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Health Care Access for Children in Latinx Immigrant Families in the Greater Philadelphia Area

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Health Care Access for Children in Latinx Immigrant Families in the Greater Philadelphia Area

Sophia King

May 3, 2020

Submitted to the Faculty of Ursinus College in fulfillment of the requirements for Honors in the
Politics Department.

Abstract

Through analysis of existing scholarly research and my own phone interviews with staff at two health clinics and one community outreach center that are located in Greater Philadelphia, this work examines what kind of gap exists in access to health care in the Greater Philadelphia Region for children of Latinx immigrant families of in comparison to other children in the nation. It discusses why this gap in access to coverage exists despite the widely supported notion of the human right to health. This study supports that Latinx immigrant children, in comparison to non-immigrant children, are less likely to have health insurance, receive less preventative medical care and often turn to non-profit organizations that provide health care and other social services. I find that low-income status and legal status are obstacles to accessing health care for many Latinx families, and the lack of resources and emotional stress compound health problems. I conclude that culturally sensitive interpreters and a holistic approach to health are key to providing quality health care. I recommend that local, non-profit organizations to recruit and train more medical interpreters competent in Spanish and English, Pennsylvania should extend CHIP and Medicaid coverage to all children of any immigration status, and the new federal public charge rule should be revoked to facilitate greater enrollment among immigrant families in CHIP and Medicaid.

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Introduction

In 2003, Jessica Santillan, a 17-year-old girl whose parents brought her to the United States without proper documentation, received an organ transplant at Duke University Hospital which she needed to treat a congenital heart problem, but died after the operation. Her story created much controversy. Besides the discussion of how medical professionals made a major error in her surgery that resulted in her death, much of the news coverage reported disapproval of an unauthorized immigrant receiving an organ transplant rather than a U.S. citizen (Hoffman 238). Her case exemplifies the contradiction-ridden medical environment that undocumented immigrants face in the United States. At the time of the operation, Jessica's family had private insurance coverage but unauthorized immigrants were not entitled to nonemergency Medicaid coverage (Hoffman 243). Congressional legislation passed in 2003 made undocumented immigrants ineligible for federal funds to cover medical care, negating a legal decision that the 1966 Medicaid Act should be extended to cover individuals without permanent legal resident status (Nickel 19).

State attempts to regulate nonemergency care for immigrants are mired in legal challenges and confusion. On the local level, many health clinics with non-governmental funding offer some forms of nonemergency care for immigrants. Jessica, as an undocumented immigrant, received her nonemergency surgery from Duke University Hospital through two other funding mechanisms: health insurance through her mother's employer and private charity (Hoffman 245). A multitude of questions arise upon analyzing her and her community's actions. Why was an organ transplant given to someone with undocumented status who was in the country illegally? How did she manage to receive medical services despite the obstacles she faced due to her immigration status? Ultimately, should those obstacles even exist? Shouldn't every child have

the right to health care services? These questions matter because Jessica Santillan and her family are just a few out of millions of undocumented immigrants in the United States.

Cases like Jessica's raise concerns about who is entitled to receive health care services. While some critics express concern about the cost of providing access to primary healthcare for undocumented migrants, others point to humanitarian and public health reasons for extending such support. Chapter 1 discusses the human rights framework around the right to health and the right to health care. Various international legal standards are widely regarded as the foundations for the human right to health. I examine legal as well as moral and practical arguments for and against approaching health as a human right, concluding along with researchers, medical professionals and national medical associations that all children should have equal access to health care services. All people should have access to health care regardless of income and immigration status. With respect to the human right to health, I explore to what extent Latinx immigrant children are able to realize this right and the types of factors that prevent them from enjoying the right to health. Through deeper analysis of utilization of emergency departments, primary care physicians and community health clinics, I identify trends in how Latinx immigrant children receive health care. I also consider how poverty impacts the type of care children receive, and to what extent children's immigration status, along with their parents' immigration status, compromises their ability to access health care. Furthermore, I assess the impact language barriers have on Spanish-speaking children and their parents in accessing health care. I aim to describe the particular situation in terms of access to health that Latinx children face in the United States, and then more specifically, in the Greater Philadelphia Region. My hypothesis is that children of Latinx immigrant families in the Greater Philadelphia Region are less likely to receive preventative care than children of non-immigrant families because their families do not

have health insurance and as a result, cannot afford to pay for many health care services. I also hypothesize that children of Latinx immigrant families face other obstacles to access nonemergency care related to family fears of deportation and concerns about barriers to effective communication with doctors because of limited English proficiency.

