the nonelderly unauthorized immigrant population will total about 14 million in 2019. Of those individuals, nearly 60 percent (about 8 million) will be uninsured. A further 25 percent (about 4 million) will have employment-based coverage, and about 7 percent (1 million) will have some alternative form of insurance (other than Medicaid). The remaining 10 percent (about 1 million) will make use of some Medicaid coverage, reflecting the current law that allows unauthorized immigrants—who are not eligible for full Medicaid benefits—to receive limited Medicaid coverage for emergency care if they would be eligible for the program apart from their unauthorized status (2009:1).

The Patient Protection and Affordable Care Act of 2010 does not allow them to buy insurance regardless of their ability to pay for it completely and with their own money, which is rather conflicting as undocumented immigrants currently have such a high uninsured rate. For instance, Passel and Cohn (2009:iv-v) found, “More than half of unauthorized adult immigrants (59%) had no health insurance during all of 2007. Among their children, nearly half of those who are unauthorized immigrants (45%) were uninsured and 25% of those who were born in the U.S. were uninsured.” The act to an extent seems rather counterintuitive, given its aims. In thinking back to Carlos and his foot injury, I thought, there was more to the story, after all.

As Didier Fassin (2004:204) argues, “From an anthropological perspective, inequalities can be understood in terms of the way in which societies treat their most

vulnerable members.” Undocumented immigrants in the United States (and arguably elsewhere) occupy a precarious position in society, lacking both the benefits of legitimacy due to their immigration status (legal exclusion) and the security of having labor rights, such as adequate working conditions, working hours, and pay (economic exclusion).

In this thesis, I examine how the United States has handled health care regarding undocumented immigrants. I attempt to answer the following questions: Why were undocumented Mexican immigrants blamed for the health care crisis? Given that undocumented Mexican immigrants are a very real presence in communities like Lawrence, KS, can and do they find and obtain health care? What are their experiences in searching and obtaining care? How do health care providers negotiate the high costs of care with low-income or non-paying patients and the ambiguity that results from U.S. medical culture? Are the obstacles to health care that undocumented Mexican immigrants face a matter of economic or legal exclusion?

I also critique the claim that fee-for-service health care is an effective way to deliver health care to this population. I argue that restrictive health care policies, which result from a mix of economic and legal exclusion and have been pervasive historically (and currently, through the Patient Protection and Affordable Care Act of 2010), have subjugated the bodies of undocumented immigrants, particularly Mexicans. These policies act as a biopolitical tool of the United States to control and regulate undocumented bodies.

I begin in Chapter 2 by providing background information, including key definitions and concepts. I also discuss relevant anthropological theory and methods. I

propose a biopolitical analysis of this topic, based on Foucault's notion of biopower as an emergent technology of power that seeks to "make live and let die" and Redfield's concept of "minimalist biopolitics." I lay the foundation for understanding undocumented Mexican immigrants and health care in the United States on the biopolitical perspective in Chapter 3 by addressing why this population was and continues to be blamed for the high costs of health care. Characterized as a burden and disease on the nation and draining the health care "system," undocumented immigrants are a perceived threat to the lives of the authorized population.

In Chapter 4, I assess how health care providers and undocumented Mexican immigrants in the community of Lawrence, Kansas, deal with the challenges and tensions that arise out of restrictive policies and the ambiguity of the United States' medical culture. Given the challenges that the two groups face in providing and obtaining health care, respectively, the current trend of restrictive health care is an insufficient way to deal with the health care needs of undocumented immigrants, who are an integral part of the U.S. economy. Finally, in Chapter 5, I conclude by examining the results and implications of my research.

## CHAPTER 2

### Illegitimate Bodies: Background, Theory, and Methods

Policies regarding migrant labor figure prominently not just in terms of housing but more broadly in terms of the extent to which minimum benefits are guaranteed to workers: when, as with Mexican workers in the United States, migrants are seen as disposable bodies—cannon fodder in the global wars of capitalism—many opportunities for primary prevention, for HIV testing, and for access to care are missed because the jobs at which migrants work provide no health care.

Hirsch, et al. (2009:214)

This endeavor to research undocumented immigrants and health care is necessarily a multidisciplinary one, as current literature regarding undocumented immigrants and their health needs comes from a variety of sources, including economists, social scientists, public health specialists, and policy makers, who attempt to understand how, when, and why undocumented immigrants use health services, how much money is spent on their health needs, and whether the care they receive is adequate (Berk, et al. 2000, Ku and Matani 2001, Ortega, et al. 2007, Nandi, et al. 2008, Portes, et al. 2009). In this chapter, I draw from these multidisciplinary sources to provide definitions and key concepts. I then move to a discussion about anthropological theory and methods relevant to this thesis.

#### **The Undocumented, Unauthorized, and Illegal Alien**

Undocumented, unauthorized, and illegal are all terms used to describe immigrants (or aliens) who unlawfully reside in the United States. For the sake of consistency, I will use the term undocumented throughout this thesis, with the exception of quotations. Globally, about 20-30 million (10-15% of the world's migrants) are undocumented (International Organization for Migration 2009). In the United States,

undocumented immigrants number around 12 million (76% Latino), with those from Mexico making up 59% (Passel and Cohn 2009:i). In reality, the phrase “crossing the border” is synonymous with Mexico, despite the fact that Canada shares an even larger border with the United States (the largest in the world). For this reason and because they are the subject of intense policy reform, I focus mainly on undocumented immigrants from Mexico in this thesis.

While undocumented immigrants are often thought of as one entity, they are differentiated in many ways. According to Smith and Edmonston 1997:21, immigrants can become “illegal” by entering the country without its permission, by overstaying their period of authorized legal entry, and by violating the terms of their authorized legal entry. LeMay (2007:2), on the other hand, states, “Of the 10.5 to 11 million unauthorized immigrants in the United States today, approximately 60% are undocumented immigrants, and 40% are overstayers, fraudulent entrants, or persons failing to depart.” Undocumented Mexican immigrants generally cross the border illegally and are employed despite their lack of authorization.

#### *Why Does Undocumented Immigration Occur?*

International and migrant labor fuels today’s global economy. Highly industrialized countries like the United States and those in Europe depend on migrant labor, much of which is undocumented, to keep their economies afloat. Passel and Cohn (2009:iii) have found that the United States’ labor force consists of about 8.3 million undocumented workers, and while there was a sharp increase from 2003 to 2007, it has likely leveled off since then. Castles (1989:106) explains, “Mass departures occur when capitalist penetration and the transformation of pre-capitalist societies has already begun:

as the development of a money economy and competition from more advanced areas upsets existing forms of production and distribution, people lose their livelihoods, and are forced to seek entry into the modern sector of the economy.” Hence, the increase of undocumented migration seen by many industrialized countries from less industrialized ones. The North American Free Trade Agreement (NAFTA) enacted by the U.S. government in 1994 is one example of what Castle argues. NAFTA, in its, arguably, inadvertent displacement of the small farmer in Latin America through competition with subsidized U.S. corn, exacerbated existing shifts in economic trends. In this particular case, free trade did not mean free movement of labor. For this reason, many who are affected by policies like NAFTA must migrate without proper documentation.

This illegal movement of laborers has had negative reactions from the American public. Especially in times of high unemployment, there is a sentiment that foreign laborers, especially Mexicans, “steal” American jobs. Paral (2009:34), however, counters this argument:

The Midwest economy—and, indeed, the U.S. economy—is creating large numbers of low-skill jobs that far exceed the number held by Mexican immigrants. This suggests that Mexican immigrants are not taking away jobs, but filling the large increases in demand for those jobs.

Chavez (1986) also describes the unique reaction to Mexican undocumented immigrants in the United States since the 1980s. He argues that Mexican undocumented immigrants have acquired a “pariah group status,” meaning that very country that offers them opportunities for employment simultaneously characterizes them as an “unnecessary economic burden” (1986:350). Samuel Huntington (2004:30), in fact, an intellectual leader of the anti-immigration movement, in his article, “The Hispanic Challenge,” argues that increasing undocumented Mexican immigration is a threat to the larger U.S.

society because they lack the entrepreneurial spirit and desire to assimilate, which will culminate in splitting the country into “two peoples, two cultures, and two languages.”

### *Labor Segmentation Theory*

In neoclassical economic theory, disparities in wages occur due to differences in workers’ abilities, such as skills, experience, or education. In contrast, labor segmentation theory posits that the labor force is effectively split into primary and secondary segments. Labor migrants tend to be employed in the secondary segment—labor-intensive jobs, which are often seasonal and unstable, with minimal investment in high technology and machinery, as opposed to the capital-intensive primary segment, which uses high levels of technology to make efficient use of the workforce (Bauder 2006:20). Even within the secondary segment, there is considerable fluidity and ranges of wages and working conditions. Migrant workers, Bauder (2006:20) states, are not spread throughout the secondary segment evenly, rather they cluster in certain types of employment, such as manual labor, service industries, harvesting, construction, manufacturing, and mining.

Bauder (2006:20) states that the existence of expendable migrant workers, expendable largely due to their lack of rights, “in the secondary labor market absorbs cyclical and seasonal business fluctuations and therefore secures the jobs of workers in the primary sector.” The demand for migrant workers in the secondary segment of the labor market helps to explain cyclical patterns of migration seen in many parts of the world. Indeed, past labor migration from Mexico to the United States was characterized by a cyclical pattern. This population is increasingly becoming rooted in the United States, as increased border security has limited the option to return to Mexico (a

characteristic of past Mexican migration) (Ettinger 2009:5). With the undocumented Mexican population unable to return, fears that they will become a strain on public systems have increased.

### **The United States' Health Care "System"**

The 2009-2010 United States health care reform was an effort to repair the country's health care system, deemed to a great extent a failure due to its lack of cost effectiveness and numerous uninsured. Despite claims made that health care in the United States is among the world's best, it is arguably the most expensive but least effective. Although health care in the United States is largely based on the fee-for-service model, many different approaches to delivering care coexist in the country. Furthermore, many have limited or no access to health care. For this reason, I do not use the term "medical system" because a system it is not.

#### *Medical Culture*

I argue that health care in the United States should be conceptualized as what Last (1981:388) has called "medical culture," which refers to "all things medical that go on within a particular geographical area." According to Last, from whose work with the Malumfashi Hausa in Nigeria the term originates, the main feature of a medical system is a consistent body of theory that guides medical ideas and practices, whereas a medical culture lacks coherency. He explains that a medical system is one in which a group of practitioners adhere to and base their practices on a common body of theory, in which patients recognize and accept the said group of practitioners and the theoretical logic (regardless if they understand), and in which the "theory is held to explain and treat most illnesses that people experience" (1981:389).

