Title
Mexican immigration and health care: a political economy perspective.

Permalink
https://escholarship.org/uc/item/84m3n5rx

Journal
Human organization, 45(4)

ISSN
0018-7259

Author
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Publication Date
1986

DOI
10.17730/humo.45.4.r4l7250376270092

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APPENDIX II—ABORTION METHODS AMONG THE NZEMA

The text below is taken from an Italian article by Elvira Stefania Tiberti (1980:167–169). The English translation is by Thomas Crump.

The basic techniques adopted by Nzema women to provoke abortions make use of vegetable substances extracted from leaves, flowers, roots, bulbs and the bark of trees, processed and administered in diverse ways according to the nature of the case.

Of all these substances, only one, ezunvini (Strychnos Sparganophorum), may actually be effective: as for the remainder, some are no more than tonics or stimulants, while others have diuretic properties or inhibit bleeding.

One has the impression, however, that after generations of experimentation, women have a more or less adequate knowledge of the medical powers of the local plants. The association between the actual effect of the substance used, and its capacity to provoke bleeding which its users hope for, rather than pure ignorance, explain the conviction with which the presumed abortive effect is asserted of plants which are no more than strong laxatives.

On the other hand, the extreme trust that Nzema women have in traditional methods may be justified by the power of extraneous objects or stimulants introduced into the vagina to provoke abortions.

The techniques used must be distinguished according to whether they are intended to be abortive or purely contraceptive. The abortive techniques include those which make use of the ezunvini, a typical West African liana, with massive thorns, although other methods are more widespread. The fruit of the ezunvini, after being pulped and steeped in water, is administered as a beverage.

In the case of the nwanzawonlanra, a typical plant of the species Commelinae occurring in tropical Africa, but with no established specific medical properties, the leaves and the roots are used. These, boiled in water, are the basis of an enema, which after two or three days use provokes bleeding. The leaves of the eyanuba (Cassia Alata)—a plant of the species Papilionaceae known for the extreme toxicity of its roots and tubers—after being pulped and boiled in sea water, are similarly used.

The same method of administration is used also for eyanuba combined with ekwiastafinlina (Hibiscus Surattentissis), which is tonic and refreshing, and for toane, an egg-shaped fruit, of which the acid pulp, properly treated, produces a gelatinous substance used as an emollient. The infusion obtained from this mixture is administered from five to seven days before the abortion takes place.

Another method is adopted in the preparation of the leaves of the akpa (Ipomoea Caprea), a herbaceous plant of the species Convolvulaceae. The leaves, reduced to pulp, and then mixed with fine glass splinters, are made up into egg-shaped pellets which are administered per anum.

In contrast to the other techniques described, which are used in the first and second months of pregnancy, this last method can only be used from the third month on. The reason commonly given is that only then is the foetus sufficiently developed to be able to absorb the glass splinters, which in an earlier stage of pregnancy would produce internal lesions and bleeding.

The kodohile (Sterculia Tragacantha), belonging to the family of Sterculiaceae, provides an alternative technique. Segments of the stalk, about 8 cm long, introduced into the vagina, are left there for the whole night, during which, according to popular belief, they “dissolve the foetus,” although the effective principle is probably that of the probe.

Finally, juice extracted from the leaves of the papaya, kapka (Carica Papaya), belonging to the species Caricaeae, is used to impregnate wads of cotton wool, which are then placed in the vagina for a period of three days.