Following my discussion of the human rights framework in Chapter 1, I highlight how poverty and family immigrant status shape the gaps in health care in the United States in Chapter 2. Families with more limited financial means and from undocumented or mixed immigration status frequently access less primary care than those with citizenship and higher socio-economic status. In order for stake holders in government, health institutions and civil society to make informed decisions, as Ruiz-Casares et al. suggest, stake holders need to understand the specific obstacles undocumented families encounter in accessing healthcare for their children and the short and long-term consequences that such limitations to access create (Ruiz-Casares et al. 7). This is the focus of Chapter 3, which covers the political and economic factors that impact the health of Latinx children. Various research studies find that immigrant children and native-born children of immigrant parents are more likely to lack health insurance and access to healthcare than native-born children of native-born parents. The heightened fear of deportation amongst immigrant families due to various changes of federal policy and attitudes related to immigrants has led to a decrease in available health services and a “chilling effect” on those who could potentially access those health services.

In Chapter 4, I introduce the Greater Philadelphia Latinx Immigrant population as a case study. I discuss available data on the number of immigrants generally, as well as unauthorized immigrants, within the Greater Philadelphia Region from the 2010 Census. In addition, I present Census data on the quantity of Latinx individuals in the Greater Philadelphia Region. Then, I

dive into the roles linguistic and bureaucratic barriers play in health care access for Latinx immigrant families. Chapter 5 then details the interviews I conducted with staff members of non-profit organizations that serve Latinx immigrant families and children in Greater Philadelphia. All three organizations serve as case studies of ground-level efforts to address the health needs of local low-income, Latinx families with mixed-documentation status and/or mixed levels of English language proficiency. My findings, based on a review of empirical studies and my own interviews, support that low-income status and legal status are two of the largest influences on health care access for Latinx individuals and families, explaining why they rely on non-profit centers that offer free or heavily subsidized medical services and do not ask questions about immigration status. My findings also support that lack of resources and emotional stress compound health problems in Latinx immigrant children. Furthermore, my findings support that sensitive interpreters and holistic approaches to health through inclusion of education and nutritional programs are key to providing quality health care to Latinx immigrant children. Finally, my findings support that non-profit organizations that provide health care and other social services to their local Latinx community face an ongoing challenge to serve all those who need and/or want their services and to continue attracting necessary volunteers and funding.

These findings lead me to offer several policy recommendations in Chapter 6. It would be advisable to address the gap in healthcare access for Latinx immigrant children on the local, state and federal level. On the local level, there must be greater numbers of medical interpreters and bilingual medical professionals competent in Spanish and English readily available and trained in culturally competent care. Health care providers have the legal obligation to provide culturally and linguistically appropriate care according to the Patient Bill of Rights and scholarly studies have overwhelmingly found that language barriers in health care for Latinx patients have

significant harmful effects on the health care services they receive. On the state level, it would be in Pennsylvania's best interests to adopt the same policies as other states that have extended benefits to all residents, regardless of immigration status, in light of the detrimental impact that underinsurance has on hospital emergency departments and overall community access to quality health care. On the federal level, the new public charge rule, which makes immigrants who rely on public benefits ineligible for lawful permanent resident status, needs to be revoked considering the growing research that suggests that this recent change in immigration policy is contributing to growing fears among immigrant families about participating in Medicaid and CHIP.

Every child should have equal access to health care services, and yet, a gap in access continues to exist in the United States. In order to uncover the causes and realities of this unequal experience in access to health care, I will engage in exploration of human rights scholarship, discussion of data and expert analysis on health care access for children in the United States, consideration of the Greater Philadelphia Area as a case study and in-depth interviews of several local non-profit organization staff leaders working on providing health care access to Latinx immigrant children and families.