Health care in the United States is best characterized as an eclectic mix of theories and practices, full of many contradictions and loopholes. Medical culture in the United States, with its mix of ideologies and practices, results in ambiguity and tension at the local level. For instance, Medicare, which is health care designed for those over the age of 65 or people who fall under special criteria, operates as a single-payer system administered by the government (interestingly, fears of socialized medicine have not stopped this program). Medicaid is a joint federal-state means tested program that provides low-income people who fall into specific categories with health care coverage. On the other hand, the younger population and employers participate in a type of market where health insurance is sold and bought, a part of the fee-for-service system.

Fee-for-service is a system in which health care providers are paid a fee for each service they provide to a patient, such as office visits and tests. Portes and colleagues explain:

In the absence of a universal health system, this means, in essence, that care seekers must be converted into ‘paying patients,’ either on their own or through some form of governmental subsidy (Portes 2009:494-495).

In the health insurance industry, fee-for-service plans are generally more expensive given the flexibility of choosing health care providers. I prefer to use the phrase fee-for-service health care instead of commoditized health care because the latter implies consumer choice, which is not often the case in health care.

Ku and Matani (2001) have noted that non-citizens, including the undocumented, tend to be uninsured in comparison to U.S. citizens. Given that most Mexican immigrants come to the United States to work, an obvious source for health insurance is through their employers; however, the jobs in which Mexican immigrants work are least

likely to offer insurance to their employees, and buying insurance out-of-pocket is too costly. For example, 22.6% of immigrants who work in industries that rely heavily on Mexican immigrants have work-based health insurance (Wallace, et al. 2007:18).

Undocumented immigrants have a high uninsured rate nonetheless and must somehow participate in the fee-for-service system of health care, despite their low-incomes and high uninsured rate.

### *Health Disparities and Their Justifications*

Singer and Baer (2007:152) describe health disparities as the “disproportionate or excess morbidity, mortality, and decreased life expectancy as well as unequal access to health care and other health-supportive resources (e.g. insurance or access to good nutrition) in disadvantaged groups in society or in the world at large.” They argue that much of the disproportionate “burden of disease” in the United States can be attributed to differences in socioeconomic status (Singer and Baer 2007:153). Nguyen and Peschard (2003), however, argue that while socioeconomic status has been considered a good indicator of health, “it is too blunt an instrument to capture the fine-grained differences that occur within groups that share the same material conditions of reproduction” (2003:450). Nguyen and Peschard (2003:453) suggest that in order to explain the correlation between social inequality and disease, local situations must be linked to broader analysis.

Portes and colleagues (2009:493) provide three reasons why health care in the United States is continually justified in comparison to other (more) universalized (and uniform) systems, even though there are obvious inequalities in access to care: the presence of safety-net clinics provided by federal, state, or charity organizations, in

addition to the notion everyone can visit the emergency room; the excellent quality of medicine in the United States, which could not have been achieved had it been socialized; and finally, the idea that if health care were universalized, people would take advantage of it, leading to its eventual demise.

There are problems with these justifications. For instance, the idea that everyone can go to the emergency room fails to hold, considering many undocumented immigrants do just that and have been vilified for it; the supposed excellent quality of medicine is only accessible to those who can afford it; and there is no evidence suggesting that universal health care would mean that people would overuse it. Portes and colleagues explain this last justification as “moral hazard,” a term commonly cited by economists (2009:493). In a study done by Portes et al. (2009), the researchers found that facing an increase in immigration, the U.S. health care “system” set up “coping” mechanisms in light of the polar views of health care as a commodity (fee-for-service) and health care as a human right. They state:

In the course of our study, we found hospitals and clinics that adhered firmly to the principle of health as a commodity and practiced what they preached by resolutely avoiding non-paying patients in general and uninsured immigrants in particular. At the other end, free clinics and a few religiously imbued hospitals vigorously endorsed the belief of health as a universal right and sought, as far as their means permitted, to put that belief into practice (Portes et al, 2009:500-501).

### **Anthropological Theory**

At the 2008 American Anthropological Association conference, Willen and Castañeda proposed a “Take A Stand” initiative to call anthropologists to take a more active role in understanding undocumented immigration and health care. This means that anthropologists must actually *take a stand* on this issue. Jennifer Hirsch (2003:231) has

proposed a “liberation anthropology,” (a parallel to Latin American liberation theology) in which the anthropologist not only gives a voice to those who have been silenced, but she also attempts to understand “the underlying causes of suffering and ill health, including the pathogenic role of social inequality,” and critically considers how the knowledge she produced will be used, such as in public policy.

### *Illegitimacy and Health Care*

The United States’ criminalization of undocumented immigrants, despite their importance in maintaining economic stability, leaves this population in an insecure position. Not only are undocumented immigrants restricted to low-skill jobs, but they also cannot access many of the public services intended for low-income populations due to their illegitimacy. Consequently, undocumented immigrants, just like other low-income populations, must deal with unequal access to health care; however, unlike other low-income populations, undocumented immigrants must also deal with exploitation from their employment and fears of deportation.

In his essay on the treatment of undocumented immigrants by the French health care system, Fassin (2004:204) argues that “the constructed illegitimacy of a category of the population tends to produce restricted access to its social rights, including in the domain that enjoys the greatest legitimacy: health care.” Fassin’s argument illuminates a fundamental problem in the construction of “social rights” or “human rights.” As undocumented populations, their rights are often questioned due to their illegality or lack of authorization. Criminality trumps humanity.

*Illegitimate Bodies: A Biopolitical Framework*

I utilize a biopolitical framework to understand how the United States handles the health care of undocumented immigrants. Biopolitics arose out of what Foucault (1990:140) termed “biopower,” “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations.” Biopower, according to Foucault, described the emergent forms of power in the 18<sup>th</sup> and 19<sup>th</sup> centuries, particularly the shift of the sovereign technique of the threat of death (letting live) to the modern power over life (making live) characteristic in capitalist societies (Rabinow and Rose 2006:195). The power of the state (by extension, its use by health professionals and scientists) in its various forms and degrees is justified as being vital to its life of the nation. In the realm of health care, biopower most notably manifests in the regulation of bodies to promote life, such as vaccination programs in public health. Rabinow and Rose (2006:195) have further developed this concept, examining how it can be used as an analytical tool for current societies’ strategies for governing life, through reproduction and genomic medicine, for example.

This focus on “making live” necessitates a definition of “life” and a consideration of whether all lives are equal. Agamben (1998), drawing from Foucault’s biopower, elucidates two types of life, bare life (zoe) and qualified life (bios). Bare lives constitute bodies, whereas qualified lives are characteristic of citizens. Bare lives must be transformed into qualified ones and the right to life must be fostered through discipline and regulation. With the inclusion of the bare lives of the legitimate population, however, comes the simultaneous exclusion of other less desirable illegitimate ones. For example, Zylinska (2005:86) notes that the “biopolitics of immigration” seeks to prevent

the bare lives of host communities from being contaminated by the “outside,” and strives to separate “genuine” bodies from those “wanting to penetrate the healthy body politic” by using technology to probe and scan bare lives.

Undocumented immigrant bodies are already subjugated through their experience of economic and political vulnerabilities. The collective worth of this population lies precisely in its lack of worth, or in other words, its exploitability. Because undocumented immigrants’ illegality prevents them from attaining and being protected by qualified life (citizenship), they exist solely as illegitimate bodies. The low collective worth of this population in the United States, in addition to negative attitudes and fears about them, results in a bare minimum type of health care, which must encompass at the least emergency medical treatment for anyone, regardless of immigration status.

Writing about health care in crisis situations, Redfield (2005:344) has coined the term “minimalist biopolitics” to refer to the activities of activist nongovernmental organizations like Médecins sans frontières (MSF), whose goal is “the temporary administration of survival within wider circumstances that do not favor it.” Organizations like MSF operate in crisis settings and do not have a presence in the United States. Redfield (2005:336) defines crisis in his essay as “a general sense of rupture that demands a decisive response, as most dramatically exemplified by the convergence of media coverage around episodes of conflict and disaster” (e.g., wars, famine, and earthquakes). Although undocumented immigrants’ experiences may not necessarily have the media coverage that natural disasters or wars provoke, I argue that they often mimic crises, crises of the everyday.

I contend that Redfield's minimalist biopolitics is applicable to the situation of undocumented immigrants in the United States in that the available health care options for them are shaped by bare minimum, basic survival types of care, including health care that seeks to preserve the lives of citizens (e.g., public health initiatives like TB testing and prenatal care for pregnant women). As communities recognize and interact with undocumented immigrants, they begin to realize that in the health care realm, there are everyday crises and emergencies that they are not equipped to handle, which can be exacerbated by not having enough resources or money to pay for services. In these instances, public health departments often take the role of managing situations of crises. This is exemplified in my own research in Lawrence, KS, where the community's plan to provide health care to undocumented Mexican immigrants began as a public health effort to help an escalating crisis in pregnant women without insurance. Elena, a nurse and case manager at the local health department, recounted its beginning to me:

Before I started working here, I don't know how many years prior to that, but so for several years, I think when the immigrant community here, especially Latino families started increasing, the nurses that were working here specifically in the program, started realizing, "Oh, we don't know where to send these women." The doctor's offices, without health insurance, were wanting to charge large sums of money, and so, the coordinator of the program, who is a long time community member, an activist, and an advocate, tried to pull some people together to say, "Look, we've got an issue. We've got some women that are here in our community, and they're having babies, and we want them to have healthy babies, so what can we do about this." So the hospital, health department, and many of the physicians in town agreed to work together to serve these women and to take turns, and so the doctors will take turns offering the prenatal care at no cost, and the hospital will provide things like lab services and certain testing fees no charge, all on the condition that emergency Medicaid is applied for and is hopefully achieved at the end of it all.

The resulting health care for undocumented immigrants is a conglomeration of bare minimum types of care, aimed at preventing major, life-threatening emergencies within financial capacity. As I will demonstrate later in Chapters 3 and 4, this kind of health care only exacerbates the problem of undocumented Mexican immigrants' lack of adequate preventive care.

As Elena's story illuminates, the main reason for Lawrence physicians organizing health care for undocumented pregnant women was an ethical one, yet toward the end of her story, she reveals that health care would be provided on the condition that state Medicaid funds would be applied for. Her story also demonstrates how financial constraints, such as Medicaid funds, can shape and restrict who receives health care and what kind. In this case, pregnant women and their young (citizen) children have their basic needs met but others must navigate low-income clinics or wait until a sickness or injury necessitates the emergency room. In addition to the tension between economic exclusion (not having labor rights) and legal exclusion (being undocumented), this ambiguity between health care as an ethical concern, a right for humans, versus the idea that health care is a fee-for-service, is a major theme in this thesis—the complex contradictions of which health care providers must often negotiate.

