An Interview-based Assessment of Access of Health Care in Philadelphia for Undocumented Immigrants

Nicole Salfi, La Salle University
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Introduction

Healthcare access in America has expanded greatly within the last century. The creation of public health programs like Medicaid, Medicare, and the Affordable Care Act have been keystones in providing to those who, without it, would not have a means to obtaining adequate health care. Still, a whole population lacks formal access to health care in the United States. Undocumented immigrants face barriers that need to be overcome to attain quality healthcare access in Philadelphia that hurts not only them, but also their families and the entire city as well. This research will explore and outline the impediments that undocumented immigrants must overcome to receive health care in Philadelphia.

Undocumented Immigrants in the United States face a myriad of obstacles in accessing proper health care. For example, one-third of undocumented immigrant children in the US live in poverty, and a majority of undocumented immigrants as a whole lack medical insurance (Passel and Cohn 2014). A lack of information regarding how the healthcare system works in the United States hinders access to health, since undocumented immigrants come from countries with different policies, practices, and systems in place to address health concerns. Undocumented immigrants’ usual methods of health care may not be accessible anymore in the United States, so how immigrants take care of themselves may change for the worse. Screenings and preventative care may be entirely new for some undocumented immigrants. Further, fear of detection by authorities, on top of cultural and language barriers are just added to the list of burdens (Escarce 2007).

Immigrants, undocumented and documented, are vulnerable populations. They are at an extra disadvantage due to poorer physical, mental, and social health outcomes (Derose, Escarce, & Lurie 2007). Barriers to undocumented immigrant health care are not isolated experiences, but
instead intersect to produce a multifaceted problem. Social and political marginalization and lack of financial resources should be taken into account, as well as the policies surrounding what undocumented immigrants have access to. Education, occupation, and salary with affect what type of medical access immigrants have access to.

Vulnerability of immigrants is also due to cultural, appearance, and religious differences that diverge from the norm. Unknowing of what to make of new populations with different ideas, the public may stigmatize immigrant populations, saying that they do not contribute to society but instead are always taking: taking jobs, welfare, services, health care, and taxpayer money. However, research has suggested undocumented immigrants are the backbone of industry, and “the group often makes up the bulk of a labor pool of low-skilled persons who are willing to work for low wages and who try and remain hidden from official authorities – a group which often fills a large regional or metropolitan demand for labor” (Passel & Woodrow 1984).

Immigrants may feel this stigmatization and feel reluctant to seeking care. Further, lack of resources on the part of the health provider or health clinic may cause frustration, and since discrimination cases are reported more for immigrants than non-immigrants, this feeling of stigmatization may cause a decline in future use of the healthcare safety net. Policies, as well, reinforce a feeling of stigmatization, since PRWORA created a “deserving” and “nondeserving” delineation for immigrants: those legal and illegal.

**Motivations Behind Research**

This research’s underlying motivations include an interest in the public health and health care access for marginalized populations within Philadelphia. An interest in becoming familiarized with Philadelphia’s safety net for those who face the most barriers to utilizing it also
motivates this research. Examining how undocumented immigrants’ vulnerability and how intersectionality theory interplay in health care access is an objective that yields a greater understanding for policy. It is important to investigate and understand the perspective and barriers that undocumented immigrants face in something as essential as access to health care.

Objectives

I aim to examine the overall health care for undocumented immigrants residing in Philadelphia. I want to assess to what degree their access is considered by examining barriers mentioned by healthcare providers and advocates. Because both advocates and healthcare providers are included, I want to look at the differences and similarities in what the two groups say about the barriers to care for undocumented immigrants are. Finally, I want to use my research and do comparative research specifically to see what Philadelphia can do better for undocumented immigrants in regards to health care. I will do this by researching other cities, other reports, and other studies to assess possible interventions.

Assessing Health Care for Undocumented Immigrants

Exploring appropriate approaches to assessing health care for undocumented immigrants is needed in order to carry out effective research. Research should focus on the social determinants of health of undocumented immigrants, with an emphasis on structural factors (Viruell-Fuentes et al. 2012). Social determinants of health “refer broadly to any nonmedical factors influencing health, including health-related knowledge, attitudes, beliefs, or behaviors,” (Braveman et al. 2011). Neighborhoods, social networks and discrimination matter and play a role in assessing health care for undocumented immigrants. Variables like air and water quality,
proximity to facilities that are hazardous to health, exposure to lead paint or pest infestation, access to nutrition foods matter when assessing health. The availability and standard of schools, transportation and job access can turn to shape populations’ opportunities to finances.

Economic resources, education, and discrimination also have been shown to affect downstream social determinants of health such as behavior. Research should focus on social factors more, especially relative to policies and long term. Longitudinal studies show that economic resources predict health determinants. Further, exploring a history of policy and of culture for and of undocumented immigrants call for a conceptual model when considering health studies and acculturation (Salant & Lauderdale 2003). Acculturation refers to the assimilation of newcomers or foreign-culture populations into a mainstream culture. However, studies apart from acculturation when considering health are important, as there tends to be an overemphasis on this trend within assessing health care outcomes for undocumented immigrants.

Figure 1, Social Determinants of Health: Depicts how all four levels of the semi-circle impact each other.
There is a paradox in the acculturation theory with first generation Mexican immigrants having better health outcomes before acculturation into America (Viruell-Fuentes). However, these correlations of “negative acculturation,” as the phenomenon has been dubbed, have been determined to be non-conclusive (Ro 2014). Requirements for studying healthcare access for undocumented immigrants cannot afford to be short-sighted or examine barriers in isolation: there is a connection, a action-reaction of each barrier that compounds the overall picture of undocumented immigrant health. “Scholarship in immigrant health and social epidemiology can make significant contributions toward one of their mutual and ultimate goals: to improve knowledge about population health,” (Acedvedo-Garcia et al. 2012).

Measuring healthcare accessibility is a challenge, and much consternation of how to effectively see access is needed. In order to effectively assess health care access for undocumented immigrants, the term “access” needs to be explored and elucidated. “Access” is broadly defined as a summary word that accentuates the fit between patient and healthcare provider. Healthcare access includes five things: availability, accessibility, accommodation, affordability and acceptability (Penchansky and Thomas 1981). Availability consists of defining where health care can be accessed, while accessibility focuses on the proximity of the services offered. Accommodation refers to how much the healthcare system stretches to meet patient needs, while affordability refers to a patient’s financial ability to access a provider’s care. Acceptability includes comfort level of a patient, and for undocumented immigrants, may factor in things such as fear of detection and stigmatization of immigrants.

Painting the Picture of Undocumented Immigrants in Philadelphia
In Philadelphia, there is an immigrant population of about 137,000. Mexico is the largest source of unauthorized immigrants in the U.S., with 70% of the 9.2 million Mexican-born people living in the U.S. in 2000 being unauthorized (United States Immigration and Naturalization Service Office of Policy and Planning 2003). Philadelphia has been an immigrant city since it’s founding in 1682, and was the most important immigrant port in the 18th century.