Chapter 1. Human Rights Framework

To begin, we must first address the legal, moral and pragmatic arguments that support the international norm of the basic human right to health, examining arguments for and against extended medical care to all, regardless of citizenship status. Legally, there is a human right to health established in international law. The General Assembly of the United Nations proclaimed the Universal Declaration on Human Rights (UDHR) in 1948 after various countries including the United States, Australia, Canada, Chile, China, France, Lebanon, the United Kingdom and the Soviet Union participated in the two year drafting process. The UDHR states in Article 25:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (United Nations 1948).

This declaration has led to several international covenants and instruments that also enshrine the human right to health. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states “The States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” These steps include “the prevention, treatment and control of epidemic, endemic, occupational and other diseases [and] the creation of conditions which would assure to all medical service and medical attention in the event of sickness” (United Nations 1966). The ICESCR serves as a legal document that firmly upholds the human right to health.

The ICESCR was expanded upon when the Committee on Economic, Social and Cultural Rights (CESCR) adopted General Comment 14 in 2000. General Comments offer clarification of individual human rights and human rights obligations. Though not legally binding, they are

considered to be highly authoritative and reflect broad international consensus. General Comment 14 is the interpretation of the right to health that is embodied in the UDHR and the ICESCR. General Comment 14 directly states “health is a fundamental human right *indispensable* for the exercise of other human rights” (paragraph 1). The Comment maintains that the right to health is not confined to the right to healthcare but also includes the right to “a wide range of socio-economic factors that promote conditions in which people can lead a healthy life” (paragraph 4). When it adopted General Comment 14, the CESCR identified the four elements of health: availability, accessibility, acceptability, quality. The document refers to availability as “public health and healthcare facilities, goods, and services to be in sufficient quantity” (paragraph 12(a)). Accessibility signifies that the services “have to be accessible to all” while acceptability means services “have to be respectful of medical ethics and respectful to the culture of individuals, minorities and communities, and have to be sensitive to gender and age” (paragraph 12(b)). Finally, quality refers to the scientifically and medically appropriateness and of good quality of services (paragraph 12(c)). Notably, Cole recognize that nation-states often do not provide equal availability, accessibility, acceptability, and quality of healthcare, but in the legal sense, the United Nations takes the view that a national government has an equal obligation to respect, deliver and enforce those rights to all people within its territory because its charter of human rights and its other conventions apply to all people regardless of their status (paragraph 12(d)). To address the generic term of “all people,” General Comment 14 explicitly “proscribes any discrimination in access to healthcare and the underlying determinants of health” (paragraph 18). The human right to health encompasses the idea that states should guarantee equal access for:

all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventative, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; abstaining from imposing discriminatory practices relating to women's health states and needs (paragraph 34).

The United Nations Development Program (UNDP) works to promote the 17 Sustainable Development Goals adopted by UN Member states in 2015, including Goal 3, which calls for ensuring healthy lives and promoting well-being for all ages through universal health coverage (UNGA, *Transforming Our World*, 14). Adequate nutrition, health care and other social and economic achievements are not merely aspirations according to the UNDP; instead, they are:

... human rights inherent in human freedom and dignity. But these rights do not mean an entitlement to a handout. They are claims to a set of social arrangements— norms, institutions, laws, an enabling economic environment—that can best secure the enjoyment of these rights. It is thus the obligation of governments and others to implement policies to put these arrangements in place (UNDP 73).

Measures taken by governments to exclude certain populations from access to health services are violations of international law, which guarantees the basic right to health to all, including children. The Convention on the Rights of the Child (CRC) represents the most significant international document dedicated to protecting the interests of children specifically. While looking into the access to healthcare services for children in the United States, it is essential to consider the implications of the CRC. While it has not been signed by the United States, it represents broadly accepted international norms. The convention enshrines children's right to health in the following article:

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.

States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care service (Article 24).

