CANARIES IN THE COAL MINE:

Healthcare Access Barriers Faced by Immigrants in Miami-Dade County

EXECUTIVE SUMMARY

Founded in 1995, Human Services Coalition is a nonprofit organization that monitors health and human service needs, provides reliable information to the public and catalyzes public planning and response. HSC supports individuals, organizations and communities to create a more just, equitable and caring society. HSC uses and promotes a range of innovative economic empowerment, civic engagement and capacity building strategies to increase individual and community prosperity. In its first decade, HSC achieved a leadership role in South Florida by serving as a clearinghouse for community collaboration and mobilization around anti-poverty strategies and programs. Moving into its second decade, HSC will focus on building the capacity of individuals, organizations and communities throughout Florida to embrace and adopt effective prosperity strategies and programs.

Human Services Coalition has prepared the following paper to address the barriers to healthcare access for immigrants in Miami-Dade County. This need is illustrated by three case studies developed through our work with clients and community advocates, supplemented by background information on existing laws and policies. All three case studies were written by Ivan Sanchez, Social Work intern with HSC beginning in March 2007.

HSC has identified three key barriers to healthcare access for immigrants: lack of information; fear of detection; and an overtaxed safety net. The first and last of these barriers may be pervasive characteristics of our healthcare system – and particularly those aspects of the system that deal with the poor and un- or under-insured – but they disproportionately affect immigrants, who tend to be poorer, work lower-wage jobs, and be less educated than the general population in Florida. These barriers, then, point us towards comprehensive solutions that need to be implemented for everyone, not just immigrants, while the second – fear of detection – points us towards the need for comprehensive immigration reform, for the good of the public health system and precarious safety net that serve the larger community.

CREDITS

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INTRODUCTION

Miami Dade County is a community in flux. The past decade has seen unprecedented growth in the area, and the scene is changing on a daily basis. The veneer of glittering high rises and a landscape littered with construction cranes belies the truth. While tourism and the real estate industry are booming, the machinery behind this success – the low-wage workers who construct the buildings, serve the meals, and clean the condominiums – grows ever more fragile.

This economy attracts immigrant workers from dozens of countries, and they come here to work jobs traditionally difficult to fill with US citizens and residents. These are jobs with low pay, high risk, no benefits, and little stability. Yet if these workers become sick or need other help, numerous roadblocks conspire to prevent them from receiving needed services. Like many low wage workers, an immigrant taking time off for illness or the illness of a child is out of the question. Undocumented workers face a particularly dehumanizing brand of disposability: not only invisible to their employers, who can readily replace them, they are also invisible to the public and live in constant fear of deportation.

STORIES OF TRUTH AND HOPE

What follows are just a few stories that illustrate these problems that immigrants face in trying to navigate our healthcare system. They were gathered by employees of the Human Services Coalition through outreach programs, contacts with partners, and its Access through Action (A2) project, which sought input for health care access solutions from community groups. The problems outlined here have less to do with glitches in any one aspect of healthcare policy and more to do with institutional barriers to accessing care in a complex system. Generally, these barriers fall into three categories:

1. Lack of information
2. Fear of detection by immigration authorities, and
3. A safety net that is overtaxed.

The stories below illuminate the larger picture: policy and practice in this country make it increasingly difficult for immigrants to meet basic needs. While two of the three barriers named above are not necessarily unique to immigrants, they are often felt most acutely by immigrants because of the particular vulnerabilities of the immigrant population. We can thus look at immigrants as canaries in the coal mine of our healthcare system: it is just a matter of time before the problems they are experiencing trickle up to the larger population. With healthcare a top domestic issue for all Americans,[1] the time is ripe for change. The challenge now becomes ensuring that the needs of immigrants are considered and included in the reform process.

[1] "Health care top domestic concern: poll," Reuters News Service, March 2, 2007

Immigrants pay their fair share for public benefit programs, while benefiting from them at lower rates than citizens.