### **Methodology**

The questions I ask and answer in this thesis are not only relevant to the current political and economic climate of the United States but can also be understood in a global context. The undocumented migration of people is an issue that countries throughout the world are experiencing and have experienced in the past. I look to the issue of health care, specifically, in examining how the tension manifests itself in the situation of

undocumented Mexican immigrants in the United States.

In this thesis, I use bibliographic research, survey data, and informal (email correspondence, telephone conversations, and face-to-face conversations) and formal interviews to support my arguments. I interviewed 5 health care professionals, 4 documented Mexican immigrants, and 5 undocumented Mexican immigrants (I have changed the names of my informants.). With their permission, I also collected stories from individuals interested in my thesis topic, such as college students, nonprofit organization employees, individuals I met at Spanish church services and community events, and a doctor working in Arizona. This thesis is also informed by the Lawrence Latino Survey (Metz, Crosthwait, and León 2007) about public service use, conducted by University of Kansas (KU) students and coordinated by a KU professor and a local organization dedicated to serving the Hispanic population of Lawrence. The survey was conducted in November 2007 and comprised 128 Latino adults (40 female/88 male). Any information I include in this thesis using this survey reflects responses from Mexican immigrants (35 female/70 male), whose data I filtered and analyzed from the survey.

I conducted formal and informal (telephone calls and email correspondence) interviews with health care professionals and Mexican immigrants using the snowball-sampling method. Interviews lasted between a half hour to two hours and were generally conducted in a space preferable to interviewees, such as a public library, workplace, or home. I contacted and searched the websites of 4 low-income clinics and the hospital in Lawrence for general information about services for undocumented immigrants and for inquiries about potential interviewees. While I use examples and interviews from

Lawrence, Kansas, I am not suggesting that my findings are representative of the entire state or nation.

*Setting: Lawrence, KS*

Immigration from Mexico into the Midwestern region of the United States has already changed many communities. Paral (2009:3-5) provides a thorough analysis of the demographic and socioeconomic factors of Mexican immigration into the Midwest, about two-thirds of which is undocumented; however, he focuses on the four states with the largest Mexican immigrant population: Illinois, Indiana, Michigan, and Wisconsin. I believe that a focus on Kansas in this thesis would complement this study, because it too is experiencing what other Midwestern states are facing in increased Mexican immigration—changes in local populations (due to population loss and increase in immigrant populations), issues of integration into communities, and lack of access to and costs of providing public services. Roughly 2-4% of Kansas's labor is undocumented, with the majority working in low-skill and labor-intensive sectors of agriculture, construction, service, and food industries (Kansas Legislative Division 2008:20). With the exception of agriculture and the meatpacking industry (mostly existing in the southwestern part of the state), this represents the types of employment available in Lawrence as well.

Lawrence, Kansas, is a predominately white (84%) city of about 90,000 people, of which 4000 are of Hispanic descent (U.S. Census 2009). The city is also the home of a large state university, which contributes to the fluctuating nature of the population. Nela, the director of a local nonprofit organization that seeks to provide services to the Hispanic community in Lawrence, explained to me that undocumented immigrants work

in various jobs. For example, men are employed in restaurants, landscaping, food services, and construction, while women work in food services, hotel cleaning, domestics, and some sell tamales.

While Kansas does not have an undocumented population that rivals California or Arizona, it, too, has addressed the issue of access to public services with three main laws: In-state tuition for students regardless of immigration status, 2007 Driver's License Security Act (anyone requesting a driver's license must provide documentation proving U.S. citizenship or lawful presence), and the 2008 Healthcare Reform Act (requires the Kansas Health Policy Authority to verify citizenship for the State Children's Health Insurance Program), which has had some trouble in being put into practice due to lack of funding (Kansas Legislative Division 2008:7-8). These laws demonstrate the unclear position of undocumented immigrants in Kansas.

With regards to state efforts in providing health care to undocumented immigrants, Kansas has Federal Health Center in Topeka that implements a Farmworker Program to provide a limited number of services, including primary care, to the state's migrant agricultural workers, including a number of Low-German speaking Mennonite communities from Chihuahua, Mexico settled and working in the southwestern part of the state. The following is the program's approach:

The Kansas Statewide Farmworker Health Program accomplishes its goals by coordinating a state-wide voucher case management system for migratory and seasonal farmworkers to obtain health services. Vouchers for covered services are obtained from Access Point Agencies made up of state-funded primary care clinics and local health departments (Kansas Department of Health and Environment 2011).

Chris, who worked with the Farmworker Program for about 7 years, stated, "Easily 95%-99% of the people that we worked with were immigrants from Mexico." Using regional

case managers and health promoters to reach migrant farm workers, the center provides primary care by issuing vouchers for covered services to this population and by partnering with state, local, and private care providers. The center tries to provide services in immigrants' native languages, namely Spanish and Low German (Plautdietsch).

Unfortunately, the Federal Health Center is limited to migrant farm workers, who not only are often difficult to find due to their mobility but also are not concentrated in Lawrence. Elena, a nurse/case manager who works at the health department, mentioned to me, "In my 5 years here, I've never actually had someone come here for prenatal care with those vouchers." She added that she knew practitioners in other clinic areas that had heard of the vouchers or had maybe provided care for patients with vouchers, but she was not sure of the specific circumstances. I concluded that vouchers were not a major course for health care for undocumented Mexican immigrants in Lawrence. Those who are not farm workers must find other ways of obtaining care, usually through low-income clinics, charity clinics, or the emergency room.

#### *Methodological Challenges, Limitations, and Ethics*

Undocumented immigration and health care are both controversial topics, even more so when they overlap. In deciding to use the word-of-mouth method to find individuals to interview, I was able to find people more efficiently who were willing to speak to me. The biggest challenge I faced was trying to actually meet my interviewees because time was crucial for them, both health care providers and undocumented immigrants. The low-income clinics I contacted were so busy that I had difficulty in finding people with whom to talk, and many did not reply to my inquiries. As I will

discuss later, this was not totally unexpected because the professionals who work at these clinics are extremely busy, trying to meet the needs of many on limited resources. I also dealt with issues of hesitancy, shyness, and discomfort with both groups, understandably so. Undocumented immigrants and the issue of whether to provide them health care is a very sensitive subject for both groups.

The Lawrence Latino Survey (Metz, Crosthwait, and León 2007) has limitations. First, many people conducted the survey, so it is difficult to judge the reliability across interviewers. Second, the vast majority of those surveyed by the organization either stated “no” or did not respond at all when questioned about their usage of health care in Lawrence. For this reason, I do not place much emphasis on the survey data as many of the interviewers themselves noted the potential unreliability of the answers they received. One interviewer, for instance, wrote, “He seemed reluctant to give information; he didn’t seem truthful on some of the questions.” Another described the interviewee as a “cholo, tough guy type.” The interviewer explained further, “Who knows if he is telling the truth? I think he was embellishing quite a bit, but he seemed kind of drunk.”

Another major challenge I faced was deciding which names to change in the thesis. Early on, I had decided to change the names of the city and all clinics, in addition to my informants. I changed my mind about the names of places, opting instead for the real names. In doing so, I felt that using pseudonyms was not necessarily enough to protect informants who work in the public sector. As public figures in the community, I realized that there was some level of traceability. Traditionally, anthropologists have studied “down,” meaning that the people they study are in less powerful positions in the societies in which they live. Anthropologists are obligated to protect their informants to

avoid further exploitation.

I found that my research was in the middle, studying both “up” (health care institutions) and “down” (undocumented Mexican immigrants). I asked myself, would the same guidelines hold if by studying “up,” I uncovered corruption? Did I have the same obligations to the health care providers that I did with undocumented Mexican immigrants? The health care providers whom I talked to in my opinion were neither corrupt nor were attempting to exert their power overtly against undocumented Mexican immigrants. They had good intentions in trying to seek out and provide health care to undocumented Mexican immigrants. In order to balance informant protection and the public character of certain informants, I ultimately decided to make vague when possible the actual roles of my informants but not change the name of the location. If I changed the name of the location, I felt that I would be contributing to this populations’ invisibility.

## CHAPTER 3

### Perceptions to Policy: A Socio-Historical Analysis of Undocumented Mexican Immigration and Health Care

Uncompensated medical care expenses for uninsured patients is a serious problem faced by hospitals throughout the nation. And immigrants do play a part in this problem, not by choice, but by their disadvantaged position in the U.S. labor market.

Leo Chavez (2008:120)

Anthropologists have long been interested in how and by whom policies are created and how their implementation shapes and organizes societies. A policy is defined as a course of action adopted and pursued by a government, party, ruler, business, etc. In their article, "Towards an Anthropology of Public Policy," Wedel and colleagues (2005:34) state, "Anthropologists can explain how taken-for-granted assumptions channel policy debates in certain directions, inform the dominant ways policy problems are identified, enable particular classifications of target groups, and legitimize certain policy solutions while marginalizing others." Assumptions can include metaphors and linguistic devices that drive policy-making (Shore and Wright 1997). The anthropology of policy follows how policies are produced, how policy-makers' beliefs and worldviews shape policies, how policy-makers relate to the local populations in which they claim authority, and how policies are experienced at the local level (Wedel, et al. 2005:34). A significant problem in the study of policy is that it continues to be seen as a reified entity; seldom are the socio-cultural contexts in which policies are formed and implemented questioned, including their political nature (Shore and Wright 1997).

In this chapter, I look specifically at policies that were aimed at undocumented immigrants. In doing so, I analyze how and why restrictive health care policies have long

been the norm in dealing with this population. I examine the historical and social forces that led to such a negative reaction to undocumented immigrants, the popular perceptions and misconceptions about their use of health care, and research that has attempted to review health care use among undocumented immigrants. I argue that the misdirected blame results in public policies that aim to restrict health care options for undocumented immigrants. Consequently, this population experiences structural violence, which is institutionalized when they are left out of or negatively impacted by public policy and is exacerbated by the continual denial of economic and legal rights.

### **Political Efforts to Address Undocumented Immigration**

Immigration from Mexico into the United States, much of which is labor migration, has a long history. Despite being considered a recent phenomenon, undocumented border crossings of immigrants have been occurring since the 1880s. Immigrants from Mexico have long been a convenient resource for United States industries in terms of proximity to the country and demand for cheap labor. Various political actions have been taken throughout history to curb or eliminate undocumented migration depending on national sentiment and the economy. De Genova (2005), in his ethnography of Mexican Chicago echoes Hanson (2007), demonstrating that it is the “deportability” of undocumented Mexican immigrants that makes them such valuable commodities in the first place:

...the legal production of migrant ‘illegality’ has never served simply to achieve the apparent goal of deportation, so much as to regulate the flow of Mexican migration in particular and to sustain its legally vulnerable condition of deportability—the possibility of deportation, the possibility of being removed from the space of the U.S. nation-state (2005:8).