In order for children to enjoy their rights to freedom and justice, they must also have access to adequate health care. The Convention on the Rights of the Child is the most rapidly and widely ratified human rights treaty in history—with 196 countries as “states parties” (Mehta). Only the United States has not ratified the CRC (Mehta). Critics in the United States claim that the treaty undermines national sovereignty and parental rights, but U.S. delegates played an active role in drafting the convention, which refers repeatedly to the rights and responsibilities of parents to raise and provide guidance for their children (“25th Anniversary of the Convention on the Rights of the Child”). The United States has a “libertarian” legal framework that “gives parents the authority and responsibility to make decisions about their children’s health care, and favors parental rights over society’s collective responsibility to provide for children’s welfare” (Huntington and Scott 179). This framework also maintains that “Neither the federal government nor state governments have an affirmative obligation to protect and promote children’s health, nor do children have a right to such protection” (Huntington and Scott 179). When the government has no positive obligation to promote children’s health, as a result “children’s health programs are often underfunded and vulnerable to political pressure” (Huntington and Scott 179). Children in the United States already enjoy many fundamental rights, including rights to privacy, due process and freedom of expression, but children’s rights advocates argue that ratification of the CRC is still important in order to increase support for programs to reduce child poverty and expand children’s access to health, education and family services. The United States

is one of the richest nations in the world, yet it has one of the highest rates of child poverty among developed nations (Rothschild). The National Center for Children in Poverty finds that 43 percent of children in the United States live in families barely able to afford their most basic needs. One in 25 families with young children lives on about \$2 or less per day (Rothschild). Infant mortality is more common in the United States than in many other economically advanced nations. Still, the United States spends a smaller share of its GDP on benefits for families than other wealthy nations (Rothschild).

We must also consider the moral implications of not providing equal access to health services for all, especially children who are most vulnerable and reliant on their parents and the state for support. Phillip Cole advances an ethical argument that all human beings have a right to health, which means that states have a moral obligation to ensure that everyone living within their territory, including irregular migrants, have access to public healthcare (217). Cole debunks various counter-arguments, including concerns about a right to health expressed by liberal theorists including John Rawls. Rawls differentiates natural primary goods from social primary goods, arguing that only the latter are under society's control. As a "natural" primary good, health may be influenced by the basic structure of society, but society cannot control health outcomes; Rawls therefore concludes that a just society does need not to directly provide for its members' health (Cole 2019). Cole relies on the work of Samuel Scheffler to oppose Rawls' position. Scheffler insists that social justice is concerned with the question of the fair distribution of resources and health is not a commodity that can be distributed, but the right to health *care* can be. Scheffler (quoted in Cole) writes that the things people need for a healthy life *are* distributable commodities: ". . . people are not said to have a natural right to a good health or a good life, for these are not distributable goods. Rather, each person is said to have a right to

adequate food, clothing, and medical care” (220). Julian Le Grand serves as another proponent in this vein. Le Grand (quoted in Cole) writes: “Although in one sense it is true that it is impossible to redistribute health, this does not mean that the distribution of health is insensitive to public policy. For it is obviously possible to influence by policy many of the factors that *affect* health, such as nutrition, housing and work conditions, and, of course, medical care itself” (220). Cole concludes that a right to health is compatible with liberal thought since the equitable distribution of healthcare resources is part of a socially just allocation of goods and necessary in order to avoid systematic inequalities in health (Cole 220).

Cole argues that morally we are obligated to provide unqualified access to public health systems because it is necessary for individuals to realize their human potential as “active and autonomous” members of society (Cole 218). He draws upon John A. Hall who maintains that a crucial component of the liberal idea of freedom is the “secure provision of the basic necessities of food and health, the absence of which makes life miserable” (quoted 218). Hall goes beyond mere sufficiency – freedom must supply the power required to enable the individual to choose from a significant range of opportunities, rather than simply fulfill “basic” needs (Cole 218). Synthesizing Hall’s position, Cole writes that “the framework of social rights ensures access to the conditions that underpin the capability to be a fully active participator in the other frameworks, the power to be an active and autonomous chooser and doer of one’s own lifeplans, and the lifeplans and projects of one’s community, and those of the wider national and global community, that is, the power of agency” (Cole 218).