In the 1980’s, Koreans, Vietnamese and Greeks moved to areas like Olney, Logan, and West Philadelphia that housed earlier waves of immigrants (Miller). In fact, Philadelphia has the largest and fastest growing immigrant population that makes up 9% of the population between 2000-2006 (Katz 2008). Nearly 75% of the greater Philadelphia’s labor force growth since 2000 is attributed to immigrants. In the United States, Mexico is the largest source of unauthorized immigrants, making up 6 million of the 10.5 million Mexican-born people in the US (Hoefer, Rytina, & Campbell, 2006).

In terms of what is available for undocumented immigrants regarding health care, there is what is termed the healthcare safety net. There are 15 FQHCs that operate in 38 sites in Philadelphia, with 97% of the people going to them falling 200% below the Federal Poverty Level (Fennelly 2016). Undocumented immigrants are also eligible for emergency Medicaid, and can access clinics and hospital services reared towards vulnerable populations or those that do not require health insurance. The majority of undocumented immigrants lack health insurance.

**Methods for interviewing**

The research I will be conducting uses this knowledge on top of interviews to outline the forces surrounding healthcare access undocumented immigrants in Philadelphia receive (Teitel 2016). Advocates of undocumented immigrants and healthcare providers of undocumented
immigrants were interviewed. Advocates of undocumented immigrants can be classified as anyone working for an organization that assists undocumented immigrants in some way. They provide insight into healthcare access since they work daily with undocumented immigrants and have some perspective from this. Healthcare providers of undocumented immigrants can be defined as anyone who gives any form of medicine or care to undocumented immigrants.

The healthcare providers will yield information surrounding health accessibility of certain services, such as: dentistry, podiatry, optometry, nutritional information, chronic care, mental health care, TB and HIV tests, immunizations, and gynecology were assessed. Further, questions pertaining to traditional medicine, ethics, and policies were included on both advocacy and health provider questionnaires. There were questions pertaining to the social determinants of health that affect immigrant populations, including culture and language. The last question asks to refer me to any other advocacy workers or healthcare workers for undocumented immigrants, providing new acquisition of interviewees by a snowball effect. The first few were garnered using my connections at La Salle through the help of Sara Shuman in public health, Miguel Glatzer in political science, and Tara Carr-Lemke from the Explorer Connection.

I reviewed the interviews on an advocate versus healthcare provider perspective, to assess what matched and what did not in terms of answers. I compared answers to the research and literature already conjured surrounding the subject of undocumented healthcare access. Together, all these things helped to provide a larger perspective of how healthcare access for undocumented immigrants functions in Philadelphia. The layout of the report will provide research first surrounding the barrier or concern to healthcare access, and then interviewee responses. The standard chart used to clearly see interviewee responses numbers healthcare providers and advocates and includes their affiliations in parenthesis next to the given number.
The intersectionality factors will be presented in the paper with the research collected presented first with the title “RESEARCH,” and the interview information following it under the title, “WHAT INTERVIEWEES SAID.” The interviewees’ answers to the questions were revelatory in comparison with the research done on intersectionality issues. The comparison of healthcare providers and advocates for undocumented immigrants also provided insight on the two perspectives with the trends in their responses. In the remainder of this report, intersectionality will be explored further as factors of poverty, language barriers, cultural barriers, policy barriers, and public health and ethics concerns.

Sources of interviews

HEALTHCARE PROVIDERS:

The interviews conducted for healthcare providers came from 6 Federally Qualified Health Centers, and 1 care facility specifically for undocumented immigrants. Federally qualified health centers are specific health centers for those with low incomes, accepting health insurance but not requiring it. They have a sliding scale of payment, and some are health center grantees. The neighborhoods the sources serve range from North to South Philadelphia, displaying the variety of places that undocumented immigrants reside in Philadelphia.

Table 1, Health centers interviewed

<table>
<thead>
<tr>
<th>Care Facility</th>
<th>Number of People Interviewed</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puentes de Salud</td>
<td>2</td>
<td>Undocumented Immigrant Care</td>
</tr>
<tr>
<td>Esperanza Health Center</td>
<td>2</td>
<td>FQHC</td>
</tr>
<tr>
<td>Strawberry Mansion Health Clinic</td>
<td>1</td>
<td>FQHC</td>
</tr>
<tr>
<td>PHMC Care Clinic</td>
<td>2</td>
<td>FQHC</td>
</tr>
<tr>
<td>Catholic Worker Free Clinic</td>
<td>1</td>
<td>FQHC</td>
</tr>
</tbody>
</table>
Puentes de Salud is a non-profit health clinic that means “bridges of health” in English. The organization, started in 2006, provides quality care to the Latino population of South Philadelphia at a reasonable cost. They provide mostly to those whose immigration status and lack of insurance deem them unable to receive quality care normally accessible to insured citizens. The organization relies on donations and volunteer medical students from Philadelphia hospitals. Puentes de Salud is unique because it is a health system that specifically serves undocumented immigrants, preferring those who lack insurance to focus on the more marginalized populations. The rest of the health centers named are FQHCs.

There are three locations in Philadelphia for Esperanza Health Center: in Kensington, Hunting Park, and Fairhill. They have a mission to provide affordable, bilingual health to immigrants in North Philadelphia. The majority of the patients that they serve are Latino.

Strawberry Mansion Health Center is in North Philadelphia, and serves mostly black populations. Maria de los Santos is under the umbrella company of Delaware Valley Community Health, and is also in North Philadelphia and serves mostly Hispanic populations. Fairmount S Center is in South Philadelphia and caters mostly to the Hispanic population. Care Clinic is in Center City, and caters mostly to black populations, just like Catholic Worker Free Clinic and PHMC. These health systems are clinics that form the basis of the safety net for undocumented immigrants, as well as other marginalized and impoverished communities in Philadelphia.

ADVOCACY:
The interviews conducted for advocates came from 7 places, one per interview. They are mixed in whom they provide support to, but are familiar with the undocumented immigrant population in Philadelphia and all answered to the best of their ability. Three of the seven places interviews provided assistance in accessing health care for undocumented immigrants. Similar to the case with health centers in Philadelphia, the neighborhoods the sources serve range from North to South Philadelphia.

Table 2. Advocacy organizations interviewed

<table>
<thead>
<tr>
<th>Advocacy</th>
<th>Number of People Interviewed</th>
<th>Description</th>
<th>Healthcare access avenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIAS</td>
<td>1</td>
<td>Refugees/immigrants</td>
<td>No</td>
</tr>
<tr>
<td>SEAMAAC</td>
<td>1</td>
<td>Refugees/immigrants</td>
<td>Yes</td>
</tr>
<tr>
<td>New Sanctuary Movement</td>
<td>1</td>
<td>Immigrant/undocumented immigrant</td>
<td>No</td>
</tr>
<tr>
<td>African Family Health Organization</td>
<td>1</td>
<td>Immigrant/undocumented immigrant</td>
<td>Yes</td>
</tr>
<tr>
<td>Pennsylvania Immigration and Citizenship Coalition</td>
<td>1</td>
<td>Immigrants/refugees</td>
<td>No</td>
</tr>
<tr>
<td>Juntos</td>
<td>1</td>
<td>Immigrant/undocumented immigrant</td>
<td>No</td>
</tr>
<tr>
<td>Nationalities Service Center</td>
<td>1</td>
<td>Immigrant/refugees</td>
<td>Yes</td>
</tr>
</tbody>
</table>

New Sanctuary Movement (NSM) works to end injustices against immigrants and has root values of “dignity, justice, and hospitality lived out in practice and upheld in policy.” The organization is immigrant-led, interfaith and nonviolent and is an important unifying effort rooted in compassion. They work with North and South Philadelphia communities, particularly Kensington where Visitation Church is at the intersection of Kensington and Allegheny. Also, the parish St. Thomas Aquinas on the west side of Broad Street is an active area for NSM. They
primarily work with Central American and Mexican immigrants, as well as Indonesian immigrants.