### *The Need for Cheap Labor*

Between 1929 and 1939, the so-called Mexican Repatriation occurred. According to Johnson (2005:2-3), “In a time of severe national economic crisis, the deportation campaign sought to save jobs for true ‘Americans’ and reduce the welfare rolls by encouraging Mexicans to ‘voluntarily’ leave the country.” As many as one million people of Mexican descendants were pressured or forced to move from the United States. Approximately 60% of those who were “repatriated” were actually citizens or children who were born in the United States (Johnson 2005:4). This act of “targeting” by the United States was certainly not the last of its kind.

With the beginning of World War II, the United States faced an extreme labor shortage; however, many of the potential temporary laborers had either forcibly or voluntarily left for Mexico. The Bracero Program, which began in 1942 under the presidency of Franklin D. Roosevelt, allowed temporary contract laborers from Mexico to work in the United States, particularly in the agriculture and railroad industries. Although the initial agreement between Mexico and the United States ended in 1947, the program continued, especially in agriculture, under a variety of laws until its official end in 1964. The Bracero Program offered an alternative to hiring undocumented immigrants and was supposed to decrease undocumented immigration; however, numbers still rose (Garcia 1980:39).

In 1954, at the urging of President Eisenhower, Operation Wetback began. Concerned about the rise in undocumented immigration, particularly from “wetbacks” (derived from immigrants crossing the Rio Grande). It was an effort to remove about one million undocumented immigrants from the southwestern part of the United States.

While the focus of Operation Wetback was “illegal aliens,” Mexican nationals in general were targeted, and in some cases, American-born children of undocumented immigrants, who were citizens, were also deported to Mexico (Garcia 1980:125).

### *Efforts to Reform Immigration*

The Immigration Reform and Control Act of 1986 (IRCA) was a law that intentionally targeted undocumented immigrants. This act attempted to stop undocumented immigrants from coming to the United States by imposing fines on or imprisoning employers who hired the undocumented and by granting amnesty to undocumented immigrants who were already living in the United States (ended May 5, 1988). IRCA did not go according to plan:

The problem created by the legalization and employer sanctions provisions of IRCA is that for undocumented immigrants who were not legalized and subsequently became unemployed or locked into their present employment, there is no access to legal employment (Hayes 2001:7).

Not only were the undocumented unable to access legal jobs, they also had to deal with exploitation from employers, as they did not have full legal protection. In effect, as Hayes states, “the intent of IRCA was to literally starve the undocumented out of the country by cutting off their means of livelihood” (Hayes 2001:7). As the current situation attests, IRCA failed to do its job, leaving the undocumented in an even more vulnerable position in U.S. society. Furthermore, as Katel (2005:398-399) has stated, “the government has nearly stopped enforcing 1986 sanctions on employers who hire illegal immigrants.” Employers claimed that they could not adequately distinguish between legal and fake documentation. This demonstrates a contradiction, with

employees being punished but not employers. It also suggests the reliance employers have on undocumented immigrants and their expendability.

The next major attempt at immigration reform occurred under the Illegal Immigration Reform and Immigrant Responsibility Act of 1996. This act created the concept of “unlawfully” present persons and also allowed states to take immigration matters into their own jurisdiction. States with large undocumented populations like California, and more recently Arizona, have attempted to do just that. In 1994, California’s Proposition 187 attempted to “starve” undocumented immigrants once again, attempting “to sharply restrict the access of undocumented immigrants to the public services, including schools and hospitals, and to reduce them to a very debased status” (Santa Ana 2002:xiii). Proposition 187 passed even though many deemed it unconstitutional. The American Civil Liberties Union and Mexican-American Legal Defense and Education Fund eventually overturned it.

#### *Access to Health Care*

Very few policies have addressed undocumented immigrants’ access to health care positively since the early 1990s, when undocumented immigrants’ use of public services began to gain widespread public and governmental concern. As I will discuss later in the chapter, the hospital, due to its inability to turn away patients dealing with medical emergencies, often deals with an imbalance in burden. This is in part from the use of the emergency room for childbirth by undocumented Latina immigrants. In their 1996-1997 study, Berk and colleagues (2000) found that hospitalization rates for childbirth were higher in four sites (El Paso, Houston, Fresno, and Los Angeles) for undocumented Latinas, while physician visits were lower for undocumented Latinos in

comparison to the rest of the U.S. population. The Sixth Omnibus Budget Reconciliation Act of 1986 attempted to address this, among other concerns of reimbursement, by expanding the eligibility of pregnant women and their children for Medicaid funded services, such as prenatal care, which is available only to undocumented immigrants. Emergency Medicaid, on the other hand, only covers medical conditions (like labor and delivery), which if not given immediate attention could result in serious harm to a patient's health.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or more commonly known as the Welfare Reform Bill, restricted funding for legal and undocumented immigrants. Immigrants who were admitted into the United States after August 1996 no longer eligible to apply for or receive Medicaid. With the exception of emergencies (Emergency Medicaid), immigrants had to wait after their first five years in the country. According to Ku and Matani (2001:248), the policy was effective: "The Medicaid participation of low-income noncitizens fell and uninsurance rates climbed from 1995 to 1998." The Deficit Reduction Act of 2005 directly impacted undocumented immigrants and their ability to access Medicaid. Under this act, anyone seeking Medicaid must produce the appropriate documents verifying that he or she is a citizen or legal resident.

Finally, and most recently, President Obama signed into law in March 2010 the Patient Protection and Affordable Care Act (PPACA), which was the product of the health care reform pushed by the administration during 2009. As I described in Chapter 1, undocumented immigrants were completely left out of reform, unable to participate in the health insurance exchanges or access Medicaid (except Emergency Medicaid). As I

have explained, historical and political actions by the United States generally adversely affected undocumented immigrants, increasing limitations and barriers. Such actions were often undertaken depending on the political and economic climate of the country, which help to explain the diverse historical reactions to undocumented Mexican immigrants—readily welcomed during times of economic prosperity and disparaged during economic decline. I, however, ask whether they are a drain in the first place?

### **Misconceptions of Undocumented Mexican Immigrants Health Care Use**

#### *Cost-Benefit Analyses*

It is difficult to assess the question of whether undocumented immigrants contribute or take away from the U.S. economy, considering the analyses that have been done use various methods to determine who is undocumented and take into account different variables. Additionally, one has to consider how the terms “costs” and “benefits” are operationalized. What is considered a cost and a benefit varies according to the study. For example, a study could take into account only financial costs without considering low prices resulting from cheap labor costs. Additionally, comparing and extrapolating from cost-benefit analyses can be difficult due to the scope of the studies, meaning local, state, or federal levels. Hanson (2007:19) elaborates on my point:

Overall, immigration increases the incomes of U.S. residents by allowing the economy to utilize domestic resources more efficiently. But because immigrants of different types—illegal, legal temporary, and legal permanent—have varying skill levels, income-earning ability, family size, and rights to use public services, changes in their respective inflows have different economic impacts.

Nevertheless, 67% of American voters believe that undocumented immigrants are a significant strain on the U.S. budget (Rasmussen Reports 2010).

In an effort to determine the economic impact of undocumented immigrants in their

own state, the Kansas Legislative Division of Post Audit (2008) reviewed the most comprehensive studies (11 states) regarding costs and revenues of undocumented immigration. They found a number of difficulties in generalizing and comparing the impact. For example, not all studies looked at both costs and revenues; the time when the study was conducted varied; undocumented immigrants were not always defined in the same way; studies looked at various levels of government affected; and the services provided by governments and the structure of their taxes also varied (2008:11).

Nevertheless, of the two most comprehensive studies (Texas Comptroller and the Bell Policy Institute in Colorado), the researchers reviewed, it was “estimated that the combined state and local costs exceeded the revenues associated with illegal immigrants” (2008:11). The federal government, on the other hand, actually enjoys an increase in revenue because undocumented immigrants pay federal income and withholding taxes (Hanson 2007, Nadadur 2009). Programs that incur costs are often implemented at the state level. This uneven burden between the federal and state governments is one reason for high tensions when it comes to costs and benefits of undocumented immigration. Nadadur (2009) concludes that undocumented immigrants make a positive contribution to the U.S. economy due to its segmented nature, while at the same time incur a cost at local and state levels; however, he suggests that more research needs to be done to determine tax contributions vis-à-vis fiscal costs. Hanson (2007:5) takes a stand in the debate, stating that overall, undocumented immigration might actually be preferable to legal immigration:

there is little evidence that legal immigration is economically preferable to illegal immigration. In fact, illegal immigration responds to market forces in ways that legal immigration does not. Illegal migrants tend to arrive in larger numbers when the U.S. economy is booming (relative to Mexico

and Central American countries that are the course of most illegal immigration to the United States) and move to regions where job growth is strong.

Hanson's argument is not far-fetched, considering the historical patterns of undocumented immigration I described earlier in this chapter and De Genova's (2005) notion of "deportability."

### *Perceptions and Misconceptions of Health Care Use*

Building on the historical and political events that have shaped undocumented Mexican immigrant identity, in this section I discuss current attitudes toward undocumented Mexican immigrants in relation to health care, which often revolve around discussions of citizenship and deservingness. Conversations with people at a Mexican Festival I attended at a local church in June 2010 demonstrated to me the variability of attitudes in Lawrence and surrounding areas, two of which I reference here.

Charlotte, 45-years-old, told me about her husband who owned a small construction company and had inadvertently hired an undocumented Mexican immigrant. She and her husband had recently moved from Lawrence to Kansas City, KS. She recounted, "He was probably in his 40s, but he was a really good worker, really hard working and responsible. Anyway, one day, he was off work and got arrested for some crime he committed when he was fourteen. Fourteen!" When I asked her about what she thought about providing health care to undocumented immigrants like the one her husband had hired, she responded enthusiastically, stating, "Just because they're here illegally doesn't mean they don't deserve health care. I mean, they're here working and contributing, citizens or not." Unfortunately, Charlotte had to leave before I could ask her if her husband had offered health insurance to his undocumented employee.

Hannah, a young Lawrence resident and student, felt differently. Speaking to her about health care and undocumented Mexican immigrants, she responded, “They are here illegally, so yeah, I don’t think they should.” Hannah felt that because undocumented Mexican immigrants could choose to come to the United States, that “we’re not really obligated to give them benefits. I think it sets a bad example.” Jacob, Hannah’s boyfriend and also a student, agreed with her, adding, “It’s not fair to citizens.” Hannah’s comment that by providing health care to undocumented immigrants would “set a bad example” and Jacob’s, that it would not be fair to U.S. citizens,” rests on the assumption that undocumented immigrants would inevitably take advantage of anything, as Hannah stated, “handed to them.”