Mainly, Cole relies on the capability approach advanced by Nobel prize-winning economist Amartya Sen and Martha Nussbaum which prioritizes the individual capacity to live a fully human life and demands support for basic necessities such as food, clothing and medical

care that people need to realize their capabilities – that is, to become fully free (Cole 221). Cole argues all human beings have a right to health since this right is essential for human agency, which then gives us the capacity to exercise our freedoms (Cole 221). When it comes to capacity, Sen (quoted in Cole) assesses “a person’s capability to do things he or she has reason to value” the focus is on “the freedom that a person actually has to do this or be that – things that he or she may value doing or being” (222). The focus on freedom and agency is crucial, as a welfare “dictator” could decide and impose welfare outcomes on a population, such that all members enjoy high levels of health and well-being and a wide range of “functionings” without ever engaging in the process of deciding what sort of life they want to lead (Cole 222).

Cole further distinguishes between being human in a biological sense, and being human in a biographical sense, having a life story which is recognizably human, in that it includes the elements we take to constitute human flourishing, including social and political, as well as economic and physical, elements (Cole 220). Human flourishing is the main priority for Martha Nussbaum in her consideration of human capability. According to Cole, people who are politically, culturally, socially or economically excluded lack the conditions for secure access to this kind of life story, the conditions which would empower them to lead lives that express their full humanity (Cole 221). By recognizing the importance of agency, human flourishing thereby consists not only in the opportunity to have a recognizably human life story, but also the power to write that story, to have a say over its content, and indeed the power to create it as it goes along (Cole 221). For Cole and other liberal theorists, the ethical argument for a human right to health is grounded in moral theories of the requirements for human flourishing and societies’ obligation to provide basic necessities, including healthcare, to all. For some critics, however, it is simply not feasible for societies to guarantee such rights to all.

The “catastrophe” argument maintains that in order to uphold policies and institutions that are distinctively liberal, such as public welfare systems, there has to be a system of controls that restrict access to those systems; otherwise, they will be overwhelmed (Cole 227). This line of argument suggests that liberal institutions have a distinctive, perhaps intrinsic, moral value, such that states should protect them; it further asserts that opening national welfare systems, such as public health, to all within the territory regardless of status, would be to undermine radically those systems (Cole 227). Cole is largely skeptical about this line of argument because he questions how it constitutes a moral defense of exclusion (Cole 227). Rather, he counters that if public welfare systems are that valuable, the case for excluding others from them looks even less morally defensible. The danger is that this defense of exclusion takes us toward what he calls a “liberal realist” position, which maintains that as the international order is dangerously anarchic, the only rational approach for nation-states is to pursue their self-interest. Realism rejects what it sees as “moralism” at the international level – the only rational course is to pursue a self-interested amorality: the national interest is the only standard against which a state can judge its conduct (Cole 227). In contrast, Cole allows that the commitment to global justice and human rights gives rise to internal as well as external obligations on nation-states when it comes to the provision of welfare.

In contrast, David Kelley, a libertarian scholar, rejects the idea of both internal and external obligations, arguing that there is no human right to health and we should not attempt to put it into practice. According to Kelley, the government should not be in the business of guaranteeing social and economic “goods” such as guaranteed access to health care. He differentiates welfare rights from liberty rights and writes that “Liberty rights impose negative obligations: the obligation not to interfere with one's liberty. Such rights are secured by laws that

prohibit murder, theft, rape, fraud, and other crimes. But welfare rights impose on others the positive obligation to provide the goods in question” (Kelley 4). Kelley defends the position that citizens and governments do not have a moral duty to provide welfare rights to others. Indeed, he argues that compelling people to provide welfare goods to others is a violation of individual liberty insofar as it requires people to be altruistic – i.e., to sacrifice their own interests or rights on behalf of another; because he argues liberty and welfare right are incompatible, he believes “there is no such thing as a right to health care” (Kelley 8). Kelley suggests that citizens cannot be blamed for the poor health of others, so they should not have to pay for their health care; moreover, Kelley argues that guaranteeing a right to health would be impossibly expensive. David Kelley argues that people can rely on charity if they wish, but they cannot insist on charity. For Kelley, need does not give people a right to the ability and effort of others. People in need are likely to find that others will voluntarily help them – as physicians are likely to do – but such help reflects altruism rather than duty.