Mexican Immigration and Health Care: A Political Economy Perspective

by Leo R. Chavez

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This paper examines the case of Mexican immigrants in the United States and their access to medical services within a political economy of health framework. Such an approach stresses the provision of health care is independent of health factors per se and that access to health care is not equally distributed throughout a population. The first section reviews the three major concepts influencing medical anthropologists working within a political economy framework: (1) the social origins of illness; (2) the allocation of health resources; and (3) fieldwork in Third World countries. The analysis then focuses upon the reasons for limiting
mented by Mexican immigrants—both legal and undocumented—and their use of U.S. medical services has led me to work. Research I have conducted on the problems encountered by Mexican immigrants—both legal and undocumented—and their use of U.S. medical services has led me to specify what I mean by the political economy of health. When policy-makers view the fiscal resources to pay for health services as limited, they must make determinations which limit access to health services. How those determinations limiting access are made depends upon the historical, political and economic relationships between the actors (socially, culturally or economically defined subgroups) in a given society.

The implications of this process of allocating health services within a framework of political and economic constraints are the following:

(a) the provision of health care is independent of health factors per se, e.g., the well-being of the general population and its constituent ethnic and racial subgroups;

(b) access to health services is dependent upon factors which are economically and politically determined;

(c) access to health care is not necessarily equally distributed within a population; ethnic/racial subgroups within a society may find their access to health services limited as a result of their socioeconomic characteristics, many of which are beyond their individual control; and

(d) cultural factors may add to the problem of access to health services for a given subgroup in a community, but cultural beliefs are not a major cause of limited access (see also Chavez 1984).

The following sections examine the major influences on a political economy approach to health as utilized by medical anthropologists, and explore the reasons for limiting immigrants' access to health services. The specific case of Mexican immigrants in San Diego, California, is presented, focusing on the socioeconomic characteristics which affect their access to health care and the effects of limited access to health care on this population.

**Anthropology and the Political Economy of Health**

Medical anthropologists working within a political economy framework have been influenced by three major concepts: the social origins of illness, the allocation of health resources and underdevelopment.1 The idea of the social origins of illness derives from the work of Engels who, in *The Conditions of the Working Class in England* (Engels 1971), pointed to the organization of economic production and the social environment as the roots of illness and early death among working class people (Waitzkin 1981:79; see also Doyal 1979). The variables Engels focused upon as contributing to rapid deterioration of the worker's and his family's health were poverty, unhealthy working conditions including exposure to dangerous chemicals, crowded housing, poor nutrition and lack of political power, resulting in social alienation, depression and self-destructive behavior such as alcoholism.

Frankenberg (1980) echoed Engels' assertion that the causes of illness must often be sought in social relations. Moreover, Frankenberg argued that the relationship between patients and practitioners must also be viewed from a perspective which considers class relations and the social organization of production. As he wrote:

The economy of health care (traditional or Western), the ideology of beliefs and practices relating to disease and of the concept of disease itself, the politics of healer-patient and patient-patient relations, like other aspects of economy, ideology and politics, are all subject to and the subject of changes in the nature of production relations and the relationship between one set of production relations or mode of production and another (Frankenberg 1980:197; see also Kelman 1971).

The importance of examining the allocation of health resources within a society has also influenced medical anthropologists. Rudolf Virchow, a 19th century medical researcher and contributor to anthropological thought, also believed the origins of illness often were to be found in social and economic conditions (Virchow 1958). As Waitzkin (1981:84) has observed, Virchow:

argued that economic insecurity and political disenfranchisement were, through a complex chain of causality, social problems that generated disease, disability, and early death. Economic stability and active political participation by the poor, in Virchow’s view, were necessary for good health.

Virchow’s concerns for the health of the poor led him to criticize the factors which limited the availability of medical services, particularly the practice of hospitals requiring payment for medical services from the poor (Waitzkin 1981:88). Virchow also observed firsthand the problems of communication which arise when a minority within a society speak a language other than that of the majority population (in his case, the Polish-speaking minority in Germany). He urged physicians to receive training in the languages of the people they served (Waitzkin 1981:84). In short, Virchow was profoundly concerned with the unequal distribution and consumption of health resources, which was, in his opinion, symptomatic of the principal problem in social medicine: unequal access to society's products (Waitzkin 1981:97).