A related concern is the assumption that they will take advantage of services that are free. For example, public concerns often stem from undocumented Mexican immigrants being a burden on health care by taking advantage of safety-net clinics, thereby overusing and abusing it. Cosman (2005:6) argues that undocumented immigrants’ “stealthy assaults on medicine” are a burden to hospitals that incur high costs in treating them, often in emergency rooms. An analysis done by Mohanty and colleagues (2007:1431) refutes this to an extent; the researchers found that with the exception of the children of immigrants’ use of the emergency room, immigrants’ health care expenditures were much lower, about 55%, than U.S. citizens. However, as Chavez (2008:120), in the epigraph, states, hospitals, specifically emergency departments, and other safety-net clinics, do indeed have to deal with an uneven burden because of the limitations that undocumented immigrants experience in access to health care, not because they are inherently overusers and misusers of health care.

The overuse and misuse argument also rests on the notion that despite being uninsured, undocumented immigrants use health care services that are available to them regularly. With the possible exception of high-density areas, undocumented immigrants use of emergency rooms is relatively low in comparison to citizens. For instance, a study done by Berk and colleagues (2000) in four communities with high concentrations of undocumented Latino immigrants, El Paso and Houston, Texas and Fresno and Los Angeles, California, suggests:

Compared with other Latinos or the U.S. population as a whole, undocumented immigrants obtain fewer ambulatory physician visits; rates of hospital admission, except related to childbirth, were comparable between undocumented immigrants and other Latinos.

While undocumented immigrants do use the emergency room, especially for childbirth, public concerns are likely exaggerated. This issue exposes a conundrum: restrictive policies have made it so that emergency rooms are generally the only choice for many undocumented immigrants, who often wait until they absolutely must to get care. They must inevitably choose a service that is expensive. Astonishingly, the very act that condemns undocumented immigrants, their “overuse” of the emergency room, is also used to justify health care in the United States, the premise that anyone can use the emergency room (see Chapter 2).

Opponents of universalizing health care also draw support from undocumented immigrants’ potential to exploit services. Portes and colleagues (2009:493) explain this in terms of the moral hazard argument (commonly used by economists), meaning “the idea that if care were free and universal, people would take advantage of it and overuse the system, leading to its breakdown.” Despite various fees and co-payments asked of even the poorest patients, there is no evidence supporting this claim. Nevertheless, the

fear exists. Irene, who works in a low-income clinic, expressed her apprehension about the Patient Protection and Affordable Care Act of 2010, which mandates that all individuals have health insurance. She explained:

A lot of people are worried about what's going to happen in 20 years, because I think there's going to be a flood and a strain on the system if you're going to give everybody insurance...the ER is scared that they are suddenly going to get this flood of people who are going to start coming in for all kinds of things and there's not going to be enough doctors or practitioners to take care of them.

A related concern is the fear that universalized health care would motivate more undocumented Mexican immigration, and in turn, strain public services. As I explained earlier, it has been long recognized that Mexican immigration occurs not because of the free, exploitable social services that the United States offers but because immigrants seek employment. Labor migration is deeply intertwined with undocumented migration, serving as a key reason for border crossings from Mexico to the United States. Nor do undocumented immigrants cross the border to secure free benefits by producing “anchor babies,” whose mere birth in the United States “instantly qualify as citizens for welfare benefits” (Cosman 2005:6). As Chris, who worked 7 years with the Kansas Farmworker Program, replied when I asked him about why undocumented immigrants came to Kansas in particular:

The biggest myth that you hear is that people, they certainly don't come to Kansas to have their babies...because you could go to Texas or you know 2 feet over the line and have your baby. You could go to Laredo, for example, and have a citizen baby...you know, generally people come to the U.S. to work.

His response can be extrapolated to the rest of the country, considering other parts of the United States beyond the Southwest, especially the Midwest and Eastern coast are seeing substantial increases in their undocumented populations (Paral 2009).

Despite evidence that undocumented Mexican immigrants do not use health care nearly as much as U.S. citizens and that the care they receive is less adequate, those who strongly oppose undocumented immigration continue to hold the notion that undocumented Mexican immigrants misuse and overuse of services as the crux of their argument. Cosman (2005:6), for example, suggests that undocumented immigrants' freeloading has contributed not only to the closing of "some of America's finest emergency medical facilities," but also to the resurgence of many "fatal diseases that American medicine fought and vanquished long ago" and the perpetuation of violent crime.

### **Discourse on Deservingness and Public Policy**

Negativity surrounding this population, as Chavez (1986:347) explains, reinforces in the public's mind the idea that "immigrants, particularly the undocumented, take more from U.S. society than they contribute through taxes and productivity, despite overwhelming evidence to the contrary." This notion that undocumented Mexican immigrants drain economic resources spills over to the moral realm. In order to demonstrate how the health care system inculcates negative attitudes about Mexican immigrants (undocumented and documented), Horton (2004), in her work on Medicaid managed care in a New Mexico hospital, exemplifies what Chavez argues. Examining the differing attitudes toward Mexicans and Cubans through the construction of categories of "deservingness," Horton (2004) demonstrates that the differential treatment Mexican immigrants receive at the hospital is a result of the negative moral worth that health professionals attribute to them, thereby leaving this particular population with poor health and unmet needs. In their study of health care access and use among

undocumented Mexicans and other Latinos, Ortega and colleagues (2007:2357) report similar findings; the undocumented immigrants in both groups thought that they would receive better health care if they were a different ethnicity.

Just as stereotypes and misconceptions about the undocumented can and do influence public policy, so too does it influence immigrant's attitudes about their own worth and their rights in the United States. In Lawrence, I came across Pedro, a 31-year-old graduate student and legal resident from Baja California, Mexico. Pedro came to the United States five years ago, while his wife, Marisol, joined him a year later. When I asked Pedro whether he thought immigrants, undocumented and documented, deserved health care, he was very hesitant in answering my question. As a legal resident, he still had felt the difficulties in accessing care, particularly due to his financial situation. What struck me the most was that even after five years in the county, he felt that he had no right to voice his opinions:

What I was saying any human being should have right to health care but I don't know, it's, it's a very complex question that I think the American citizens should ask or should...Because it's not our country. We not free to give our opinions.

Even with some poking and prodding, he continued to feel conflicted as to what answer he wanted to give. While I expected hesitancy from the undocumented immigrants to whom I spoke, I did not from legally residing immigrants from Mexico. Pedro's unwillingness to speak his opinions illustrates how negativity surrounding undocumented Mexican immigrants has wide effects.

### *Popular Perceptions to Policy*

Misconceptions of undocumented Mexican immigrants often spill over to the arena of policy-making. Wedel and colleagues (2005:37) argue that in classifying people

and problems, policies actively create new categories that shape individual identity (e.g. citizen, non-citizen, asylum-seekers, illegal immigrants, etc.). Recall how Hannah and Jacob characterized undocumented Mexican immigrants' use of public services and Irene's anxiety about low-income patients' future newfound insured state as a "flood and strain on the system." The researchers continue, "In short, modern power largely functions not by brute imposition of a state's agenda but by using policy to limit the range of reasonable choices that one can make and to 'normalize' particular kinds of behavior" (Wedel, et al. 2005:38).

In his study of public discourse metaphors about Latino immigrants in the 1990s, Santa Ana (2002:xiii) argues that metaphors about Latino immigrants have shaped public policies. Drawing on the theoretical work of Donald Schön (1979), he utilizes the concept of the generative metaphor to understand policies regarding Latinos:

The single conceptualization of social issues is based on what Schön calls a "generative metaphor." Such a productive metaphor structures the way that individuals in a society, from the layperson to most policy experts, come to think about a given social situation.

Undocumented Mexican immigrants, who arrive in "waves," "inundating" the United States, along with other undesirable "blights," are often considered diseases needing to be treated or eradicated (Santa Ana 2002:42). Furthermore, their identity as an unnecessary burden to the health care system because of freeloading, affects the way policy-makers deal with this population. Santa Ana (2002:42) explains further:

Public policy solutions for the social issue will typically take the form of solutions consistent with the conventional metaphor. Thus acceptable policy solutions will be those which are prefigured in terms of the metaphor, to the exclusion of other views.

Biopolitical strategies to deal with such perceived blights, diseases, and burdens, include policies that restrict access to care. For example, the 1996 Welfare Reform Act's exclusion of all immigrants, including legal permanent residents, from receiving Medicaid for five years demonstrates that the stigma of overuse or misuse of services goes beyond undocumented immigrants.

The confluence of the historical treatment of and social attitudes towards undocumented Mexican immigrants has served as a convenient scapegoat for the rising costs of health care. Looking back to California's Proposition 187 and subsequent policies, which attempted to stymie immigrants' access to public benefits, they were also justified under the assumption that immigrants in general took more from the system than U.S. citizens and did not deserve care, being direct threats to the bare lives of individuals and the life of the nation. Indeed, even the Patient Protection and Affordable Care Act's lack of attention to undocumented immigrants health care needs stems from this notion that they drain resources, diverting them from more deserving people like citizens.

Ultimately, their subaltern identity is perpetuated by the lack of legality, which leaves undocumented immigrants at the mercy of ephemeral economic interests, and by misconceptions about their use of health care and the resulting policies. This form of violence is what some anthropologists call structural violence, where social institutions or society at large slowly kills specific populations through the denial of basic needs (e.g. racism, sexism, or classism). This type of violence is difficult to address due to its complexity, being rooted in historical, social, economic, and political forces. Structural violence explains why health disparities and differential access to health care exist, not

only for undocumented immigrants but also other marginalized groups in the United States.

### **Conclusion**

In this chapter, I have demonstrated that negative attitudes toward undocumented Mexican immigrants and misconceptions about their use of health care effectively create a scapegoat for the unmanageable rising costs of health care. Lack of legal rights isolates them further, leaving them vulnerable to acute exploitation. Much of the legislation, including current health care reform, is directly impacted by the social attitudes toward undocumented immigrants and vice versa. Furthermore, in an effort to rationalize the efficiency of fee-for-service health care in the face of obvious inequalities in access to care, undocumented immigrants (in particular, Mexicans) become a scapegoat for the high costs of health care.

Basing public policies on social perceptions, despite their inaccuracy, directly and negatively impacts undocumented immigrants' access (or lack of) to health care. Ultimately, it keeps undocumented immigrants and their health needs (among others) invisible. As Chavez (2003:208) argues, once having acquired the status of burden to society, it "can mask actual health needs and the structural factors that cause ill health among immigrants, particularly poverty, crowded living conditions, dangerous occupations, lack of medical insurance, and the burdens associated with pariah status." This can consequently affect the general population.