THE CANARIES IN THE COAL MINE:

A LOOK AT FLORIDA'S IMMIGRANT POPULATION

There are several reasons to focus on immigrants for a study about access to healthcare in Miami-Dade County. First, there is the simple fact that just over half of Miami-Dade residents are immigrants, making them ubiquitous consumers within the healthcare system. Second, due to demographic factors such as education and poverty rates, immigrants are a more vulnerable population on the whole than non-immigrants. The third reason for the focus on healthcare access barriers within the immigrant community is the insidious way that rising immigration and xenophobia are leading to policies that undermine long-standing social benefit programs, such as Medicaid.

According to a recent study by Florida International University's Research Institute on Social and Economic Policy, 22.1% of immigrants in Florida do not have a high school degree - more than twice the rate of non-immigrants (12.7%).[2] Their annual earnings are $3,400 lower than those of non-immigrants ($20,000 versus $23,400), because they are concentrated in low-wage, low-skill service jobs.[3] These jobs are less likely to provide health insurance: only 39.1% of immigrants are insured through their employers, versus 52.4% of non-immigrants.[4]

In addition to the low-paying jobs and lack of education, many immigrants come from countries that offer universal healthcare coverage to all residents, so there is frequently a cultural lack of understanding of the need for health insurance – one which is very difficult to address when the population in question lacks basic reading skills, is overworked, or is afraid to come out of the shadows.

According to the FIU report, "Non-immigrants receive $614 more per capita in public assistance benefits than do immigrants in Florida."[5] These are services that immigrants are paying for, though: between 2002 and 2004, immigrants paid a higher share of their incomes in federal taxes per capita than did non-immigrants (16.57%, compared to 15.18%).

XENOPHOBIA IN PROGRAM ADMINISTRATION

Taken generally, then, immigrants pay their fair share for public benefit programs, while benefiting from them at lower rates than citizens. Yet in 2006, when Congress enacted the Deficit Reduction Act (DRA), it included a provision that all applicants to Medicaid (including current recipients at the time of re-determination of eligibility) must prove citizenship by producing "a U.S. passport, birth certificate, or driver's license from a state that verifies social security numbers."[6] Previously, Medicaid applicants had been allowed to self-declare their citizenship, and most states had

[2] Emily Eisenhauer, Yue Zhang, Cynthia S. Hernandez and Alex Angee, "Immigrants in Florida: Characteristics and Contributions," Research Institute for Social and Economic Policy of the Center for Labor Research and Studies, Florida International University. May 21, 2007. p. 19.

[3] *Ibid.*, p. 21.

[4] *Ibid.*, p.26.

[5] *Ibid.*, p. 35

[6] "Deficit Reduction Act of 2005: Implications for Medicaid," The Kaiser Commission on Medicaid and the Uninsured, February 2006. p. 5

mechanisms in place to verify any such self-declarations that aroused their suspicions. Congress enacted this provision of the DRA at President Bush's urging, in order to save Medicaid money ostensibly by clearing the rolls of undocumented immigrants who were abusing the system.

Yet none of the research corroborated the Bush administration's claim that unentitled immigrants were costing the system money. Mark McClellan, who at the time directed the Center for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, went so far as to assert that "states have little evidence that many non-eligible, non-citizens are receiving Medicaid as a result" of the "vulnerabilities" in the self-declaration policies.7 Daniel R. Levinson, Inspector General for the US Department of Health and Human Services, found that the new requirements were not only unnecessary, but would likely be problematic, as well. In a survey of State Medicaid Directors, he found that "Medicaid directors report they allow self-declaration to increase access." A majority of directors expressed concerns that a documentation requirement would "delay eligibility determination," "result in increased eligibility personnel costs," and "be burdensome and/or expensive for applicants to obtain copies of birth certificates or other documentation."[8]

Only 39.1 percent of immigrants are insured through their employers, versus 52.4 percent of non-immigrants.

And indeed, states have seen the new, onerous rules hit particularly hard those populations that, though entitled to Medicaid, are less likely to possess the required forms of identification, including African-Americans, senior citizens, adults who lack high school diplomas, and adults living in rural areas.[9] The New York Times reported this past March that the number of children enrolled in Medicaid in Florida declined about 5% to 1.2 million in the first six months after the law was enacted, and quoted Albert A. Zimmerman, a spokesman for the Florida Department of Children and Families, as saying that "Nearly all of these people [who lost coverage] are American citizens."[10]

The Medicaid documentation provision of the Deficit Reduction Act was, therefore, clearly not designed to save the government money by reducing Medicaid fraud. Instead, it seems to have been an attempt to cut federal funding for a public entitlement program by pushing eligible people from the rolls while creating greater personnel costs for states. In addition to the low-paying jobs and difficulties accessing needed information, then, immigrants are also faced with the indignity of being used as scapegoats in an ideological battle over the role of government in the provision of social services.