Engels and Virchow provided complementary explanations emphasizing that illness is deeply embedded in social relations and social reality. Medical anthropologists studying Third World countries struggling with the legacy of colonialism and underdevelopment have added another dimension to this perspective. They have increasingly used this approach to examine the relationship between the larger (macro) economic system and the allocation of local (micro) health services (Frankenberg 1980; Janzen 1978; Morsy 1979), and the contradiction between the interests of metropolitan elites and rural masses (Leeson 1974).

Fieldwork in developing countries has led some medical anthropologists to examine the way health systems develop (Leeson 1974; see Kelman 1971 for an interpretation of the
development of the U.S. medical system). Janzen (1978), examining field studies of medical systems in Asia, Africa and Central America, concluded that governmental and professional medical agencies (what he calls "corporate authorities") exercise political authority and power, and it is important for medical anthropologists to understand that political process. Janzen (1978:129) states that:

Not only is corporate structure a factor in the allocation of resources for the medical system, it is present in the very definition of priorities in society's response to nutritional, climatic, disease, and demographic crises or challenges.

Frankenberg (1980) has shown that despite rhetoric which may emphasize the importance of traditional medicine, the elite in developing countries continue to seek Western medicine. This results in the development of large-scale, finance-consuming hospitals. Frankenberg's central assertion is that the realities of class interests in relation to health care influence the development of medical systems and who has control and priority of access to medical resources.

Although not a medical anthropologist, Oscar Gish (1971, 1979) has worked on the problems of health care in developing countries. Gish, too, argues that the elite in developing countries establish medical systems which respond to their own interests and needs.

...although in the Third World the pattern of disease and more limited availability of resources means that primary care ought to be given higher priority than in industrialized countries, the allocation of resources in such countries is frequently skewed even more towards secondary and tertiary level hospital care than it is in the richer nations. This perverse situation reflects the greater inequalities of income distribution and power that exist within most Third World countries, as compared to those in the First World (Gish 1979:204).

Gish draws two important lessons from his assessment of health care delivery in developing countries. First, he cautions against the development of a two-tier health care system, in which one tier serves the minority with access to extensive, high technology care and another, less adequate tier serves the rest of the population. Second, he emphasizes that the major obstacles to just and efficient health care systems in developing countries are not "limited resources, poor communication, or lack of technological knowledge and data, but rather social systems that place a low value on the health care needs of the poor" (Gish 1979:209).

International migration raises a further problem needing analysis. Due to the world-wide migration of peoples, the Third World is moving to the First World. The method of analysis developed in the political economy of health care perspective assists us in understanding the specific case of Mexican immigrants and their relationship to the U.S. health care system.

The following section of this paper examines the general context and societal attitudes concerning Mexican immigrants, particularly the undocumented, or those who entered the U.S. without permission from the U.S. Immigration and Naturalization Service (INS). The interest of policy-makers, practitioners and the public is to reduce the fiscal cost of providing unreimbursed health care (that is, care to the "poor"). The provision of health care to Mexican and other immigrant patients is often viewed as conflicting with the interest in cost reduction. The result is the implementation of policies, explicit or implicit, which limit access to health services.

The next section presents data collected on the social and economic characteristics of Mexican immigrants in San Diego, California. The purpose of this section is to examine nonmedical factors which influence the accessibility of health services. The final section examines the implications of the Mexican immigrants' status for the utilization of health services.

**Motivations for Limiting Access**

**THE PUBLIC'S PERCEPTION OF IMMIGRANTS.** If polls, articles in the press and Letters-to-the-Editor can serve as a guide, the American public is apprehensive about continued immigration. A recurring image is that of the floodgates opening to allow waves of foreigners into the country. The mood that has been articulated by many politicians is that "we have lost control of our borders."

In actuality, large numbers of immigrants and refugees are seeking a new life in the United States. Newcomers average about 800,000 to one million a year, including legal as well as undocumented immigrants. Such large total numbers of immigrants have not been equaled since the first decade of this century, when annual flows averaged about 880,000 entrants (McCarthy 1983:2).