## CHAPTER 4

### Negotiating Ambiguity: Undocumented Mexican Immigrants and Health Providers in Lawrence, Kansas

I believe that health care is a basic human right for anyone and everyone, regardless of nationality, status, citizenship, income level, whatever...As health care professionals in the community, I feel that we all ought to be helping whoever happens to be in our community, even if that person's just passing through and happens to get sick or if that person happens to be living here for a lifetime or living here for a few years.

Elena, nurse/case manager

In the last chapter, I argued that the historical and social treatment of undocumented Mexican immigrants has led to the formation of a negative identity on which public policies regarding health care are erroneously based. Perceived as a threat to the bare lives of citizens and the nation as a whole (by undermining the health care “system”), undocumented Mexican immigrants are left to maneuver a medical culture largely designed to bar them from most services. The restrictive manner in which the United States handles the health care of undocumented immigrants ignores the fact that they are a very real presence in the country and that they can and do get sick.

By presenting and analyzing challenges health care providers in Lawrence experience in attempting to provide health care to undocumented Mexican immigrants and the complex situations immigrants themselves face, I seek to demonstrate the ambiguity and resulting problems created by the U.S. medical culture, especially in its approach to “bare minimum” health care, which downplays primary or preventive care and fails to consider that this population (along with other low-income groups) can barely participate in the prevailing fee-for-service model of health care. Health care providers, on the other hand, must juggle providing quality health care and making a profit.

## Health Care as a House of Cards

During an unusually hot and sunny afternoon in September 2010, I made my way to the health department in Lawrence for an interview with Elena, a nurse/case manager. Before our formal interview began, Elena, expressed uncertainty about my research: “What exactly are you researching? Is this strictly academic? Will you publish it in a newspaper?” Her questions made me realize that (in addition to the fact that I had not done a good job explaining my research in my e-mail) providing health care to undocumented immigrants is a delicate venture in Lawrence, despite many of my informants’ inclinations to feel otherwise (many cited Lawrence’s supposed liberalness and the presence of a university). Elena, however, pointed out that specifically with the undocumented population “there’s a lot of controversy and questioning out there” when it came to lack of documentation. She explained further:

Maybe the doctor was generous in offering to take in a patient, but I’ve often been questioned by office staff when I’m calling to help make an appointment, you know, ‘Why doesn’t this person have papers?’ Oh boy, there are a lot of these people here in this community, those kinds of comments from people who are involved.

Cognizant of the high stakes involved in doing research in an already tenuous environment, in addition to the need to establish an innocuous presence in the community, I promptly described my research interests in more detail and assured her that I had no intention of undermining the efforts of the health professional community to provide health care to undocumented immigrants. Elena used an apt metaphor to exemplify the efforts of health care providers in Lawrence: a “house of cards,” a seemingly stable structure that could easily fall down with the slightest of wind.

Thinking back to her initial reaction to my research, I realized that I had the potential to be that wind.

### **Health Care Provision in Lawrence**

Health care provision aimed at migrant communities, particularly undocumented populations, is challenging due to myriad factors. Chavez (2003:197) explains that “...immigrants often enter the labor force at the bottom, where low incomes, lack of medical insurance, and little available time present obstacles to their use of medical services.” Indeed, the biggest barrier to accessing fee-for-service health care is the lack of money. Undocumented immigrants are part of a larger low-income population that deals with similar issues of inequality in access to and quality of health care. This population’s inability to pay for insurance or pay out-of-pocket for services severely restricts which types of care they can obtain in U.S. medical culture. This became apparent as I began researching where the undocumented Mexican population obtained health care in Lawrence, Kansas.

Low-income clinics are one of the few choices for undocumented immigrants to obtain primary care, and the two main clinics in Lawrence both operate on a sliding scale fee system. As I discussed in Chapter 2, the way health care is administered in the United States to undocumented immigrants reflects what Redfield (2005) terms, “minimalist biopolitics,” meaning that survival or bare minimum types of health care are provided to this population. Ambiguity and tension result when undocumented Mexican immigrants are restricted to fee-for-service health care regardless of their low incomes and when the only affordable health care is “bare minimum” care, meaning public health initiatives or the emergency room. In presenting my findings, I seek to demonstrate the

nuances in the way legal and economic exclusion manifest in undocumented Mexican immigrants' access to U.S. medical culture, and the effect it has on health care providers, as well. I also present issues that U.S. medical culture fails to take into account with regard to undocumented Mexican immigrants and their health care needs.

### *Documentation*

Before beginning my research, I had hypothesized that the lack of documentation would be a major obstacle for Mexican immigrants seeking health care, and in many ways, the various obstacles and challenges I present in this chapter are somehow related to the issue of documentation. One health provider mentioned to me in passing that immigrants were more likely to be denied health care because of their inability to pay, not because of a lack of documentation. As I scoped out the options for health care undocumented Mexican immigrants have in Lawrence, I found that to a large extent, this assertion held because undocumented Mexican immigrants cannot access fee-for-service health care if they do not have the financial means to do so. Nevertheless, there were cases where documentation did hinder and cases where it did not. I address the latter first because I quickly found out that none of the low-income clinics or the hospital mandated proof of citizenship in order to obtain health care or emergency services.

However, other types of documentation are required, such as proof of residency in the county and proof of income. For example, Maria, a young woman in her 30s from Ecuador, works with a nonprofit organization that helps the hospital make payment plans with patients, many of whom are Mexican immigrants who would like to pay for the services they receive but need financial assistance or time to make the payments. She told me the story of Eduardo, an undocumented immigrant from Mexico who was

seeking treatment at the hospital. Eduardo came to the hospital to show proof of income. He had three statements, all with a different name and Social Security Number. The receptionist at the hospital simply accepted them without questions. “But if Eduardo had been in Topeka,” Maria concluded, “they would have refused him.”

A case where documentation proving legality became a serious issue was in patients’ access to medication. Irene, who is a full-time provider at a low-income clinic, explained that many drug programs have free drugs for low-income patients, including brand name drugs, as long as they meet their guidelines. She explained: “But, what happens is that some of them require you to be a U.S. resident, or to be a citizen, or to have a green card.” Irene elaborated on how this becomes an issue by describing a situation that occurred with one of her patients, Claudia. Claudia, a young woman from Mexico, was taking insulin. Irene quickly found out that Claudia’s undocumented status, coupled with her low income, meant that as her health care provider, she would need to make adjustments:

It’s a huge challenge because it’s so expensive. There are two really good new insulins, both are long lasting and everybody likes them because they are so easy to use. But, they’re about \$150 per vial, which can last up to 10 days. You’re then talking about \$450 per month, which they [undocumented Mexican immigrants] can’t afford. So, then it’s maybe switching her off something that works really well, but is expensive, to something that you take 3 times a day and you have to check your blood sugar more, but is cheaper. She’s probably going to get better results with the newer insulin just because of the way it acts, compared to her compliance with a different, more regimented insulin.

The interaction between Claudia and Irene illustrates the ethical dilemma of providing health care not just to undocumented Mexican immigrants, but the low-income population, in general. In order to provide affordable health care to Claudia, Irene sacrificed quality. She acknowledged that the cheaper medication would not only be less

effective but that her patient would be less likely to comply because of its regimented nature. Nevertheless, Irene prescribed it, taking into consideration the overall situation Claudia was in.

### *Fear and Discrimination*

The experience of fear and discrimination, as I discussed in Chapter 3, is a result of the criminalization of the undocumented. Fear, such as in being deported, can prevent undocumented immigrants from seeking services. In their study of fear and undocumented Latino immigrants in Houston, El Paso, Fresno, and Los Angeles, Berk and Schur (2001:155) found that fear associated with the lack of documentation “is a powerful deterrent to people obtaining care they believe they need.” The researchers conclude, “These findings raise serious public health as well as moral concerns (Berk and Schur 2001:155). Ana, a volunteer interpreter for the health department, told me of a recent scare in Lawrence in which undocumented Mexican immigrants feared that if they went to Wal-Mart to fill their prescriptions, their information would be given to the police, and they would be deported. She explained, “They stopped going to fill out their refills at that Wal-Mart because of that rumor.” Wal-mart, along with smaller drugstores like Walgreens, is a crucial source of medication due to their low prices. Rumors, such as the one Ana mentioned, can be a major obstacle to undocumented immigrants’ access to affordable medicine.

Discrimination is another concern for both health providers and undocumented Mexican immigrants. In the Lawrence Latino Survey (Metz, Crosthwait, and León 2007), for example, respondents reported being discriminated against by the police, employers, landlords, and neighbors, and in stores, schools, and financial institutions.

For example, a 23-year old female from Jalisco, Mexico, stated that she was refused at another health department (reasons were not provided in the survey). In my interview with Ana, I asked her if she felt that the female patients for whom she interprets ever felt discriminated against. She quickly responded with a “no,” but later in the interview, she recounted a narrative about Magdalena, who went to her doctor’s appointment and felt discriminated against, even though Ana and the doctor disagreed:

I was really, really ashamed because this doctor speaks Spanish, and he was telling that she had diabetes, gestational diabetes. He said, well, considering that you are Mexican with this diabetes, we have to take good care of you. He said that in Spanish. And she suddenly said, ‘Digo otra vez, la discriminación!’ *Again, the discrimination!* And I said, ‘Qué? Es cierto que entre los mexicanos hay diabetes. Mis cuatros abuelas tuvieron diabetes!’ *What? It’s true that among Mexicans, there is diabetes. My 4 grandmothers had diabetes!*

Ana ended by explaining to me that despite her shame and her wish (but inability) to reprimand Magdalena, she tried to explain what the doctor meant to the patient. When the doctor stated “considering that you are Mexican with this diabetes,” Magdalena took it as an affront to her being from Mexico, while Ana interpreted it as Magdalena not understanding the significance of diabetes in the Mexican population. Magdalena’s response to the doctor demonstrates that she has experienced discrimination before.

### *Language*

The language barrier, Elena explained, “often plays a role in everything, in accessing and knowing where to go.” She gave the example of explaining to immigrants about Emergency Medicaid and other benefits for which they may be qualified. Irene, too, acknowledged that the dearth of Spanish speakers in the medical field in Lawrence has had an impact on whether undocumented immigrants (and immigrants, in general) feel comfortable in clinical settings. When Irene’s clinic hired Rosa, a Spanish speaker

of Puerto Rican descent, to be the office manager, Irene said that there was a positive reaction: “I think they feel empowered to step into this clinic, especially the Hispanics, because of Rosa. Once one Spanish speaker knows that somebody in the medical field speaks Spanish, they’re all over it because there’s not a lot that do.” Irene stated that although her clinic did see undocumented immigrants, they were not the majority of the 1,400 active low-income patients at the time, despite Rosa’s presence.