[7] Daniel Levinson, "Self-Declaration of U.S. Citizenship for Medicaid," Department of Health and Human Services, Office of the Inspector General, 2005, p. 26

[8] *Ibid.*, p. 11

[9] Leighton Ku, Donna Cohen Ross, and Matt Broaddus, "Survey Indicates Deficit Reduction Act Jeopardizes Medicaid for 3 to 5 Million U.S. Citizens," Center on Budget and Policy Priorities, Feb. 17, 2006.

[10] Robert Pear, "Lacking Papers, Citizens are Cut from Medicaid," *The New York Times,* March 12, 2007

NO-WIN SITUATION:

BARRIERS CAUSED BY A LACK OF INFORMATION

"Anita" came to the US in 2000, where she met her husband. They have two U.S.-born children, ages six and one.

Currently, she is not working. Her husband works as a day laborer just to make ends meet for this family of four. In spite of her reliance on Miami's unpredictable public transportation, this mother has been running around trying to apply for benefits for her two U.S. born children for more than three months. When she came into our office, she said in Spanish: "I filled out an application and took it to DCF three months ago. I went back to see the status of my application and they told me that they did not have it, and that I have to do it online." Anita, who has worked so hard to secure health benefits for her children, can hardly read or write.

She was able to get help filling out the online application, but is still waiting for an answer from DCF.

This loving mother and her partner, in addition to all their everyday problems, live in constant fear of being detected by the authorities and deported for being undocumented.

Anita's story illustrates the largest barrier identified by the A2 dialogue groups: lack of information. In its most basic form, lack of information means that people who are eligible for health care programs do not know they exist, or do not know how to apply. In more complicated cases like the Anita's, lack of information can mean that people who know they are eligible and want to enroll are unable to navigate the increasingly complex system of application, re-application, and eligibility determination for low-income health care programs.

In Anita's case, it would seem that applying for KidCare should be a simple matter of providing proof of eligibility for her two American children. Once the Florida Department of Children and Families (DCF) receives an application for KidCare, the agency begins the eligibility determination process. DCF may send a letter to the applicant to request supporting information such as birth certificates and proof of income. Parents have ten days to comply with the request, or their application is rejected and they must begin the process anew. While letters are available in languages other than English, literacy is an issue for many immigrants, even in their native language. Additionally, the transient nature of some immigrants (and low-income populations in general) means that they may end up receiving the letter too late, if at all.

NAVIGATING THE RED TAPE

In Florida, Medicaid eligibility is determined by the Department of Children and Families (DCF), but there are three other agencies (including one private company) that are responsible for administering KidCare: the Agency for Health Care Administration (AHCA) runs the MediKids program for children ages 1-4, and Medicaid for children up to age 18 with family incomes at or below the poverty level; the Department of Health (DOH) handles special needs cases through its Children's Medical Services network; finally, the Florida Healthy Kids Corporation determines eligibility for non-

Medicaid programs, collects the monthly premiums, manages the customer service call center, and administers the Florida Healthy Kids program for children ages 5-18 between 101% and 200% of the Federal Poverty Level.

The high number of participating agencies increases the opportunity for paperwork to get dropped on its way between agencies and adds to confusion for parents who believe they are applying to one KidCare program that will cover their child or children until adulthood. And because changes in age, family income or family size can shift a child's eligibility from one program to another, it can be difficult for parents to keep up with which program their child qualifies for and how long the coverage will last. The entanglements of bureaucracy have created a need for outreach and case management to help clients navigate the system and make sure they stay on top of their children's files as they wend their way through the system. Because outreach is substantially under-funded, however, this case management falls to community groups like the Human Services Coalition on a somewhat ad-hoc basis.

Literacy is an issue for many immigrants, even in their native language.