However, the proportional impact of immigration today is much less than it was earlier in this century. According to the Census, only about 4% of the nation's population was foreign born in 1980, compared to 14.7% in 1910. Clearly, the perception that immigration is having an unprecedented impact is unfounded. Of course, the pattern of immigrant settlement is not evenly distributed throughout the country. Particular states experience immigration to a greater degree than other states. In California, for example, about 15% of the population was foreign born in 1980, according to the Census.

A major controversy surrounds the number of undocumented immigrants in the country. Part of the problem is that little agreement exists within the government on the actual number. On the one hand, the Select Commission for Immigration and Refugee Policy (1980:5) estimated that there are about six million undocumented immigrants in the United States. On the other hand, researchers at the Census Bureau estimated that, based upon the 1980 Census, there were about 2 million undocumented immigrants, with 55% coming from Mexico, another 22% percent from other Latin American countries, 10% from Asia, 9% from Europe and Canada and 4% from the rest of the world (Passel 1984; Warren and Passel 1983). The Immigration and Naturalization Service also periodically contributes additional estimates of the size of the undocumented population, with as many as 10 to 12 million often given as possible upper ranges. The confusion over the number of "uncountables," or undocumented immigrants, adds to the public's apprehensiveness concerning this population subgroup.

These apprehensions have led the public to a negative perception of the immigrants' effect on American life. According to a poll conducted by the Los Angeles Times (April 6, 1981), "62% of the public thought that illegal aliens take
more from the U.S. economy through social services and unemployment benefits than they contribute to the U.S. economy through taxes and productivity." The public's perception that immigrants, particularly the undocumented, over-use health services, as well as other social services, leads to a reaction such as that encountered in the L.A. Times poll.

Views concerning a "drain on the U.S." by immigrants are often reinforced by politicians seeking rationalization for budgetary problems. When political statements are combined with the desire of newspaper, magazine and television editors to make their work appeal to the public, the result is further reinforcement of a perception based more on emotion than empirical evidence.

For example, the March 7, 1983 issue of U.S. News and World Report featured a story on immigration. The cover was a photograph of a Mexican woman across a river separating the U.S. from Mexico. The caption read: "INVASION FROM MEXICO: IT JUST KEEPS GROWING." Inside, the story discussed the cost of immigrants to U.S. society, including the cost of providing them with health care, and quoted unnamed "government officials" who estimated that the cost to Los Angeles for educating children of undocumented workers runs as high as $415 million dollars. Not only were the sources unnamed and their respective branches of government unspecified, but no study was cited to verify this figure. The article did not even cite the County of Los Angeles' own study (North 1982), which estimated the total cost to the County for health care, police costs, welfare, education and other services for the total undocumented population at $213,800,000.

The lack of empirical evidence provided to the public on the cost of undocumented immigrants is only exceeded by the lack of information on the fiscal and productive contribution made by this population. In the Los Angeles case, the County's report estimated that the total tax contribution made by undocumented residents equaled $2,535,500,000. Had this figure been cited in U.S. News & World Report, it would have indicated the large contribution made by undocumented immigrants. 2 The latter article also failed to mention that not all undocumented immigrants are Mexican. Without adequate information, the public's concern about immigrants in general, and undocumented immigrants from Mexico specifically, increases.

Although many such examples exist, their thorough discussion would take us beyond the confines of this work. The point to be made is that such reporting reinforces in the public's collective mind the perception that immigrants, particularly the undocumented, take more from U.S. society than they contribute through taxes and productivity, despite overwhelming evidence to the contrary (Cornelius et al. 1982; Müller 1984; Weintraub and Cardenas 1984).