SEAMAAC, or Southeast Asian Mutual Assistance Association Coalition, works specifically towards supporting immigrant and refugee populations in obtaining social services, health services, and education. They are in South Philadelphia, and service Southeast Asian populations.

HIAS is an organization that advocates for the rights of vulnerable displaced populations. Their reach is broad, and their service is not limited to any one country or region of origin. They ensure that new populations into the United States are welcome and treated with respect. They are the only Jewish organization to assist refugees, and their organization began in 1881 with assisting fleeing Jews from Russia and Eastern Europe. In the 2000s, HIAS began assisting non-Jewish peoples fleeing turmoil and seeking resettlement.

African Family Health Organization (AFHO) specifically connects refugees and immigrants, including undocumented, of Caribbean and African descent to health care. They are aware of the numerous health barriers that immigrant populations face, including language and cultural barriers. They have a behavioral health program, a breast cancer program, HIV/AIDS education, preventative care for obesity, and focuses in maternal and child health. AFHO also is partnered with HIAS, Nationalities Service Center, and SEAMAAC. They serve in North, Northeast, and West Philadelphia.

Pennsylvania Immigration and Citizenship Coalition (PICC) is much more broad, mostly because it’s focus is not specifically in Philadelphia. Their focus is representing the needs of immigrants and migrants in Pennsylvania to public officials and the general public. They partnered with Philadelphia to develop access to programs such as Global Philadelphia to
increase language access. They advocated especially for immigrants after the terrorist attack on the Twin Towers on September 11, 2001. PICC also provides knowledge of the contributions of immigrants to policy makers.

Juntos focuses on empowering the community members as a community-centered Latino organization in South Philadelphia. They do various trainings on knowing rights, education, and access to help with applying for college and schools. Nationalities Service Center (NSC) is an organization that welcomes new peoples to the US by assisting in occupation placement, housing, health care, language, and knowing their rights. They hold community initiatives, and advocate against and assisting those who have had to deal or continue to deal with domestic abuse, human trafficking, and torture victims. They, like HIAS, serve a broad population of immigrants.

Results:

OVERALL:

Advocates and healthcare providers rated the overall access that immigrants have to health care in Philadelphia drastically differently. I asked interviewees to provide an answer of how they rated health care on a scale of 1-10. The healthcare provider average answer was 8.29 out of 10. The advocate average answer was 2.29 out of 10. Also, healthcare providers overwhelmingly displayed their cost of care as low, either set between $10-20 or on a sliding scale. Advocates mentioned that cost, especially fear of cost, is a major barrier for undocumented immigrants in the larger picture. A reason for these differences might be that advocates see a larger picture, while healthcare providers rated their own personal performance as high, because they are working their hardest. Also, healthcare providers might not see that undocumented
immigrants are afraid of costs because those who are afraid might stay at home or seek alternative remedies instead of meeting with healthcare providers.

The care provided by the clinics interviewed included HIV tests, TB tests, podiatry services, optometry services, dentistry, chronic health support, standard immunizations, nutritional information, mental health care, and OBGYN services, directly or via referral. However, optometry care is harder and more expensive to access, often provided by referral to specific places such as the Eye Institute in Philadelphia. Further, populations from Latin America require X-Rays to get TB results, since they received a TB vaccine that makes the simple and less expensive bump test null. X-Rays are also more expensive. Healthcare professionals often pointed out that it is not the primary care, doctor’s appointment, or even medicine that is expensive; it is the lab tests and surgeries. As one doctor put it, “Nothing is a problem until there is actually a problem.” Further, doctors also expressed qualms about not being able to do everything within their ability, due to limitations with specialty medicine access and lab tests, to help the patient get better that would normally be available with insurance.

Table 3, Health centers’ access to immunization, dentistry, and OBGYN services

<table>
<thead>
<tr>
<th>Care Facility</th>
<th>Immunizations</th>
<th>Dentistry</th>
<th>OBGYN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puentes de Salud</td>
<td>Yes, for children, only flu adults</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Esperanza Health Center</td>
<td>All standard</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Strawberry Mansion Health Clinic</td>
<td>All standard</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PHMC Care Clinic</td>
<td>All standard</td>
<td>Yes</td>
<td>Refer Jefferson</td>
</tr>
<tr>
<td>Catholic Worker Free Clinic</td>
<td>All standard</td>
<td>Refer to Parrish Street Clinic, Abbotsford Health Center, Steven Klein Health Center</td>
<td>Refer Jefferson</td>
</tr>
<tr>
<td>Maria de los Santos</td>
<td>All standard</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 3, Health centers’ access to mental health, optometry, and podiatry services

<table>
<thead>
<tr>
<th>Care Facility</th>
<th>Mental Health</th>
<th>Optometry</th>
<th>Podiatry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puentes de Salud</td>
<td>Behavioral health counselor</td>
<td>Provide Optomology</td>
<td>Once a month</td>
</tr>
<tr>
<td>Esperanza Health Center</td>
<td>Behavioral health specialist</td>
<td>$50, referral to Dr. Collazo</td>
<td>Referral Dr. Lee</td>
</tr>
<tr>
<td>Strawberry Mansion Health Clinic</td>
<td>COMWAR referral</td>
<td>Referral to Eye Institute, Drexel</td>
<td>Yes</td>
</tr>
<tr>
<td>PHMC Care Clinic</td>
<td>Behavioral health counselor</td>
<td>Referral to Eye Institute</td>
<td>Yes</td>
</tr>
<tr>
<td>Catholic Worker Free Clinic</td>
<td>Behavioral health counselor</td>
<td>Referral to Eye Institute</td>
<td>No</td>
</tr>
<tr>
<td>Maria de los Santos</td>
<td>Behavioral health counselor</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Fairmount S Center</td>
<td>Behavioral health counselor</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 5, Health centers’ access to nutritional information, HIV/TB tests, and chronic disease services

<table>
<thead>
<tr>
<th>Care Facility</th>
<th>Nutritional Information</th>
<th>HIV/TB Tests</th>
<th>Chronic Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puentes de Salud</td>
<td>Promotoras</td>
<td>Yes, HIV $30</td>
<td>Yes</td>
</tr>
<tr>
<td>Esperanza Health Center</td>
<td>Have to be existing patient</td>
<td>Yes</td>
<td>Not a lot of cardiology available in general for undocumented patients, but we do the best we can</td>
</tr>
<tr>
<td>Strawberry Mansion Health Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>Refer out if it gets out of hand</td>
</tr>
<tr>
<td>PHMC Care Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Catholic Worker Free Clinic</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Maria de los Santos</td>
<td>Yes</td>
<td>Yes, HIV $3</td>
<td>Yes</td>
</tr>
<tr>
<td>Fairmount S Center</td>
<td>Yes</td>
<td>Yes, HIV $3</td>
<td>Yes</td>
</tr>
</tbody>
</table>

INTERSECTIONALITY:
The focuses of intersectionality, which should always be referenced when assessing the access of health care for undocumented immigrants, were poverty, language barriers, cultural barriers, and policies surrounding access of care for undocumented immigrants. These forces have a grand impact on the access of undocumented immigrants, because even if there is quality primary care offered, fear and lack of knowledge can immediately deter an undocumented person from access.