Human rights scholar Tony Evans, on the other hand, argues that welfare rights such as the right to health are not so different from liberty rights. According to Evans, liberty rights also require active government support, such as using taxpayer dollars to pay for military and police and deploying state resources to ensure that all people are able to exercise their right to vote. For supporters of socioeconomic rights including the right to health, it is hypocritical to oppose an obligation to pay for health care but support an obligation to pay taxes to protect citizens’ liberty rights. Amartya Sen (quoted in Cole) argues that it is mistaken to believe that “that civil and political rights consist in simply leaving people alone – many civil and political rights require extensive positive action by governments, for example genuine and inclusive democratic procedures ... [therefore] the exclusion of all economic and social rights from the inner sanctum

of human rights, keeping the space reserved only for liberty and other first-generation rights, attempts to draw a line in the sand that is hard to sustain” (218-219).

Similarly, for Evans, just as the government has a duty to actively work to ensure liberty rights, it also has an obligation to work to secure the right to health for its people by implementing policies that serve that goal. Arguments such as Kelley’s that emphasize the priority of civil and political freedoms appear less compelling if there is no clear distinction between negative and positive rights (Evans 203). If rights are never wholly positive or negative, then correlative duties cannot be wholly positive or negative (Evans 205). In addition, Evans makes the case that health constitutes a basic right without which other rights cannot be enjoyed; without guaranteed access to adequate healthcare, many individuals’ health will suffer and they will not be able to enjoy other rights.

Paul Farmer, a physician and medical-anthropologist, makes a similar argument, insisting that health care is a human right and that charity is inadequate since it assumes that the poor and marginalized people are responsible for their own fate, rather than subject to structural inequalities. Farmer uses the term structural violence to convey the idea that poor health outcomes stem from unfair conditions in society that deprive poor and marginalized individuals of the ability to control their own fate, including their health; he defines structural violence as “historically given (and often economically driven) processes and forces that conspire – whether through routine, ritual, or as is more commonly the case, the hard surfaces of life – to constrain agency” (Farmer 40). Farmer insists that racism, sexism, political violence, and grinding poverty place some people at systematically greater risk for health problems; while such individuals are at the mercy of larger forces beyond their control, Farmer notes that these forces reflect the interests and decisions of powerful actors. As such, most deaths and illnesses of the poor and

socially marginalized are “not the result of accident or a *force majeure*; they are a consequence, direct or indirect, of human agency” (Farmer 40).

Farmer insists that societies have a collective responsibility to help people whose health suffers due to such inequities, but he also acknowledges that there are major obstacles to addressing structural violence. He observes that “the suffering of the world’s poor intrudes only rarely into the consciousness of the affluent, even when our affluence may be shown to have direct relations to their suffering” (Farmer 31). Such observations can be extended beyond his discussion of poverty in Haiti to the context of undocumented immigrants in the United States. As will be covered later, many undocumented immigrants contribute to the strength of the American economy. Yet, when they or their children have health issues, the American safety net frequently fails to provide them the same access to health care as it provides to its citizens. From Farmer’s perspective, this denies the reality that human rights are universal, but risks of having rights violated are not; the poor are more vulnerable and more likely to suffer, making it imperative to work to protect the rights of those who are most likely to have their rights violated (Farmer 212).

Seth Holmes, in *How the Poor Suffer*, also draws on the experiences of poor and marginalized groups to show the health consequences of structural and symbolic violence. In this case, Holmes shares his observations from living with Triqui migrant workers who travel between Mexico and the United States to work on strawberry farms. His anthropological studies provide ample evidence that the health of people of immigrant status is worsened by factors beyond their control, which calls for greater awareness and effective intervention. He gives various examples of health ailments of migrants he gets to know, both physical and mental, arguing that these ailments are bodily manifestations of suffering due to structural inequities,