This entanglement of programs is made all the more complicated by the Deficit Reduction Action, discussed above, which places burdensome documentation requirements on Medicaid applicants. However, Medicaid is just one way in which Florida children can enroll for health coverage under KidCare; children whose families are not eligible for Medicaid may still qualify for other KidCare programs administered by one of the four agencies.

The complicated bureaucracy of KidCare is frustrating enough for English-speaking citizens who are able to navigate the online application process. Add language barriers, fear of deportation, and computer illiteracy to the mix and lack of information means the difference between access to preventive care for children who are U.S. citizens or visiting the emergency room when health problems become unmanageable.

DRIVEN TO DECEPTION:

FEAR OF DEPORTATION

In November, 2005, Ricardo had had a cold for more than a month, and felt that his wellbeing was deteriorating rapidly. Within a month, he had lost about nine pounds. Two years prior to he had tested positive for HIV. He did not know anything about the progression of the disease because he had not seen a doctor in years.

Ricardo came from Peru nine years ago because he saw no future for himself in his native country, and believed he could make a better life in the United States. He arrived on a tourist visa and overstayed.

Today, his HIV symptoms are under control and he is receiving medical care through an employer who is unaware of his true legal status; however, his legal status remains an issue with no prospective solutions. This constant preoccupation causes him much stress. He lives in constant fear and feels as though he is on a dead end street. Ricardo is depressed and his mental state is evidently affecting physical health.

Ricardo's story illustrates the second barrier: fear of detection by immigration authorities. Ricardo, like all of the people who have shared their story for this paper, lives with deep anxiety regarding detection and deportation. While his HIV symptoms are under control, his mental health is suffering. His employer does not know that Ricardo is ineligible to work legally in this country – and if he loses his job, he will have no health coverage.

Overall, immigrants are far less likely than native citizens to have health insurance. A report by the Kaiser Commission on Medicaid and the Uninsured from 2004 shows that "Between 42% and 51% of non-citizens lack health coverage, compared to 15% of native citizens."[11] Immigrants living here illegally are not entitled to public benefits – nor to employer-based benefits, since they are not legally allowed to work.

Between 42% and 51% of non-citizens lack health coverage, compared to 15% of native citizens

Yet it is often difficult for immigrants living here legally to obtain coverage, as well. For public programs such as Medicaid and SCHIP, an immigrant needs to have legally resided in the country for five years before being eligible for benefits. As far as private insurance goes, a system that relies (as America's does) on employer-based coverage often leaves immigrants out. According to the report by FIU mentioned above, Florida employers provide insurance coverage to 52.4% of non-immigrant workers, while only 39.1% of immigrants receive health insurance through work. This is surely due in large part to the concentration of immigrants in low-wage professions. Despite their lower rates of coverage, however, the Kaiser report notes that "new immigrants are not primarily responsible for the growth in the overall uninsured population, mainly because their numbers are still small compared to the U.S. population as a whole."[12]

[11] "Immigrants and Health Coverage: A Primer," The Kaiser Commission on Medicaid and the Uninsured, June 2004. http://www.kff.org/uninsured/upload/Immigrants-and-Health-Coverage-A-Primer.pdf

[12] Leighton Ku and Timothy Waidmann, "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care among the Low-Income Population," Kaiser Commission on Medicaid and the Uninsured, August 2003.

The failure of Congress to pass a package for comprehensive immigration reform this year means that situations like Ricardo's won't be resolved any time soon. Yet his story illustrates that the failure to address the situations of the approximately 12 million undocumented immigrants currently living in this country has repercussions throughout society. If Ricardo had not found a way to obtain employer-based health insurance by withholding information from his employer, he would have been condemned to die as his HIV progressed. Yet what he has done will probably disqualify him from ever being allowed to normalize his status. Most immigrants in Ricardo's situation would probably not have found a way to obtain health insurance.

Florida employers provide insurance coverage to 52.4% of non-immigrant workers, while only 39.1% of immigrants receive health insurance through work.

While the details of comprehensive immigration reform are still in the making, it is clear that current proposals do not go far enough to adequately address the health and other basic needs of immigrants currently working and living in the United States.