Affordability, language, and cultural barriers are the most cited barriers to care by the 14 interviews conducted. The healthcare providers interviewed are a group hardworking and dedicated individuals who often go above and beyond to ensure that the undocumented population receives the best quality care they are allowed to give. Also, the advocates interviewed are providing much-needed support systems and gateways to adjusting and thriving in the United States.

Limitations to my research include not interviewing undocumented immigrants themselves to gain the most important perspective, and the small pool of interviews conducted, since there are a lot more than 14 people in Philadelphia providing support for undocumented immigrants. Further, I could have limited my advocates to just those that provided avenues to healthcare access. I also could have gotten perspectives of healthcare providers who worked in hospitals or in ER rooms with undocumented immigrants.

**Poverty and Undocumented Immigrants**

**RESEARCH:**

The systemic distribution of healthcare access in Philadelphia correlates heavily to what area you are in, and how wealthy people living in that area are. Ten times as many primary care
physicians more accessible in the richer neighborhoods when compared with poorer ones (Beeler 2016). In fact, a report by the Philadelphia Department of Public Health found that Philadelphia as a whole has a 900:1 ratio of patients to primary healthcare providers within a short distance. However, in South Philadelphia, which is one of the areas where undocumented immigrants are found to live, has a ratio of 3000:1. This ties healthcare access to income level within Philadelphia.

Figure 2, Health access map: shows 6 lowest levels of geographic access to primary care providers (Brown 2015).

Philadelphia has areas that have an overload of primary care providers, which leads to the 900:1 overall ratio of patients to care providers within a short drive.

In 2011, 32% of undocumented adults and 51% of undocumented children had family incomes below the federal poverty level (Capps et al. 2015). Further, level of salary is linked to ability to afford insurance. A lot of undocumented immigrants who might have access to insurance cannot afford the deductible. “A lot of people who are totally willing to pay for their
health care, but they just can’t afford the prices in the regular system,” Jason Odhner in Phoenix notes (Phippen 2015). Further, the diseases that often plague undocumented immigrants are preventable, and often, because there is no preventative care, force immigrants into expensive emergency room treatments.

An especially poignant case for the barrier of cost comes in the form of diabetes. A large undocumented immigrant population is Latino. Latinos are almost twice as likely to get diabetes than non-Latinos in the United States, and those with diabetes spend 2.3 times more on medical expenditures than those with diabetes. Santillan in 2014 explored the frustration that a researcher sensed from undocumented Hispanics at Puentes de Salud when they realized the mounting costs associated with their diabetic care. “UIs realized that, without insurance, just one bottle of [Accu-check] strips costs $115, not including the machine, which cost $37. In addition, regular checkups with a physician cost them at least $100 per visit.” The researcher noted that these costs do not account for missed time at work at doctor appointments. Further, having health insurance is an important factor in promoting awareness for hypertension and diabetes (Barcellos, Goldman & Smith 2012).

Playing into socio-economic factors and poverty is the type of education received by undocumented immigrants. Of undocumented immigrants aged between 25-64, 47% have less than a high school education in contrast to the US’s 8% (Passel & Cohn 2009). The 2007 median household income for undocumented immigrants was $36,000, which relates to what type of health access options there are. A third of children and a fifth of adults who are undocumented immigrants live in poverty, double the rate for children and adults of US-born parents.

WHAT INTERVIEWEES SAID:
In terms of poverty, healthcare providers said that the cost is low. “If there is an expensive medication or procedure, we refer them to city health centers,” said Healthcare Provider #3. All clinics interviewed expressed a commitment to affordability, with seven out of seven mentioning it. Only three out of seven mentioned that undocumented immigrants might be deterred from cost. Healthcare Provider #1 from Puentes de Salud noted that she thinks, “people don’t come because they are scared of cost,” even though that particular place only charged between $8-10. Healthcare Provider #7 from Puentes de Salud mentioned, “Cost is pretty cheap. You can get on Medicaid if you are undocumented and pregnant, and they will cover the cost of the delivery and a short post-partum window. Things like pre-natal vitamins are not going to be covered, so a lot of people will not take prenatal vitamins because they have to pay for them.

Further, six out of seven health providers mentioned that costs in Philadelphia are overcome by grants and hard working volunteers, and that there are tremendous barriers in Philadelphia. Some also mentioned that there was government funding for the sliding scales of FQHCs.

On the other hand, advocates expressed a much gloomier picture, stating that people just do not have funds. “They are sick and they remain sick,” advocate #1 from SEAMAAC proclaimed. “Some of them die.” Advocate #2 from PICC said that undocumented immigrants will not even go to the ER because they are afraid of large costs, and that they could not pay for full prices even if they wanted to. Six out of seven advocates expressed that undocumented immigrants were fearful of costs, with Advocate #5 from HIAS admitted that she was unsure.

The difference in opinion might be due with the cost of upfront care of clinics, which is cheap, compared to lab and more specialized procedures that come out-of-pocket for undocumented immigrants in Philadelphia. Further, advocates may not be fully aware of the actual costs, but this might also not be what they are referring to. Perhaps they mean fear of
costs, an assumption that health care is going to be expensive. It often is expensive, if there is a chronic disease such as diabetes. Also noted, further in the interview process, healthcare providers cited fear of cost and lack of insurance as a barrier. Therefore, although upfront costs of clinics may not be expensive, they are only low if there is no additional follow-up procedures or specialty medication needed.