The language barrier also manifests in other health care settings. For example, the undocumented Mexican immigrant community and health care providers have to deal with alcoholism and domestic abuse. Heather, a young woman who coordinates and conducts a variety of programs for Mexican immigrants in Lawrence, pointed out that the women’s shelter in the community lacked Spanish speakers, which made it difficult for those seeking and providing help. Nela, who is the director of a local nonprofit organization, told a similar story about managing alcohol abuse in the Mexican immigrant community. She described how they referred men to alcohol detoxification programs; however, because no one spoke Spanish, they had no effect.

### *Cultural, Ethnic, and Intra-Community Challenges*

Health care providers stressed cultural and ethnic differences, particularly in notions of healing and illness. Elena explained, “A lot of people that I have worked with come from real small rural communities in Mexico, where their access to health care is even more limited, so they are much more familiar with home births, local midwives, and the support of all the family.” Even so, the Lawrence Latino Survey (Metz, Crosthwait, and León 2007) indicates that only 3 individuals stated that they used any form of complementary and alternative medicine, none of whom elaborated on why or what type.

My own inquiries matched that of the survey. Indeed, one woman asked if I would tell her if anyone mentioned the presence of curanderas in Lawrence.

Another issue is the treatment of the undocumented Mexican immigrant community as one, undifferentiated group. For example, Nela described how some indigenous groups did not get along with others in the workplace. Health providers also noticed that despite the seemingly homogeneous quality of the community, there were tensions among the undocumented Mexican community in the form of ethnic differences and intra-community grievances, which in turn can exacerbate health concerns. This was exemplified in Nela's attempt to form focus groups for women to talk about issues like domestic violence. Attempting to get a group of women together, Nela realized that some women would recognize each other as former girlfriends of their current boyfriends or seducers of their boyfriends. Ana, a volunteer interpreter with the health department, also experienced this in her efforts to teach women lullaby songs and how to take care of their babies. She explained, "If you try to make a group, try to come together, these women, perhaps, fight among themselves because one of them has been cheating with the other one's partner, husband, or whatever."

In their collaborative and comparative work *The Secret: Love, Marriage, and HIV*, Hirsch and colleagues (2009) examine the relationship between mobility and extramarital sex and call attention to the loneliness and isolation labor migration creates and fosters. This results in sexual risk-taking, in which migrants, particularly men, engage. Nela's story demonstrates that female migrants, too, engage in sexual risk-taking. Ana, a volunteer interpreter for the health department, expressed her concerns about the situation of women and that not enough was being done for them:

Something that is bothering me is that we cannot help these women to have a good relationship with their partners. Some of them are drinking a lot and having other women. Because of their lack of education, and as a man, a macho man, if you have a woman that is pregnant, it is possible that he will not have intercourse with her for the 9 months and 6 weeks after the delivery, so they go with other women...Even if they are in a good relationship, they change a lot of women and that's how they get all of these Chlamydia and Gonorrhea and all these things. And then the woman says, "I was pregnant, and now that I am having intercourse with this man, I am having this disease. This is not my fault."

Although Ana begins by stating that women need help ameliorating their relationships with their men, her story highlights the complexity of the situation, the underlying structural conditions that Hirsch and colleagues (2009) addressed in their work and the helplessness that women felt in contracting diseases from their partners.

In order to deal with this effect of labor migration, the health department in Lawrence has tried to curb the consequences of men and women having sex with multiple partners through sexually transmitted infection (STI) testing and mandatory treatment. The health care providers of the health department mandate that infected women and men take medicines in their presence in order to continue receiving other benefits like the Women, Infant, and Children supplemental food program. In this way, infected bodies are disciplined and regulated in order to protect the health of the Lawrence community.

#### *Gendered Access to Care*

By the end of my research, it became apparent that despite efforts by the Lawrence health professional community to provide health care services to all undocumented immigrants, in practice provision was highly gendered. According to Paral (2009:27), approximately 58% of Mexican immigrants are men; while for other groups, the percentage of men is approximately 49%. Although men make up approximately half of undocumented immigrants, the majority of the public services available are for pregnant

women and young, nursing children. This is not surprising because, as argued earlier, bare minimum types of health care reflect emergency type of situations. Recall in the previous section the role of the health department in treating STIs. It is noteworthy that women are generally the first to be treated for infections. Through women, male partners are contacted and treated. Men without pregnant girlfriends or wives may not necessarily be treated through that particular avenue.

In Elena's work as a nurse and case manager, she often works with families, and she noticed how the construction of gender also plays a role in seeking access to health care:

This is my own personal analysis, but the men tend to put off their own health care needs more and more than women do. A woman I see is a little more responsive to "I've had this pain for a little bit." The men—"I've got something in my eye. No, I'm not going to go to the emergency room. No, I'm not going to go. I'm not going to do that." So, I don't know if it's the system, or if it's a gender issue.

Walter and colleagues (2004:1159) have also noted how gender, particularly the construction of masculinity, structures "the experience of embodied social suffering among workers who are rendered vulnerable by the structural conditions of undocumented immigrant status." Just as structural vulnerability degrades immigrant bodies, so too can the expressions of masculinity and femininity, in distant, highly unstable, and stressful locations.

Few options exist for undocumented immigrant children, as well. Elena mentioned that while low-income clinics do take children as patients, "they tend to be more comfortable with adults in my opinion." She explained further, "Because of the system that I told you about, it's hard to get an appointment, and it can be quite difficult. Kids tend to get sick quickly and without warning, and it's just a small clinic. It's not

able to meet all of the needs.” Undocumented children’s health is often framed as a public health concern. Take, for example, President Obama’s (CBS News 2009) statement on the topic of health care and undocumented immigrants:

The one exception that I think has to be discussed is how are we treating children, partly because if you've got children who may be here illegally but are still in playgrounds or at schools, and potentially are passing on illnesses and communicable diseases, that aren't getting vaccinated, that I think is a situation where you may have to make an exception.

His response reveals the distinction between “us” and “them” is not limited to working undocumented adults, but to all unauthorized persons, regardless of age. The need to provide health care is seen as necessary not because children themselves deserve not to suffer, rather that the life of the authorized population could be placed in jeopardy if undocumented children are left unchecked. A crisis could ensue.

Older undocumented immigrant children must also deal with the stress of living with the limitations lack of documentation presents, such as not being able to apply for a driver’s license or trying to find a job after being educated. Nela described the frustration teenaged undocumented immigrants experience in mixed status families, seeing their sibling have opportunities that they cannot have. Nela mentioned that she has seen several teens diagnosed with depression because of this; yet there are few resources available to them.

### **Strategically Managing Limited Resources**

Health care providers and undocumented Mexican immigrants deal with the lack of knowledge about available services and the need to keep costs down by networking, meaning that they create and foster connections within the community. For example, the health department, Elena told me, serves as an entry point for many undocumented

patients into health care in Lawrence, or the door to the house of cards she mentioned. She explained, “All of the folks who work here are familiar with the agencies, so people often think that the health department will help them if they are sick.” The staff at the health department often directs undocumented patients to the appropriate clinics. Irene also described her clinic as a metaphoric door. Once inside, a patient could have access to the network of 70 or so volunteers, most of whom are specialists. Nela, the director of a nonprofit organization, also acted as a networker, helping undocumented Mexican immigrants find doctors willing to see them. She sometimes takes patients (usually men) to her own doctor, who charges about \$100.00 for an appointment, and where they could receive free samples. Nela explained, “They are really nice about that.” Nevertheless, I questioned the efficacy of Nela’s efforts.

Health professionals are not the only ones who seek to build and utilize a network. I met Andrea at a local church service being conducted in Spanish. She spoke enthusiastically of her husband, Roberto, who had acquired his U.S. citizenship recently. Andrea was not sure where exactly her husband was at the moment due to his busy schedule, but she excitedly told me about her husband’s influence in the undocumented Mexican community as a cultural broker. Roberto, at the time, was working a part-time job with a nonprofit environmental agency, not getting as many hours as he would have liked. The following is an excerpt from my field notes:

Roberto functions as a sort of “go-to” guy in the community. He’s known by the two main ethnic groups here in Lawrence, the Mixtecos and the Tlapanecos. He usually has people call him, and he charges them based on what they need. He charges more for DUIs because those men are often repeat offenders. His logic is that if they can manage to buy a couple of six packs to drink, then they probably have the money to be bailed out and pay him extra. He also helps people with health care needs. For example, if someone has been in an accident, he’ll get a call and take that person to

the emergency room. From what Andrea described, he acts as a person who diagnoses people's illnesses, too. For example, if someone has skin irritations, like a jock itch or a rash, he'll take them to the store and show them what they need. Andrea said, "It's kind of the stuff that they would be able to do on their own if they could read the labels at the store."

Undocumented Mexican immigrants who contact Roberto feel at ease due to his reputation in the community as a trustworthy and knowledgeable person. His ability to move quickly and help people out in the community, as opposed to having them come to an office, also caters to undocumented Mexican immigrants' inability to be flexible with regard to work schedules and transportation.

Returning to the network of health care providers, challenges arise if one health care provider decides to pull out, it could collapse the house of cards. The very network that acts against the challenges created by restrictive health care policies can create complications in sustaining effective care. Elena pointed out, "If anyone pulls out at any point, it would be quite challenging." This almost happened in the case of C ezar, a legal Mexican immigrant, who has diabetes. He had already had laser treatment for one of his eyes and was having more problems. C ezar told Irene, who works at a low-income clinic that he would be getting health insurance soon, but it still caused problems. Irene recounted:

So, I said "Okay, let's get your eye exam set up." So, I sent him to the doctor, and they got really mad at me because they saw he was going to get insurance. They felt that he should wait instead of them doing it for free. And I'm like, "What? He has eye disease, go ahead and see him. But you know, they'd rather wait until they can bill his insurance. They were really angry. They were considering not seeing our patients anymore because of it. All because there was the potential that he would get insurance, and they could get the pay.

C ezar's situation illustrates tension that the health care professionals face between providing quality health care and making a profit. Even though the network of volunteers

strives to make health care affordable for undocumented immigrants, it is still reliant on and restrained by the commodity mentality, the need to obtain a fee for a service rendered. Irene mentioned afterward that the office decided to keep seeing patients referred by the clinic because they wanted to keep helping.

Additionally, providers must strategically manage a limited amount of resources. The area clinics, for instance, try not to duplicate services covered by other clinics. For example, the health department provides medical care related to public health, such as immunizations available to the community on a sliding scale, tuberculosis and sexually transmitted infection testing and treatment, annual exams for women, and some contraception. These services are not available at the low-income clinic where Irene works. Managing limited resources in this way raises new challenges and barriers with which to contend, such as with the two main clinics that provide primary care. Elena explained:

The resources are few and the demand is high...there are a lot of people without health insurance, so it's difficult for those two small agencies to be able to meet everyone's needs, especially in a timely fashion. Their system is such that they don't have a lot of personnel. They operate with a lot of volunteers, whose schedules change, so it can be quite a long time for someone who requests an appointment to actually get in and be seen.