UNDER THE FLORIDA SUN:

OUR OVER-TAXED SAFETY NET

"Luz" extended her small dry hand in a friendly gesture. I shook it and I noticed heavy calluses on it. The skin of her face was burned by long hours of sun exposure. She said she was 39 years old. She looked fifty.

She came to Open Door Clinic hoping to get immediate help, because that day she could not go to work. Luz's joints were hurting more than ever. She said that her whole body had been aching for more than a year and that the pain had lately intensified. Her hands were now swollen. She obviously needed an immediate medical intervention.

Since she arrived in the United States 12 years ago, Luz had been working very hard to achieve her dreams. She was scared of being sick. What would happen if she were no longer able to work, or to get proper medical care for her debilitating condition? If she is detected, she faces deportation to her native Mexico, where opportunities are very limited.

I did what I would do in similar situations; I referred her to the closest clinic with an emergency room, but she had no means to get there. Undocumented immigrants are not allowed to have a driver's license.

Without saying a word, she left, as troubled as before.

Luz's time was limited. She only had one day to solve her urgent problem. The next day, she was supposed to go back to work once again under the beating Florida sun. If she didn't return to work, she would be replaced.

The Open Door Clinic in Homestead is one of a handful of clinics serving the needs of the uninsured immigrant population in Miami-Dade County. Venamher Clinic, another such clinic that was recently featured in *The Miami Herald*, allows patients to purchase annual membership for a nominal fee, and then provides doctors' visits for $25. For uninsured, low-income residents of the county, these and similar clinics constitute a tenuous safety net for those who cannot afford private insurance and do not qualify for Federal and State healthcare programs. However, these clinics are chiefly primary care centers, and are not set up for urgent care or for visits with specialists.

In rural immigrant communities such as Homestead, where people lack transportation, insurance, and familiarity with America's patchwork healthcare system – and where they're afraid of detection by immigration authorities, can't afford to take time off work, and toil at labor-intensive jobs that expose them to the elements (and often to toxic pesticides) – providing interventive primary care presents a huge challenge. Homestead is also faced with another problem typical of poor rural communities: a critical shortage of doctors. Inadequate access to specialists is one of the main barriers identified by the Union of the Uninsured, an A2 group based in Homestead. While there are specialists who practice at Homestead Hospital (part of the Baptist South Florida System), precious few of these doctors are willing to see uninsured patients – which Baptist, as a private hospital, can't require them to do in non-emergency situations. Many uninsured residents in South Dade rely

on CHI, the system of six Federally Qualified Health Centers and 17 school-based health clinics that is affiliated with Jackson Memorial Hospital, for their primary care. In 2006, CHI had 257,000 patient care visits.

However, when these patients need to see a specialist, they have to travel an hour to Jackson (which is the only public hospital in Miami-Dade County and the only teaching hospital in South Florida), where they face long waiting periods to get in to see certain specialists. At one point the waiting period to see a cardiologist was eight months. Once patients manage to get an appointment, they have to be re-screened for eligibility in order to be placed on Jackson's sliding fee scale, which differs slightly from that of CHI despite the two institutions' affiliation. The scales differ in part because Jackson has historically struggled to balance its books, due in large part to uncompensated care administered in its overtaxed emergency room. Even if Luz had seen a primary care physician, it is not clear she would have wound up in any better shape, since preventive medicine is most effective when all parts of the healthcare system are fully functional.

There is still, then, a gaping disparity between the needs of undocumented immigrants and the kinds of care they can receive in comfortable, immigrant-friendly clinics like Open Door and Venamher. These clinics are faced with no choice but to divert patients back into the traditional health system which has failed them all along. When Open Door was unable to serve Luz immediately, she was referred to the emergency room.

Undocumented immigrants such as Luz are more likely to find themselves in the emergency room when things get bad; even with clinics such as Open Door, preventive care is an unaffordable luxury when workers fear being found out or missing a day's pay. Regular doctor's visits could mitigate the effects of a chronic health problem and catch serious illnesses before they interfere with work. However, for many low-wage workers in South Florida, a visit to the doctor means time away from work, less money earned, and the risk of replacement. Luz might like to visit a doctor regularly to keep her arthritis under control, but it is simply economically unfeasible for her to do so.