Table 6, Healthcare provider vs. advocate on cost barriers for undocumented immigrants

<table>
<thead>
<tr>
<th>Healthcare Provider #</th>
<th>How does cost factor in?</th>
<th>Advocate #</th>
<th>How does cost factor in?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Puentes de Salud)</td>
<td>Low, $8-10, but lab costs and expensive meds we refer out to clinics</td>
<td>1 (SEAMAAC)</td>
<td>Insurance is expensive, fear deters</td>
</tr>
<tr>
<td>2 (Maria de los Santos &amp; Fairmount S)</td>
<td>Sliding scale up to $25</td>
<td>2 (PICC)</td>
<td>Health bills expensive, people won't go</td>
</tr>
<tr>
<td>3 (Esperanza)</td>
<td>Patient access liaisons, sliding scale</td>
<td>3 (AFHO)</td>
<td>People do not have the money, may die</td>
</tr>
<tr>
<td>4 (Esperanza)</td>
<td>Patient access liaisons, sliding scale</td>
<td>4 (NSM)</td>
<td>Fearful because of it</td>
</tr>
<tr>
<td>5 (Care Clinic &amp; Strawberry Mansion)</td>
<td>Not much, difficult for MRI</td>
<td>5 (HIAS)</td>
<td>I don't know</td>
</tr>
<tr>
<td>6 (PHMC Care Clinic &amp; Catholic Worker Free Clinic)</td>
<td>Low, but labs and radiology refer out and more expensive</td>
<td>6 (NSC)</td>
<td>People are afraid</td>
</tr>
<tr>
<td>7 (Puentes de Salud)</td>
<td>$10-20, lab services, huge ER bills might deter</td>
<td>7 (Juntos)</td>
<td>It is difficult</td>
</tr>
</tbody>
</table>

**Limited English and Accessing Health**

RESEARCH:
Those who do not speak English and are newcomers to America face nonfinancial barriers to accessing a regular source of care, accessing health insurance, and accessing preventative care. Non-English speakers are less satisfied with care and reported more discrimination (Derose et al. 2009). Accessing health care in the US while not properly speaking English or not speaking English at all prevents immediate communication. Capps et al. (2016) reports that only 30% of undocumented immigrants aged 19 and older are English proficient. Further, specifically with undocumented immigrants, there is a language barrier since it is found that undocumented immigrants have the most difficulty understanding their diagnoses (Ortega et al. 2007).

Language access is a barrier that is tricky. Interpretation services reduce but do not eliminate the barrier. Limited-English proficient adults have higher risk of lack of access to health care and older non-English proficient adult undocumented immigrants have a 52% greater risk of reporting lower emotional health in comparison with the English-proficient (Ponce, Hays, & Cunningham 2006). Follow-up visits and preventative care are impacted by language barriers, and it has even been shown that those with language barriers are less likely to be given a follow-up visit after admittance to the ER (Sarver & Baker). Undocumented Latinos with interpretational phone lines given reported more dissatisfaction with care.

WHAT INTERVIEWEES SAID:

Language is another barrier to health care that is not a direct healthcare factor. Language is an important form of communication when it comes to health care, because doctors want to be clear with patients about what their diagnoses are, and patients want to be clear with doctors about what their symptoms are. Health providers expressed that there is a big difference when
the healthcare provider and patient do not speak the same language, saying that resources and information are lost. However, 4 out of 7 healthcare providers said there was no barrier, either because of interpretation services offered or because they themselves speak Spanish. However, 3 out of 7 healthcare providers said there are language barriers, including Healthcare Provider #7 from Puentes de Salud, who said:

In the past, someone would come in who has chopped off their finger and someone from Puentes de Salud would go to the Emergency Room with them to help translate. I think other facilities have to work on their interpretation services to make health more accessible for these especially vulnerable populations.

Although some healthcare providers mentioned that there are qualms with language in accessing health care for undocumented immigrants, they understated the problem in comparison to advocates. Seven out of seven advocates expressed that language is a barrier for accessing health care for undocumented immigrants. Advocate #4 says, and Advocate #5 also pointed out, that not only is the language itself a barrier, “but also the elevated and technical nature of medical language that makes for very hard situations.” Also advocates mentioned hospitals not providing interpretation even though it is promised, and that language goes beyond healthcare provider-patient interactions and into every step of the process. Advocate #5 from HIAS mentioned an anecdote:

I had the chance to hear two immigrant women talk about how difficult it was for them to be diagnosed with cancer when the doctors and nurses did not speak Spanish. It was frustrating during such an emotional, confusing time. Advocates expressed a higher degree of concern over language than healthcare providers, but this is perhaps because most healthcare providers have interpretation services or language fluency. Their facility might not have a language barrier, but other facilities and services in
Philadelphia might. Further, fear of language as a barrier deters patients from even seeking access, according to the research above.

Table 7, Healthcare provider vs. advocate on language barriers for undocumented immigrants

<table>
<thead>
<tr>
<th>Healthcare Provider #</th>
<th>Are there any language barriers?</th>
<th>Advocate #</th>
<th>Are there any language barriers?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Puentes de Salud)</td>
<td>I am a Spanish speaker</td>
<td>1 (SEAMAAC)</td>
<td>They are everywhere, in every step of process</td>
</tr>
<tr>
<td>2 (Maria de los Santos &amp; Fairmount S)</td>
<td>It uses more resources and information is lost when a provider doesn't speak Spanish like I do</td>
<td>2 (PICC)</td>
<td>Reoccurring barrier</td>
</tr>
<tr>
<td>3 (Esperanza)</td>
<td>No barrier, have interpretation</td>
<td>3 (AFHO)</td>
<td>Yes, and we educate client to ask for services.</td>
</tr>
<tr>
<td>4 (Esperanza)</td>
<td>No barrier, have interpretation</td>
<td>4 (NSM)</td>
<td>It is complex, medical language is difficult</td>
</tr>
<tr>
<td>5 (Care Clinic &amp; Strawberry Mansion)</td>
<td>There are barriers despite translation phone line, I speak French and Spanish</td>
<td>5 (HIAS)</td>
<td>Medical language is difficult</td>
</tr>
<tr>
<td>6 (PHMC Care Clinic &amp; Catholic Worker Free Clinic)</td>
<td>No barrier, have interpretation</td>
<td>6 (NSC)</td>
<td>Hard to demystify</td>
</tr>
<tr>
<td>7 (Puentes de Salud)</td>
<td>Everyone needs to speak Spanish here, but it is still a problem elsewhere</td>
<td>7 (Juntos)</td>
<td>Extreme barrier</td>
</tr>
</tbody>
</table>

**Cultural Barriers**

**RESEARCH:**

Immigrants who are undocumented are less likely to use health care due to fear of detection in Philadelphia. “Many people are afraid because the first thing that happens when you go to the hospital is they’ll ask for a green card or identification,” notes Estela, an undocumented
immigrant from Mexico (English 2015). Since there was an undocumented immigrant that was arrested in Texas after going to a gynecologist and presenting false identification in 2015, anxiety about the possible deportation repercussions while simply accessing health care in the U.S. for undocumented populations.

Also, undocumented immigrants have been found to be especially reluctant to use disaster relief services due to fears of deportation, causing some families to stay away from medical and other relief during Hurricane Katrina and during the fires in California in 2007 (Tsou et. al 2009). Language also plays into disaster relief services for undocumented immigrants, because if language is a barrier for normal medical care access for undocumented immigrants, it most certainly will be one during a disaster. Promotoras at clinics, including Puentes de Salud, increase cultural understanding and provide more stability for patients feeling out of place (Pérez-Escamilla & Song 2010).

Swan in 2010 did a study at Puentes de Salud on two diabetic groups to explore the beliefs and health practices of Mexicans with diabetes. It was found that Latinos link diabetes with depression, and that food is central to their culture. Further, a sense of “maschismo” and the social stigma of diabetes relates to a patients’ sense of denial. Knowledge of what is going on in a patients’ head is important as a physician, to ensure that they can effectively and cross-culturally communicate the diagnoses and prescriptions.