The public's negative perception of immigrants is not uniformly applied to immigrants from all countries or all parts of the world. Anti-immigrant or nativist reaction has led the public to view specific immigrant groups as undesirable (Cornelius 1982). For example, a recent attitudinal study conducted in California revealed that one in five Californians supported some form of discrimination concerning the countries from which immigration should be allowed (Barkan 1984:16). Those who supported discrimination targeted Mexico, followed by Japan, Cuba and Vietnam. When regions of the world were targeted, a majority wanted to curb Asian immigration (Barkan 1984:16). With respect to immigration from Mexico, the author noted that "Mexican undocumented immigration also appears to be influencing reactions to legal Mexican immigration" (Barkan 1984:20).

The evidence indicates that the public's overwhelming concern is with the social, cultural and economic costs of immigrants to society. Less concern is paid to the "pull" of immigrants by an economy that needs low-skilled workers, and their positive contributions (Cornelius et al. 1982). The conclusion to be drawn from this discussion is that because of uneasiness about immigrants and their cost to society, the public may be receptive to policies which limit access to health services for immigrant, particularly undocumented, populations.

POLICY-MAKERS. Motivations for limiting access to health services are embedded in arguments made by policy-makers at the local, state and federal levels for avoiding fiscal responsibility for the cost of medical care. To a large degree, such arguments are part of the changing role of government vis-à-vis the sick. Considering overall policy changes affecting health care, two clearly affect Mexican immigrants, particularly the undocumented. The first is the general trend toward restricting access to government-sponsored health programs, such as Medicaid (Medi-Cal) and Medicare, thus making it difficult for the "working poor" to meet eligibility requirements (Bellavita 1983). The second is the shifting of fiscal responsibility for indigent health care.

The principal issue to be resolved is, "who shall pay" for unreimbursed medical costs incurred by undocumented immigrants (Arnold 1979; Conard 1975; Young et al. 1979). In California, for example, the state has transferred its responsibility for medically indigent adults to local county governments (San Diego Union 1982:1-2). The issue is not so easily resolved, however, and a great deal of litigation has occurred, with private hospitals suing county governments, community groups suing county supervisors, and county governments suing the federal government (Bauer and Schultz 1980; Clark 1980a, 1980b; County Health Alliance 1981; Sequoia Community Health Foundation Inc. 1981).

The basic point of conflict in legal suits over health care for undocumented immigrants concerns the definition of residency (Chavez 1983). Private hospitals claim that residency is concerned with the establishment of domicile and length of residence, not immigration status, which would make indigent undocumented patients the responsibility of county governments. County governments take the position that undocumented immigrants are not legal residents and therefore the government is not responsible for their health care costs. On the other hand, county governments argue that the federal government is actually responsible for any health costs, since the presence of undocumented immigrants results from a failure in federal immigration policy. The federal government has been unreceptive to arguments for its assuming greater responsibility for the cost of undocumented immigrants at the local level despite it being the principal beneficiary of unclaimed withholding and social security taxes paid by undocumented workers (Cohen 1977; Cornelius et al. 1982; North 1982). Given the lack of agreement on where the ultimate responsibility lies for the unreimbursed
health care costs, there is little pressure from the medical system or government to improve undocumented immigrants' access to health services.

**Characteristics of Mexican Immigrants and Access to Health Care**

Access to medical care in the United States in non-emergency situations has become dependent upon the ability to pay, which in turn is dependent upon large personal resources or, more commonly, the guarantee of third party payment (Medicaid, Medi-Cal, private medical insurance). In addition to the financial factor, a number of intangible factors—i.e., knowledge of available resources, ease of communication—affect a population's access to health services.

The basic socioeconomic characteristics of Mexican immigrants which do not fit this pattern limit their access to the health care system. A number of studies have examined the basic characteristics of the undocumented population (Bustamante 1977; Cardenas and Flores 1980; Community Research Associates 1980; Cross and Sandos 1982; Maram et al. 1980; North and Houstoun 1976; Orange County Task Force 1978; Van Arsdol et al. 1979; Weintraub and Cardenas 1984). Recent research among both undocumented and legal Mexican immigrants in San Diego County illustrates key characteristics for each of these two subgroups. The sample is particularly suited to this task because it was gathered among a non-detained undocumented population, with women comprising about half (48.9%) of the 2,103 interviewees.