Pregnant mothers are in a similar situation; many forego prenatal care and give birth in the emergency room. Approximately 43 percent of Florida's births are paid for by Medicaid.13 The Section 1115 Medicaid waiver provides Medicaid coverage to pregnant women at or below 185 percent of the poverty line (whereas, in all other cases, Medicaid applies only to adults earning up to 100% of the Federal Poverty Level). This means that many women who normally wouldn't qualify for Medicaid coverage can enroll in Medicaid while pregnant, allowing them to access needed prenatal care, thereby increasing healthy birth rates and decreasing the emergency Medicaid costs to hospitals. This program remains under-promoted, and often health care workers are unaware of all of the eligibility requirements and procedures, as well as which clinics are able to apply for and accept the waiver.[14]

While some medical conditions require a trip to the emergency room, many are preventable through access to quality primary care services. Clinics serving the needs of the immigrant community, such as Open Door and Venamher, are having their resources and capacities stretched as immigrants who cannot rely on the traditional health care system turn to them for service. More and more, immigrants and the uninsured turn to emergency rooms, costing taxpayers far more in charity care and emergency Medicaid costs than the provision of primary care to this group would in the long term.

[13] First Coalition for the Uninsured, "Medicaid Waiver Briefs: Potential Impacts of a Section 1115 Medicaid Waiver on Duval County, FL," November 2004, p. 6.

[14] Interview with Marisa Alsing RN BSN ICCE NCSN, Senior Community Health Supervisor, Women's Health and Preventive Programs, FDOH – Miami Dade County Health Department, March 27, 2007.

CONCLUSION

Luz's feeling that she is invisible is common among undocumented immigrants. As increased homeland security measures further criminalize immigration, many immigrants are driven into hiding. These immigrants do not visit the doctor, they do not open bank accounts, they do not drive cars, and they are not on anyone's payroll records; without the papers that so many citizens take for granted, they become virtually invisible.

Anita, Ricardo, and Luz are all real people who struggle in their daily lives to meet basic needs and access health care. Their stories provide depth to the three barriers identified above: lack of information, fear of detection by immigration authorities, and a safety net that is overtaxed. Trends, such as the recent poll results naming health care as the most pressing issue to Americans and the current national debate over comprehensive immigration reform, indicate that these barriers are worsening.

If these barriers are not addressed, there will be consequences that affect all members of our society, not just those who are unable to access health care. Community health will suffer as children and their parents are unable to access preventive care. What begins as a common cold or a toothache left untreated could have serious health consequences for individuals, families, and the community as a whole. If people wait until they are severely ill to visit the emergency room, patients with real emergencies may not get treated as quickly, and the public cost is greater as people rely on charity care and emergency Medicaid to cover bills, rather than accessing preventive care, which is less costly in the long term. As the stories above show, addressing barriers to immigrant health access involves navigating complicated bureaucracy, decreasing social and legal stigma associated with immigration status, streamlining KidCare, dropping onerous paperwork requirements, and increasing access to primary and preventive care.

RECOMMENDATIONS

HSC recommends the following policies and programs in order to reduce the barriers, thereby increasing public health and community prosperity:

1. Simplification of the KidCare application process, and restored funding for outreach and education campaigns in English, Spanish and Haitian Creole to enroll all eligible families in KidCare programs.
2. Immediate repeal of the Medicaid documentation requirement of the Deficit Reduction Act.
3. Stronger wage and benefit laws to afford more protections to low-wage workers (including immigrants).
4. A clear path to normalization of legal status for immigrants.
5. Universal health coverage for all Americans.

The first two of these recommendations are program fixes to address some of the immediate problems raised in the three stories told above. With half a million children who qualify for KidCare in the

state of Florida still un-enrolled, it is clear that that program requires drastic changes. It is needlessly complex, and following an application through the system requires much more vigilance on the part of applying parents than most working people have time to dedicate. Similarly, the documentation requirement of the Deficit Reduction Act was ill-advised, and presents needless barriers to enrollment for qualified individuals.