WHAT THEY SAID:

Cultural barriers are problems that arise with differences in how diseases and illnesses are treated from culture to culture. Traditional medicine, not understanding how the healthcare system works in the United States, and difficulty understanding what the healthcare provider
means or how to act in a certain scenario causes distress for patients. Cultural barriers add to existing barriers to make access to health care that much more of a burden for undocumented immigrants.

The majority of health care providers expressed that there were cultural barriers. Six out of seven said there were. Healthcare Provider #5 expressed that she learns as she goes regarding culture. Some cited traditional medicine use, but others were unsure about specifically what measures their populations used or if they used any traditional medicine at all. Healthcare Provider #7 from Puentes de Salud worker said,

They will often get traditional treatments from non-traditional sources. For example, they will get antibiotics from a person who is selling it in a Mexican store because in Mexico, you don’t need a pharmacy to prescribe antibiotics. So they’ll bring them from Mexico and sell them. Instead of going to the doctor and getting a prescription, they’ll just get antibiotics directly.

Healthcare Provider #6 cited that there was an instance where a Muslim woman would not see a male cardiologist. Further, regarding the largest group of undocumented immigrants in the US, Healthcare Provider #7 from Puentes de Salud mentioned

Mexicans hold doctors and teachers in extremely high esteem. So basically, whatever a doctor tells them to do for themselves, they do it for themselves. It is awesome at times, especially when patients are told to lose weight and then they actually do it! Americans do not even do that. However, this also means they will not advocate for themselves.

Healthcare providers mentioned cultural barriers, but had less to say about them than language barriers.
Overall, advocate answers expressed that advocates think culture is not as big as a barrier as language. Only four out of seven expressed that there was one, with Advocate #5 from HIAS not being sure of there being culture barriers and Advocate #3 expressing that language needs to be solved first, and that this will take care of culture. Advocate #2 said there was none at all. Advocate #4 from NSM brought up that there are a lot of fears around questioning doctors, similar to what Healthcare Provider #7 brought up about Mexican undocumented immigrants. Advocates responding less to cultural barriers than language may be because advocates know less about traditional medicine sources. However, Advocate #4 from NSM noticed the differences with traditional medicine and biomedicine, which is that biomedicine does not take a “mind-body, spiritual-physical approach.” Advocate #4 also mentioned that a healthcare provider told a woman that she could not breastfeed because she “would not get it” and that it “wouldn’t work for you.” This advocate did express empathy for doctors dealing with different cultures, saying that it must be a lot of stress to deal with.

Table 8. Healthcare provider vs. advocate on cultural barriers for undocumented immigrants

<table>
<thead>
<tr>
<th>Healthcare Provider #</th>
<th>Are there any cultural barriers?</th>
<th>Advocate #</th>
<th>Are there any cultural barriers?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Puentes)</td>
<td>I grew up in S California and know some, but I am also not Latina and do not know about susto</td>
<td>1 (SEAMAAC)</td>
<td>There are a lot of barriers, not an understanding of how US healthcare system works. There are fears and confusion.</td>
</tr>
<tr>
<td>2 (Maria de los Santos &amp; Fairmount S)</td>
<td>I understand because I am Hispanic, but other providers have difficulty</td>
<td>2 (PICC)</td>
<td>Not any that come to mind</td>
</tr>
<tr>
<td>3 (Esperanza)</td>
<td>I'm sure there are, we try and hire people from the same populations to minimize risk of it</td>
<td>3 (AFHO)</td>
<td>Language must be solved first, then culture will come with it</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>4 (Esperanza)</td>
<td>I was able to teach someone from Puerto Rico that arrived just that morning, but it takes time</td>
<td>4 (NSM)</td>
<td>People are not trusting, Latinos respect authority</td>
</tr>
<tr>
<td>5 (Care Clinic &amp; Strawberry Mansion)</td>
<td>We learn as we go, but there are absolutely barriers</td>
<td>5 (HIAS)</td>
<td>Don't know</td>
</tr>
<tr>
<td>6 (PHMC Care Clinic &amp; Catholic Worker Free Clinic)</td>
<td>Yes, there was an instance with a male cardiologist and Muslim woman</td>
<td>6 (NSC)</td>
<td>Absolutely, it is a difficult barrier</td>
</tr>
<tr>
<td>7 (Puentes de Salud)</td>
<td>Mexicans in particular hold physicians in high esteem</td>
<td>7 (Juntos)</td>
<td>Culture is a lens and if these are misaligned, information is lost</td>
</tr>
</tbody>
</table>

**Public Health and Ethics Concerns**

**RESEARCH:**

Public health concerns are a call to attention to ensuring that all residents in Philadelphia and in the US as a whole are receiving quality access to health care. This comes into play mostly with communicable diseases, such as HIV and tuberculosis especially (Foley 2005). Because 11 million people have some form of TB in the United States, and 66% of those 11 million people are born outside the US, it is pertinent that quality and effective medication (Kyanko 2016).

From an ethics standpoint, physicians have a duty to care for those who require medical attention, regardless of immigrant status or insurance from a standpoint simply of respecting the human dignity of all. Physicians have a primary responsibility to individual patients, but to the community as well (AMA 2016). From a public health standpoint, the hardships that undocumented immigrants face become pertinent to society with communicable diseases. Since
these immigrants are undocumented, they may have not gone through the overseas and domestic screenings in place to prevent the spread of disease and to further familiarize newcomers to the US health system (Refugee Health Guidelines 2016). Especially a large portion of undocumented immigrants work in food service jobs according to Pew Research Center, the lack of access of health care could affect the larger community if communicable diseases are not treated effectively. Healthcare providers are advised to advocate for their patients, assess available resources and legal sanctions, and participate in policy that produces a more equitable system (Coyle 2016).

There are ethical concerns on a state and local governmental level with the significant barriers that are placed on attaining quality healthcare access for undocumented immigrants. As a city, Philadelphia has a social responsibility to ensure that the residents are able to be healthy and prosper, regardless of status (Kuczewski 2016). Making an ethical argument for providing healthcare access to undocumented immigrants requires looking at these people as just that: people. Exploring the idea that everyone residing in America is taken care of and allowed to pursue a prosperous life also goes back to America’s founding roots. America is an immigrant nation, and the children of these undocumented persons are legal citizens.

Those undocumented immigrants who are afraid of getting deported or who lack knowledge about the FQHCs and healthcare safety net that are provided for them rely on emergency rooms. Waiting until people are in a state of emergency is problematic from a preventative point of view, from an economist point of view, and from an ethics point of view. People living in Philadelphia without any preventative care, which is problematic when considering communicable diseases. Care needs to be given for the benefit of everyone, not just the individual. With noncommunicable diseases, more of an ethical viewpoint applies. Do we
allow people to lie in wait for their chronic illnesses to get so bad, they need to keep revisiting the emergency room? Allowing undocumented immigrants preventative care could also save money with costly emergency room visits.