such as lack of access to quality healthcare. In addition, Holmes illustrates the impact of symbolic violence, which refers to the psychological harms that result from the ways that individuals internalize racism and other forms of discrimination and mistreatment. Holmes recognizes how people around the Triqui migrant workers try to ignore their suffering. He argues we must do more than just offer emergency health care to immigrants. Triqui migrant workers face structural violence, which is manifested as social inequalities and hierarchies, along social categories of class, race, gender and sexuality (Holmes 2). During fieldwork, many Triqui people experienced notable health problems affecting their ability to function in their work and families (Holmes 2). The Triqui pickers bear an unequal share of sickness and pain, live in the coldest and wettest shacks in the most hidden labor camp with no insulation, no heat, and no wooden ceiling under the tin roof, and they hold the most stressful, humiliating, and physically strenuous jobs, working seven days a week without breaks while exposed to pesticides and weather (Holmes 4). Holmes highlights how their physical health issues are compounded by broader economic forces that eliminate jobs for indigenous Mexican farm workers and drive them to sneak across a mortally dangerous border in search of work (Holmes 3). Meanwhile, government policies that criminalize undocumented workers translate into low wages and poor working conditions. Illegal immigrants live in fear and remain transient wherever they work, despondently reproducing the same situation for their children, who cannot stay in school to seek a better future (Holmes 3). For Holmes, the health of vulnerable migrant farmworkers reflects problematic assumptions that certain groups of people do not deserve help for the health problems they face.

Philosophy professor James Nickel also argues that it is morally unacceptable to refuse necessary care to non-citizens (Nickel 21). Nickel rejects the argument that only citizens have a

morally valid claim to health care and points to evidence that undocumented immigrants contribute to community through work and taxes (Nickel 22). In contrast to critics who argue that undocumented immigrants “have forfeited their moral standing and rights by illegally entering or remaining in the country,” Nickel argues that this “is a very minor ‘crime’ – particularly since the government has not consistently treated unauthorized immigration as something to be morally and legally condemned” and, as such, does not justify denial of basic rights, including education and access to medical care (Nickel 23). Moreover, Nickel notes that the forfeiture argument should not apply to “children who have no control over their place of residence” (Nickel 23).

Even when acknowledging the moral arguments in favor of providing health care to all people regardless of immigration status, some question the possibility that there is not enough to go around. Much like the “catastrophe” rationale discussed above, some critics of a human right to health claim that there are practical limits on societies’ ability to guarantee such a right while defenders of the right to health forward pragmatic arguments of their own. David Kelley forwards a pragmatic critique, insisting that guaranteeing a right to health would be prohibitively expensive. He worries that everyone will demand the highest – and most expensive – level of health care, insisting on maximum care (Kelley). Like Kelley, Maurice Cranston (quoted in Cole) maintains that it is feasible to institute traditional political and civil rights since these arguably only “require governments, and other people generally, to leave a man alone . . .” (218). Cole utilizes Amartya Sen’s reply that: “. . . if feasibility were a necessary condition for people to have rights, then not just social and economic rights, but all rights – even the right to liberty – would be nonsensical, given the infeasibility of ensuring the life and liberty of all against transgression” (219). Thus, the objection that social and economic rights are qualitatively

different and more expensive to realize than civil and political rights reflects a false distinction between the two sets of rights. It also forwards a misleading argument about cost that serves as a justification for denying access to adequate healthcare for all. Tony Evans addresses the fear that exists that providing for the basic needs of the poor would be too burdensome on the rich, often expressed as the ‘deluge’ effect (Evans 199). The emotive term suggests that the rich would drown in the sea of socioeconomic claims made by the poor (Evans 199). Evans insists that satisfying a right to health does not require granting universal access to the latest technological and scientific resources for health, but rather a minimum that provides the basis for leading a dignified life (Evans 205). Therefore, the ‘deluge’ effect related to provide a right to health is an unfounded fear (Evans 205).