The last three recommendations are based on the idea that, as canaries in the coal mine of our health care system, the barriers immigrants face are a strong indication of where other Americans may soon find themselves. Immigrants tend to be poorer than the general population, but with union membership ever-declining, the workforce skewing further towards service-sector jobs (and dragging wages down on its way) and the gap between rich and poor growing larger as the middle class is erased, the concerns of low-wage immigrant workers are increasingly the concerns of the native-born American workforce writ large. As long as America continues to have so many working poor, we will continue to lag in preventive medicine, and to have health care problems related to poverty – un-monitored hypertension and diabetes, asthma, high infant mortality rates, etc.

Community health will suffer as children and their parents are unable to access preventive care.

Higher wages will not fix the problem, however, as long as a significant portion of our workforce is tangled up in a dysfunctional immigration system. There must be a clear path for individuals and families to navigate if they wish to become residents or citizens of the United States, so that they can come out of the shadows and be the productive, engaged members of society that they deserve the chance to be. Beyond that, though, immigrants' legal status must be normalized as a show of commitment on the government's part that it does not wish to use the legal limbo of many immigrants as an excuse for regressive policies (such as the citizenship requirement of the Deficit Reduction Act). While immigration is a federal issue, Florida is uniquely poised to lobby on behalf of the immigrants living in our state who have come here from dozens of countries to contribute to our strong state economy.

Perhaps the most fundamental flaw in our health care system is one that goes far beyond immigrants: it is the fact that it seems to be predicated on the idea that certain groups of people – native-born citizens, children – are entitled to quality health care, while others – immigrants, poor adults – are not. By starting from a point of inequality, a system is created in which the burden of proof is on the patient to show that he or she is deserving of the quality of care that we are all entitled to as a human right. There absolutely must be a national guarantee that everyone living in this country has an equal opportunity to partake of the world-class health care our system is able to provide. Anything less will practically assure that significant portions of the population are always left out.

BIBLIOGRAPHY

Alsing, Marisa S. RN BSN ICCE NCSN, Senior Community Health Supervisor, Women's Health and Preventive Programs, FDOH – Miami Dade County Health Department. Personal Interview. 27 March 2007.

Eisenhauer, Emily, Zhang, Yue, Hernandez, Cynthia S., and Angee, Alex, "Immigrants in Florida: Characteristics and Contributions," Research Institute for Social and Economic Policy of the Center for Labor Research and Studies, Florida International University. 21 May 2007. p. 35.

"Deficit Reduction Act of 2005: Implications for Medicaid," The Kaiser Commission on Medicaid and the Uninsured, February 2006.

"Health care top domestic concern: poll," Reuters News Service, 2 March 2007.

"Immigrants and Health Coverage: A Primer," The Kaiser Commission on Medicaid and the Uninsured, June 2004.

Levinson, Daniel, "Self-Declaration of U.S. Citizenship for Medicaid," Department of Health and Human Services, Office of the Inspector General, July 2005.

Ku, Leighton, Cohen Ross, Donna, and Broaddus, Matt, "Survey Indicates Deficit Reduction Act Jeopardizes Medicaid for 3 to 5 Million U.S. Citizens," Center on Budget and Policy Priorities, 17 Feb. 2006.

Ku, Leighton and Waidmann, Timothy, "How Race/Ethnicity, Immigration Status and Language Affect Health Insurance Coverage, Access to Care and Quality of Care among the Low-Income Population," The Kaiser Commission on Medicaid and the Uninsured, August 2003.

"Medicaid Waiver Briefs: Potential Impacts of a Section 1115 Medicaid Waiver on Duval County, FL," First Coalition for the Uninsured, November 2004.

"Myth/Fact: Ten Key Myths about the Border Security and Immigration Reform Agreement," Office of the Press Secretary, 18 May 2007.

Pear, Robert, "Lacking Papers, Citizens are Cut from Medicaid," *The New York Times,* 12 March 2007.

Preston, Julia, "With an Immigration Compromise Committed to Paper, the Time for Scrutiny Begins," *The New York Times,* 22 May 2007.

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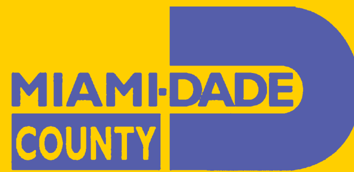
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