WHAT INTERVIEWEES SAID:

Although ethics are not a barrier to healthcare access for undocumented immigrants, ethics is an important consideration as a push for better healthcare access for undocumented immigrants. Healthcare providers and advocates alike both mentioned times when they felt ethics had been violated. For example, Healthcare Provider #3 from Esperanza mentioned that she feels disconcerted with the fact that there is only coverage for undocumented populations if the condition is “immanently life threatening. Like, if we do nothing, this person will die.” Healthcare Provider #7 revealed,

Patients who require complex care could be seen if they had insurance. I had a patient who was from Palestine, and he needed insulin, lab work, and a stress test. I am trained to manage that, but I couldn’t because it would be too expensive for him. He asked, ‘Why can’t you help me?’ I was like, ‘I can, I want to, but it would cost too much.’” This ethical case is concerning, and also helps shed light upon cost factoring into healthcare providers’ perspective of barriers, although not previously expressed in whether cost was a barrier. This is evidence that when answering the question about cost being a barrier to care for undocumented immigrants, healthcare providers answered especially about the primary care they provide, and not about the additional lab tests and specialized medication needed for any serious illnesses or conditions.

Advocates expressed similar concerns with ethics. Advocate #3 from AFHO mentioned a person who never received eye care because they lacked insurance and money. Advocate #3 also
cited lack of insurance for a client who has Hepatitis C, so they could not receive antiviral medication, a public health concern as Hepatitis C is a communicable disease. Also, with public health, Advocate #4 expressed concern with sending undocumented kids to school sick and spreading infections, impacting the community.

Table 9, Healthcare provider vs. advocate on public health concerns for undocumented immigrants

<table>
<thead>
<tr>
<th>Healthcare Provider #</th>
<th>Is lack of care a public health concern?</th>
<th>Advocate #</th>
<th>Is lack of care a public health concern?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Puentes de Salud)</td>
<td>Comprehensive health care is a right and we can afford it</td>
<td>1 (SEAMAAC)</td>
<td>Everyone needs access to have a positive impact on the community</td>
</tr>
<tr>
<td>2 (Maria de los Santos &amp; Fairmount S)</td>
<td>Yes, it is currently a drain in the system the way we do things.</td>
<td>2 (PICC)</td>
<td>Yes</td>
</tr>
<tr>
<td>3 (Esperanza)</td>
<td>H1N1 flu outbreak a couple years ago is a good example. More education is needed also to fix this</td>
<td>3 (AFHO)</td>
<td>Yes</td>
</tr>
<tr>
<td>4 (Esperanza)</td>
<td>It is absolutely a concern</td>
<td>4 (NSM)</td>
<td>Growing population in schools is a concern with this, especially with lack of preventative care</td>
</tr>
<tr>
<td>5 (Care Clinic &amp; Strawberry Mansion)</td>
<td>We do not currently have the systems in place to diagnose everyone, and this is tricky</td>
<td>5 (HIAS)</td>
<td>Don't know</td>
</tr>
<tr>
<td>6 (PHMC Care Clinic &amp; Catholic Worker Free Clinic)</td>
<td>Undocumented immigrants with STDs do not feel confident and feel isolated.</td>
<td>6 (NSC)</td>
<td>Yes, it threatens everyone</td>
</tr>
</tbody>
</table>
Yes, this is true for everyone. Education and holistic health needs to be more present everywhere to prevent public health concerns. Absolutely, because if you don't take care of everyone, then gaps will occur and more than just one population will fall in those gaps.

### Policy Shaping Immigrant Care

RESEARCH:

Immigrants, by law, are ineligible for federally funded public health insurance with the only exception of Emergency Medicaid under the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) (Gusmano 2012). The law was made to prevent hospitals from just “dumping” patients who could not afford to pay for care (Zibulewsky 2001). There are implications with just treating undocumented immigrants in extreme cases. The law defines emergency medical conditions as “manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in – (i) placing the health of the individual…in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ” (Department of Health 2013). Only having access to emergency care ignores chronic diseases that require care and medications that could prevent expensive tax-funded emergency room visits. EMTALA does not require additional treatment, only stabilization of a patient (Liu 2012).

The Personal Responsible and Work Opportunity Reconciliation Act of 1996 placed further impediments for undocumented immigrants accessing healthcare services that were not emergency services (Kullgren 2003). Made to promote self-sufficiency and dissuading immigrants from moving to the US for welfare, PRWORA says that states should take matters into their own hands. New York has decided to provide Medicaid for those who would not
necessarily have access to it as residents between 21 and 65 whose income fall below the standard of need due to Aliessa et al. v. Novello, with the verdict that denying access to health violated the Equal Protection Clause of the New York State Constitution (1 No. 73 2001). For example, Permanent Residence Under Color of Law (PRUCOL) is a public benefits eligibility that is nullified with PRWORA. This has implications countrywide, as PRUCOL is not the only public benefits that were cut with the enactment of PRWORA. My research will look at what public benefits remain after PRWORA for this vulnerable population in Philadelphia.

Despite the challenges that PRWORA presents to providing undocumented immigrants healthcare access, the US relies on a “safety net” of health providers (Fremstad 2004). This includes public and non-profit hospitals, federally qualified community health centers (FQHCs), and immigrant health clinics. A hospital recognized as a “disproportionate share hospital” (DSH), which takes into account the percentage of low-income and uninsured patients that the hospital provides health care for received additional payment from Medicaid (Gusamano and Thompson 2012). Together, Medicare and Medicaid DSH programs provide more than $20 billion to hospitals that qualify annually. Also, FQHCs and Immigrant Health Clinics are not for-profit, meaning they are not funded by the federal Health Resources and Services Administration (HRSA) (Brown and Sparer 2003). Both are required to use a sliding fee scale, and to have a majority of members of the community on the board of directors.
Figure 3, Federally Qualified Health Centers in the Philadelphia Area

The Patient Protection and Affordable Care Act does not qualify for undocumented immigrants (Edward 2014). However, the law includes more funding for the healthcare safety net, with an $11 billion increase in funding for FQHCs. However, the scary side to the law is the $22 billion reduction in Medicare DSH payments and an $18 billion in Medicaid DSH payments. Because these reductions are based on the idea that the hospitals will not need to give out this money once the healthcare reforms are in place, this leaves immigrants who are unqualified and uninsured out. The pressing effects of these are important to explore, especially in the immigrant city of Philadelphia. Further, immigrants are less likely to access health care ser

WHAT INTERVIEWEES SAID:

Policy surrounding healthcare access for undocumented immigrants is important to explore. Policies surround and decide not only what undocumented immigrants qualify for and
are able to access, but also what healthcare professionals are allowed to do to help their patients. Seven out of seven healthcare providers expressed that they are applying for grants to continue serving this vulnerable population. They also expressed qualms with the barrier of insurance, stating that if insurance were easier and less expensive to obtain for undocumented immigrants, more preventative care and follow ups would take place. “They [undocumented immigrants] are in the mindset of hanging onto pennies, because of the uncertainty of life,” mentioned Health Provider #5. All healthcare providers mentioned their clinics do not require health insurance, and all but Puentes de Salud would accept it since Puentes focuses specifically on uninsured undocumented immigrants.