TABLE 1. CHARACTERISTICS OF MEXICAN IMMIGRANTS, SAN DIEGO COUNTY SAMPLE, BY IMMIGRATION STATUS AND SEX (TOTAL N = 2,103)

<table>
<thead>
<tr>
<th>Characteristics (medians or percentages)</th>
<th>Undocumented</th>
<th>Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men (N = 588)</td>
<td>Women (N = 491)</td>
</tr>
<tr>
<td>Years in the U.S.</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Age at interview</td>
<td>26.8</td>
<td>27.3</td>
</tr>
<tr>
<td>Years of education</td>
<td>5.6</td>
<td>5.6</td>
</tr>
<tr>
<td>% Illiterate</td>
<td>11.4</td>
<td>14.5</td>
</tr>
<tr>
<td>% Cannot speak English</td>
<td>49.6</td>
<td>60.0</td>
</tr>
<tr>
<td>% Cannot read English</td>
<td>68.0</td>
<td>68.8</td>
</tr>
<tr>
<td>% Currently employed</td>
<td>92.9</td>
<td>63.5</td>
</tr>
<tr>
<td>Annual job income</td>
<td>$7,334</td>
<td>$6,243</td>
</tr>
</tbody>
</table>

Data by household (1,335 discrete households comprised of 5,973 individuals)

- Total annual family income: $9,359, $13,281
- Household size: 4.1, 3.9
- % Owns house: 3.8, 29.8

Additional factors impeding the use of health services result from the ways in which the Mexican immigrants are integrated into the economy. They typically hold low-paying jobs which often do not provide benefits such as medical insurance. In the San Diego sample, undocumented Mexican immigrants tended to earn less than their legally-immigrated counterparts, and women earned less than men (see Table 1). When total family income was calculated, the proportion of households below the poverty level among undocumented immigrants was 67.2% in the San Diego sample have been in the United States five years or less.

The level of educational attainment is another important factor. The level of education for informants in San Diego ranged from those with no previous schooling (about 8%) to a few with college degrees. The median years of schooling for legally-immigrated Mexicans was slightly above that for their undocumented counterparts, but both groups can be characterized as having a limited formal education. The illiteracy rate thus must be taken into consideration. As Table 1 indicates, large proportions of both the legal and undocumented Mexican immigrants interviewed cannot read or write, raising obvious difficulties when medical forms must be filled out, especially legal consent forms, or when information on medical problems is presented in writing.

Similar problems arise with language. Once again, Table 1 indicates that large proportions of legal and undocumented immigrants do not speak English. Women are less likely than men to do so. The problem of miscommunication between hospital staff and Spanish-speaking patients is exacerbated by the general lack of Spanish-speaking medical practitioners. According to one report, only about 1% of the state of California's physicians and nursing personnel are Latino, not all of whom would speak Spanish (California Raza Health Alliance 1979).

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Informants (19.5%) was slightly above that of Hispanic families in San Diego generally (18.1%) at the time (Bureau of the Census 1983:6–1321). However, the figures are skewed by the large number of employed, single men in the undocumented sample, which is reflective of the proportion of single men in the general undocumented population from Mexico. If poverty status is examined for families of three or more members, 25.8% of the undocumented and 29.8% of the legal immigrants are living below the poverty level. Given their status as relatively low-wage earners, Mexican immigrants would find it difficult to present personal resources in order to gain access to medical services.

The general lack of medical insurance further complicates access to health care. Hispanics in the United States generally have low levels of private insurance coverage. According to a recent report by the Robert Wood Johnson Foundation (1983:6), 14% of Hispanic men nationwide were without medical insurance, compared to 7.1% of Whites and 11.9% of Blacks. Mexican immigrants fare even worse with regard to their coverage by private medical insurance. Lack of medical insurance was typical among both men (61.3%) and women (57.8%) in the San Diego sample.