When I interviewed Irene, the sole health care provider at her clinic, and mentioned what Elena had told me, she explained, "Our clinic may not be what you see in other places because our patients are pretty lucky, I think, in that they have so much access once they get in here and get established with us." I asked her, "How difficult is it to get 'in here'?" She responded, "That's difficult (laughs) because I'm the only provider. We have a couple of appointments everyday for if somebody is sick, but for

people who are trying to get in for diabetes, I think our next appointment is at the end of January.” Our interview took place mid-October.

### **Negotiating Ambiguity**

Fee-for-service health care in the United States becomes a problem when it comes to undocumented immigrants, who cannot afford to buy health insurance, fail to meet Medicaid guidelines (except Emergency Medicaid), or simply cannot pay for office visits out-of-pocket. Chris, who worked with the Kansas Farmworker Program for 7 years, succinctly explained the situation of health care in the United States in relation to undocumented immigrants:

I think that we accept the system as being a business like any other business, while understanding at some basic level, it's a need—what I mean by that is that it's a human need just like being hungry is a human need. It's a basic physical need of a person. So, we've come up with these sort of work-arounds, you know. We're not going to let you starve, but we're not giving you a feast either.

Chris's observation that “we're not going to let you starve, but we're not giving you a feast either” illustrates the overall consensus to give medical care to anyone regardless of immigration status (exemplified by hospitals inability to deny patients needing emergency medical care); however, its current minimalist application in the United States presents tensions and challenges, many of which I have described in this chapter.

Despite the Patient Protection and Affordable Care Act of 2010 and its denial of health care to undocumented immigrants, it is at the local level where one sees and experiences that they are a very real population, comprised of individuals who can and do get sick. In juggling between providing quality care to undocumented patients and making a profit or avoiding a debt, health care providers often must sacrifice the former, which can be at odds with professional ethical guidelines or moral convictions.

Roberto's story, for example, alludes to the importance of prevention in keeping health care costs down or manageable. In addition to making a profit of his own, Roberto helped individuals who had manageable or treatable health problems before they reached a magnitude that necessitated a visit to the emergency room. More importantly, Roberto, along with the network of volunteers, demonstrates the efficacy of preventive health care.

The health care professionals in Lawrence, too, realized the importance of preventive care in keeping the undocumented immigrant population healthy and away from the emergency room. In speaking to Irene about the impact of clinics like hers, she cited a significant study done by Smith-Campbell (2000:299) on "whether a law to establish primary care services for the medically underserved influenced access to health care." Her analysis of HCA clinic in Lawrence demonstrated that funding from such a state policy did increase the availability of services to the uninsured population, which, in turn, led to 39% fewer uninsured treated at the emergency room (2000:299). Irene commented further about her clinic's relationship with the hospital:

This clinic has kept people out of the emergency room. That's why the hospital is so generous to our patients. They donate all their x-rays, MRIs, and same-day surgeries. The hospital does all that for free for my patients because they know how expensive it is to utilize the emergency room...We're saving them money...We're so busy now. They're seeing more uninsured in the emergency room because we can't get them in here.

While Smith-Campbell's study demonstrates the cost effectiveness of health care based on primary care and prevention, in the context of undocumented immigrants, other structural conditions must be addressed, as well. As I discussed earlier in Chapter 2 and in this chapter, various barriers in access to health care exist for undocumented Mexican immigrants that cannot be solved solely by a reformulation of health care. For example, poor working conditions, such as long hours and inadequate wages, directly affect

whether immigrants have time to see a health provider and what kinds of health concerns they have (recall Carlos's story in Chapter 1). Nevertheless, rethinking fee-for-service health care vis-à-vis undocumented immigrants is crucial to understanding this population's actual experiences in the face of restrictive health care policies.

### **Conclusion**

I have demonstrated in this chapter that health care providers and undocumented Mexican immigrants both experience tension resulting from the ambiguity that results from U.S. medical culture and bare minimum health care. Restrictive policies, implemented under various assumptions (e.g., undocumented immigrants' freeloading), create problems for both providers and undocumented patients. These policies fail to address that undocumented immigrants do not make enough money to fully participate in the prevailing fee-for-service health care model and the underlying issue that preventive care will ultimately keep them from needing expensive types of care like the emergency room of hospitals.

## CHAPTER 5

### Conclusion

The inequality of lives, biological and political, local and global, is perhaps the greatest violence with which anthropologists are confronted in the field, as they daily prove the truly existential and vital distance that separates them from the men and women whose histories and lives they encounter.

Didier Fassin (2007:270)

I would like to return to the young man I introduced in Chapter 1, who insisted that his broken foot was “not bad enough” to warrant a visit to the doctor. Perhaps, as I had thought at the time, he was a *macho* man, perfectly capable of handling a broken foot; however, the findings of my research reveal there was much left unsaid by Carlos. Carlos’s situation as an undocumented Mexican immigrant, working in the construction industry without being provided (or without the means to pay for) health insurance meant that health care was unaffordable and least prioritized for him. In biopolitical terms, Carlos’s health care experience (or lack of) can be explained by the control and regulation enacted on him (and undocumented immigrants, in general) by policies that limit and restrict an undesired Other.

#### *A Biopolitical Basis for Exclusion*

Undocumented Mexican immigrants, denied legal and economic rights, exist in a precarious environment in the United States. Unable to participate in fee-for-service health care due to economic exclusion and unable to fight exploitation due to legal exclusion, undocumented immigrants consequently experience structural violence, violence that results from inequalities from social, political, economic, and historical forces. Willen and Castañeda (2008:3) explain the situation vis-à-vis health care:

Within most countries hosting substantial unauthorized im/migrant populations, the hard-line version of this position—that unauthorized migrants possess no health related rights or entitlements whatsoever—has been deemed untenable. Yet virtually no host countries have accepted its opposite – i.e., that unauthorized migrants are entitled to exactly the same forms of health care or the same health benefits as citizens.

Or, as Chris eloquently stated in the last chapter, “we’re not going to let you starve, but we’re not giving you a feast either.” Unfortunately, this, in addition to perpetuating the attitude of being simultaneously welcomed and unwelcomed, works well with the U.S. medical culture because there exists a hodge-podge of avenues available for undocumented immigrants to obtain health care, thereby paving the way for a minimalist biopolitics approach to their health care. Ambiguity as to what the role of undocumented immigrants is in U.S. society presents tensions for both undocumented immigrants and their health care providers.

I described how the ambiguous nature of U.S. medical culture and restrictive health care policies aimed at undocumented immigrants make it more and more difficult for this population to obtain health care. The evidence from my research shows that both legal and economic exclusion act as a barrier to health care, and they are manifested in undocumented immigrants’ health care experience in different, nuanced ways. Health care providers, too, must deal with the ambiguity that arises from a mixture of theories and practices in U.S. medical culture. Many of my informants in Lawrence, KS, who work in the health care sector, felt the tension particularly when attempting to provide quality health care to low-income patients who cannot necessarily afford the treatment that is best suited for them.

Undocumented Mexican immigrants in Lawrence, in addition to dealing with the obstacles that occur with having low incomes, must navigate though issues of

documentation, discrimination, fear, language, and cultural differences, among other issues, in the medical setting. Ultimately, by not acknowledging these problems, particularly that neither fee-for-service nor bare minimum health care is an adequate solution to the health care of undocumented immigrants, the United States continues to control undocumented immigrants' bodies, keeping them in a precarious situation of subjugation through economic and legal exclusion.

A biopolitical analysis insightfully connects the issues of legal and economic exclusion, the metaphors that allow such exclusion, and finally, how they come together as a tool to regulate and control. Undocumented immigrants, particularly those from Mexico, are characterized as a burden to the U.S. economy and to public services, despite the lack of evidence supporting this claim. For example, I described in Chapter 3 how policies are predicated on negative metaphors surrounding the identity of undocumented Mexican immigrants, as illegal freeloaders, vectors for diseases, and as burdens to society. They are, in effect, a threat to the lives of legitimate U.S. residents, particularly of citizens. Consequently, they are characterized as an Other, an unwanted Other.

Laws (which tend to limit or restrict) are formulated taking into account only this characterization of undocumented immigrants, thereby shaping how the larger society perceives undocumented immigration. As negative metaphors become more and more pervasive, undocumented immigrants' legitimacy diminishes, solidifying their status as bare lives or bodies. It is during times of crises that restrictive policies, which are insidiously based on erroneous information and shaped by pejorative metaphors, are fashioned by policy-makers. Policies exclude undesirable bodies, despite the economic realities needing migrant labor. These policies act as a biopolitical tool by which the

United States continually blames undocumented immigrants, thereby reducing their worth to exploitable, expendable bodies.

### *Future Research*

Future research on this topic of undocumented immigration and health care might evaluate the applicability of health care as a human right and its ethical, economic, and political dimensions. For example, potential research could explore whether or not health care as a human right could be achieved. Who would be responsible for meeting the health care needs of undocumented persons? Comparative research on the topic is also necessary. How have other countries dealt with providing or not providing health care to their undocumented populations?

Although this thesis focuses mainly on how restrictive health care policies have affected undocumented immigrants, immigration reform is a key issue that needs to be addressed, as well. Immigration is a highly contested issue in the United States; nevertheless, undocumented and documented immigration *is* an integral part of the U.S. economy currently. Research should question the social-cultural contexts in which immigration policies are formed and whether the solution to managing the health care needs of undocumented persons can be addressed through immigration reform, as well. The United States must openly acknowledge both the benefits and costs of undocumented immigration, lest undocumented immigrants continue to be exploited and denied the legal and economic rights that can help improve the quality of their lives.

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\*Lawrence Latino Survey

2007 Survey data collected by 30 graduate and undergraduate students, and coordinated and compiled by Brent Metz, Rebecca Crosthwait, and Lydia León.

## APPENDIX

### Lawrence Latino Survey

<b>Health Services Use by Females (n=35)</b>							
	Assistance	Hospital	Clinic	Health Dept.	Mental Health	Curandero/a	Other
Yes	7	17	19	14	1	1	1
No	14	1	14	19	6	8	5
No response	14	17	2	1	28	26	30
<b>Health Services Use by Males (n=70)</b>							
	Assistance	Hospital	Clinic	Health Dept.	Mental Health	Curandero/a	Other
Yes	4	25	20	4	0	2	8
No	34	9	8	8	10	10	9
No Response	32	36	42	58	60	58	53

\*Does not include 11 individuals who did not provide their sex (n=11)