Advocates expressed a similar sentiment, and were dismayed at the policies in place. Most noted correctly that with the policies in place, undocumented immigrants would have to have a life-threatening disease to get treated in some cases. “Right now,” says Advocate #3, “they are invisible essentially. There is no push to get insurance, and it’s public health common sense to have health insurance to pay.” On top of the ethics concerns mentioned by the advocates, it was also mentioned that the policies in place practice poor economics. Advocate #2 mentioned, “If you have a high volume of people, regular doctor visits would keep costs down.” Regarding policy, advocates and healthcare providers were on the same page and all of them mentioned that inclusion of undocumented immigrants into the Affordable Care Act would be extremely positive.

Table 6, Healthcare provider vs. advocate on inclusion of undocumented immigrants into Affordable Care Act
### Biggest Barrier Conclusions

In a literature review done by Hacker et al. in 2015, barriers to health care experienced by undocumented immigrants were collected by reference in literature. The biggest category found, with 50%, was surrounding legal barriers to accessing insurance within the policy arena. The next up at 30% was financial capability, and then language barriers. This study is not conclusive.
of what the biggest barrier is to health care for undocumented immigrants, but provides
information on what is often focused on. Policy is focused on heavily because from policy stems
practice. However, opinions of the 14 interviewees on the biggest barrier were that cost,
language, and cultural barriers are the primary barriers. Insurance policy is mentioned once, but
it also must be noted that cost, policy, and insurance are reliant on each other. Language had a
42.9% of the vote, and cost barriers had 35.7%. Cultural barriers were cited only by healthcare
providers, making up 57.1% of healthcare provider vote but only 28.5% overall.

Table 10, Healthcare provider vs. advocate on biggest barrier for undocumented immigrants

<table>
<thead>
<tr>
<th>Healthcare Provider #</th>
<th>What is the biggest barrier?</th>
<th>Advocate #</th>
<th>What is the biggest barrier?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Puentes de Salud)</td>
<td>Cost</td>
<td>1 (SEAMAAC)</td>
<td>Cost; language</td>
</tr>
<tr>
<td>2 (Maria de los Santos &amp; Fairmount S)</td>
<td>Language; Cultural barriers</td>
<td>2 (PICC)</td>
<td>Language</td>
</tr>
<tr>
<td>3 (Esperanza)</td>
<td>Cultural barriers; Cost</td>
<td>3 (AFHO)</td>
<td>Language</td>
</tr>
<tr>
<td>4 (Esperanza)</td>
<td>Lack of insurance; cultural barriers</td>
<td>4 (NSM)</td>
<td>Cost</td>
</tr>
<tr>
<td>5 (Care Clinic &amp; Strawberry Mansion)</td>
<td>Cultural barriers</td>
<td>5 (HIAS)</td>
<td>Don't know</td>
</tr>
<tr>
<td>6 (PHMC Care Clinic &amp; Catholic Worker Free Clinic)</td>
<td>Language</td>
<td>6 (NSC)</td>
<td>Language</td>
</tr>
<tr>
<td>7 (Puentes de Salud)</td>
<td>Cultural barriers</td>
<td>7 (Juntos)</td>
<td>Cost</td>
</tr>
</tbody>
</table>

**Future Steps**

Because there are a fair number of immigrant families with mixed immigrant status,
incorporating eligibility to parents of documented children into Medicaid might be beneficial for families, and might increase the number of child use of Medicaid (Dubay & Kenney 2003). Unless PRWORA’s immigrant restrictions are cleared, newer immigrants will face the same
challenges to getting insured (Derose, Escarce, & Lurie 2007). Tracking state-level health policies for undocumented immigrants, more common than federal-level health reforms, is important to monitor for implications on what works and what does not for providing care to this vulnerable population.

Expansion of funding for community health centers who are culturally competent and able to effectively care for undocumented populations might be another alternative, since clinics such as Esperanza Health Center and Puentes de Salud appear to be doing a stellar job. To address language barriers for immigrants, perhaps increasing funding for interpreting services or offering additional pay for bilingual staff members may be necessary to increase access and quality of care.

Also, support of the safety net is a valid step needed if undocumented immigrants were to be included in the Affordable Care Act, since the safety net may not be equipped to deal with the larger numbers. Further, inclusion of undocumented immigrants into the Affordable Care Act would greatly benefit public health, healthcare costs in emergency room visits, and the general health of undocumented immigrants in Philadelphia. In California, Pourat et al. (2010) conducted research and found that allowing undocumented immigrants to buy insurance in the Marketplaces will contribute to lower premiums and reduced resource strains on safety-net providers. It has also been found that chronic disease is slowed for undocumented immigrants with insurance (Hall & Cuellar 2016).

The Camden Healthcare Coalition targeted hot spot areas where people with chronic illnesses kept revisiting the Cooper Hospital emergency room, which was a minority of the population (Gawande 2011). This minority made up the majority in healthcare costs, since the chronicity of their illnesses meant that actual care needed to go into the health care these patients
were receiving. The Coalition provided this care, and lowered cost and visits to the emergency room enormously. They are just one example of how providing prevention and actual care can end up saving cities enormous sums of money in healthcare expenses. Perhaps a coalition for undocumented immigrant healthcare

Examining what Philadelphia could do better can be done by comparing the city to other cities and places within the United States to see what initiatives and changes can be taken to better take care of everyone. A shining example of a city making moves for undocumented immigrants is Los Angeles. About 30% of California’s 2 million undocumented immigrants could be eligible for the state’s public exchange (Chavez 2012). The advocates of incorporating illegal immigrants into the Affordable Care Act say that the initiative should be approved under an “innovation waiver” to allow states to have provisions of the federal law modified, since no federal funds will be used to bolster the program.

Senator Ricardo Lara reaffirms that “health care is a human right not a privilege” (“Health For All Act” 2016). Also, California offers undocumented immigrant children access to health through Medi-Cal, a state-funded public health insurance for those with lower incomes. Further, on the state economics side, allowing undocumented immigrants to purchase their health insurance could save California money with fewer emergency rooms used.

Foreign-born populations are less likely to use public funds. For example, in 2007, the total national medical costs of nonelderly undocumented immigrants are about $6.5 billion and publically funded component is about $1 billion, a small portion of U.S. healthcare costs (Goldman, Smith & Sood 2007). Overall, undocumented immigrants only account for 1.5% of total US medical costs, which predominantly are ER costs (DuBard & Massing)In terms of taxes paid per household, this amounted to $11 per household for undocumented immigrants. A more
comprehensive analysis of healthcare costs, incorporating taxes paid by immigrants, especially on social security of which they collect no benefit.

Conclusion

Healthcare providers and advocates provided different perspectives toward the barriers that undocumented immigrants face. Healthcare providers saw cultural barriers and cost among the largest barriers to care, while advocates saw language and cost as the predominating barriers. Undocumented immigrants could have proper access to healthcare in Philadelphia if intersectional factors did not play such a large roll. Poverty, policy, cultural and language barriers play a large part in the obstacles facing access for undocumented immigrants. Future steps can be taken to better care for undocumented immigrants in Philadelphia.

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