Coverage by private medical insurance differs according to immigration status. Considering that undocumented immigrants do not have access to most government-sponsored health programs, lack of medical insurance gains added significance as a factor in the acquisition of health care. Over four-fifths (81.2%) of the undocumented interviewees in San Diego lacked coverage. Coverage by medical insurance improved only slightly for undocumented immigrants with long residence in the U.S.: 23.6% of the long-term undocumented residents (five years or more) had medical insurance, compared with 16.9% of the more recently-arrived undocumented migrants. Legally-immigrated interviewees had greater access to medical insurance, with 63.7% claiming to be covered by some kind of private insurance program at the time of the interview.

In addition to cost-related problems, undocumented immigrants encounter obstacles designed to limit their access to health care. Interviews with hospital and clinic administrators in San Diego (Cornelius et al. 1984) indicated that eligibility requirements effectively screen out undocumented patients. Restrictive eligibility criteria include information confirming residency (i.e., rent receipts, utility bills), and proof of third-party payment or the capability to assume financial responsibility. Strict financial screening could include presentation of check stubs, social security card, or similar documents.

If a patient does not have a guarantee of third party payment, he may be asked to fill out a Medi-Cal form, which is routinely sent to the Immigration and Naturalization Service for verification of the patient’s immigration status (Cohen 1977). This acts as a deterrent to undocumented immigrants who may desire to legalize their status at some future date. Receiving government assistance for medical costs could lead to their being disqualified for permanent residency status on the basis that they are likely to become a public charge. Eligibility requirements which draw attention to residence and immigration status merely add to the undocumented person’s fear of detection, thus limiting his or her use of health services.

In sum, the mechanisms which limit access to health care focus primarily on an individual’s ability to pay for services. But other mechanisms limit access in more subtle ways, such as lack of practitioners who speak Spanish, or increase in the fear factor which may already exist among certain groups such as the undocumented.

Consequences

A recent Presidential Commission on the problems of access to the medical system argued that everyone deserves an adequate level of health care, defined as “enough care to achieve sufficient welfare, opportunity, information and evidence of interpersonal concern to facilitate a reasonably full and satisfying life” (President’s Commission on 1983:20). Although such an objective may seem reasonable, the evidence indicates that for Mexican immigrants an adequate level of care is undermined by the politics of health care and the obstacles they encounter in attempting to achieve it. As a result, Mexican immigrants underutilize health services, particularly preventive services, resort to emergency room service, and sometimes encounter refusals when they seek care.

Many interviewees in San Diego (19.8%) had never sought health care in the U.S. on any occasion. Of these, most (52.5%) believed they did not have enough funds to cover the cost of care at a U.S. hospital or clinic. Another 28.6% expressed fear that using such facilities might lead to their deportation, or they would not be understood because of language differences.

Interviewees indicated a low usage of preventive services. For example, Mexican immigrant women who delivered their last child in San Diego received inadequate prenatal care, as defined by no care or care which began in the third trimester, to a proportionately greater degree than women in the general San Diego maternal population. According to the Center for Health Statistics (1982:186), 3.8% of the mothers in San Diego County received inadequate preventive care; compared to 5.7% of the legally-immigrated Mexican mothers and 13.2% of the undocumented mothers (see also Colon 1984).

The overuse of emergency rooms by undocumented immigrants is another issue. Given the obstacles to obtaining non-emergency care, especially the need for third-party payment guarantees, some undocumented immigrants have no recourse but to suffer ill-health until it becomes a major problem requiring emergency room service. The evidence suggests that undocumented immigrants who do seek care use hospitals less often than clinics or private physicians. However, when they use hospital services, they tend to use the emergency room more often than other hospital services, such as outpatient clinics (Chavez et al. 1985).

The problem of access is also reflected in the number of informants who claimed to have been denied service by hospitals and clinics in San Diego County. Fifty-one interviewees claimed they were denied service for problems such as stomach pains, infant delivery, prenatal care, appendicitis and bronchitis/pneumonia. The problem of refusal of care for financial reasons is one which appears to affect Hispanics generally to a greater proportion than other social/cultural/racial groups. The study by the Robert Woods Johnson Foun-
dation (1983:6) found that nationwide, 3.3% of Hispanic families reported having been refused health care for financial reasons, compared to 1.5% of Blacks and 1.4% of Whites.

Mexican immigrants also had a major problem obtaining dental care. Almost a third (31.1%) of the informants in San Diego had never been to a dentist, compared to 11% in the general U.S. population (National Center for Health Statistics 1982:94–95). When immigration status is taken into account, the problem worsens. Among undocumented interviewees, 43.9% had never been to a dentist, compared to 19.2% of the legally-immigrated informants. The high cost of care is a factor: 40.9% of the interviewees believed they needed dental care at the time of the interview, but half (49.7%) of those did not plan to seek care because of cost.

Conclusions

Use of the political economy of health care as a study approach has led to an examination of the factors which define priority of access to health services. Specifically, a wary public and cost-conscious policy makers often place a low priority on the health care needs of Mexican immigrants. Such a position results from the perceived need to reduce the public’s financial liability for health care. If reductions in financial support adversely affect Mexican immigrants, or other less powerful groups within the society, such consequences may be rationalized as unavoidable and, in the case of the undocumented, as necessary.

The obstacles to care encountered by Mexican immigrants derive primarily from the high cost of care in relation to their socioeconomic circumstances. Although, theoretically, health care may be open to all, in actuality, individuals who earn low incomes and who do not have private medical insurance may find entry to health care barred, resulting in the type of utilization patterns suggested here for Mexican immigrants, particularly undocumented immigrants. A two-tiered system of health care can be said to exist in the United States. Its delineation is not between poor and non-poor per se, but between the medically insured and the non-insured.

If the poor, which would include many legal Mexican immigrants, find their access to health care limited because of financial considerations, the undocumented face additional barriers because of their immigration status; they are a class within a class. The undocumented are not only low income earners generally lacking medical insurance, they must also deal with their pariah group status. They are characterized as an unnecessary economic burden by the same society that offers them employment opportunities. Until this contradiction is resolved, the question of a just and adequate level of health care for the undocumented will remain an unresolved and controversial issue.

Equitable distribution of health resources for low income and politically vulnerable groups begins through innovative alternatives for reducing barriers to health care based upon wealth and fear. Eligibility for non-emergency health care must not involve questions of residency or immigration status. A guarantee of third-party payment is unrealistic for low income earners without medical insurance. Seeking ways to provide medical insurance to those currently uninsured must be undertaken. Legislation mandating insurance through the workplace for all employees regardless of immigration status would benefit all the employed but uninsured, including undocumented workers. Such a program would be subject to an established minimum standard of protection paid for by both the employer and employee (Cornelius et al. 1984; Ellet 1981). Alternatively, programs of pre-paid health care offered to the poor and uninsured through community clinics, regardless of immigration status, would greatly reward a minimum amount of government subsidization, especially if such programs included coverage for emergency care delivered at a hospital. If implemented, these recommendations would result in substantial improvement in access to health services by immigrants and low income Americans generally.

NOTES

1 According to Hans A. Baer (1982:2), the political economy of health care is concerned with the effect that “the capitalist mode of production has on the production, distribution, and consumption of health services, and how these processes reflect the class relations of the larger societies within which medical institutions are embedded.”

2 Both the estimate of tax contributions and costs are inflated due to being based upon an inflated estimate of the undocumented population in Los Angeles County (Cornelius et al. 1982:55–60; North 1982).

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