In addition, James Nickel notes a financial incentive to provide medical services to undocumented immigrants since they are likely to stay in the country and it is in society’s best interest for them to remain healthy and productive. This is arguably also true for undocumented mothers, whose children are entitled to citizenship (Nickel 20). Along similar lines, Janet Currie and Nancy Reichman highlight that “A large volume of high-quality research shows that unhealthy children grow up to be unhealthy adults, that poor health and low income go hand in hand, and that the consequences of both poverty and poor health make large demands on public coffers” (Currie and Reichman 3). Promoting children’s health is essential for improving the population’s health, so the policies that “prevent children’s health problems can be wise investments; and policy makers should implement carefully designed policies and programs to promote child health” (Currie and Reichman 3). Currie and Reichman also argue that “we should keep in mind that investments in child health have the potential to repay current expenditures

many times over, both by allowing children to grow up to be productive citizens and by improving the circumstances of the next generation” (Currie and Reichman 9).

In addition to supporting a productive economy and wise long-term investments in future workers, Nickel also points to the importance of providing medical services to all in order to protect public health. Specific medical services such as immunization against or treatment for contagious diseases are essential to the public health of all (Nickel 20). Shari Fallek highlights that “The illegal immigrant most often is fearful of coming to public notice, lives in poverty and substandard, over-crowded and unhygienic living conditions and often, if not always, is economically depressed” (Fallek 7). These factors together that occur in undocumented immigrant communities predict high disease levels, delays in seeking medical care delayed diagnosis and delayed treatment of those diseases, and when they are communicable, spread to other persons (Fallek 7). These present a major danger to public health as rates of infectious disease (eg. tuberculosis) are higher among immigrants (Fallek 7). Because each patient possibly exposes an average of ten contacts to the disease during the course of delaying care, such an increase would spread tuberculosis beyond those who postpone care. Undocumented immigrants must have access to health care so that they may be screened for communicable diseases and treated. In the long run, treatment for undocumented immigrants will be cost-effective because it will actually halt the spread of disease to others. Spending dollars now to prevent the spread of disease will cost less than treating patients in the future. David Langness, spokesman for the Hospital Council of Southern California, quoted by Fallek, states that denying care to undocumented immigrants has been called a "public health nightmare" for everyone. Communicable diseases have to be contended with by all. Langness also comments that “Southern California is dependent on the labor of illegal immigrants ...The fact is if those folks

get sick, they have contact daily with all of us, and refusing to treat them only makes all of us sicker” (Fallek 7). Hundreds of thousands of illegal immigrants work in fields and restaurants with the food we eat. Thus, controlling communicable diseases among undocumented immigrants would be facilitated by immunization and early detection efforts. Dr. Pauline Rosenau, of the University of Texas Health Policy Institute, quoted by Fallek, argues it is naive to believe that it is economically efficient to provide emergency care but not preventative care, prenatal care, and regular medical treatment. It will only hurt those financially responsible in the end (Fallek 7).

People of all backgrounds should have equal access to health care services and ultimately, the universal human right to health exists. Health is an internationally recognized right, and governments are morally obligated to provide for the conditions that people have equal opportunity to exercise that right. Without their health, people cannot lead a fully human life nor can they contribute as fully to their community or participate in democracy. Furthermore, by considering the health of individuals from a pragmatic standpoint, healthier people lead to less spread of communicable diseases, more productive workplaces and less strain on emergency services. It is important to recognize that this right to health exists because otherwise, people currently suffering from lack of equal access to health care may go unnoticed and neglected. The gap in access to health care directly contradicts the widely supported human right to health and the factors that contribute to that gap must be examined and addressed.

Chapter 2. Poverty, Family Immigrant Status and Gaps in Health Care

The American Academy of Pediatricians' Poverty and Child Health Policy identifies a strong connection between reducing poverty and improving children's health (Jenco). Nonetheless, child poverty remains high. Research by Currie and Reichman underscores how poor and minority children face disproportionate threats to their health. These disadvantages are "are reflected in socioeconomic and racial disparities in low birth weight and infant death" (Currie and Reichman 2015: 5). The effects of low-income background also accumulate over time considering that "Poor and minority children are more likely to experience conditions that can harm their health, such as poor nutrition, pollution, and substandard housing (Currie and Reichman 2015: 5). In 2018, the child poverty rate in the United States was 16%, significantly higher than the 11% poverty rate for adults and the 10% poverty rate for seniors, resulting in the second-highest child poverty rate among 29 developed countries (Peter G. Peterson Foundation).

In contrast to high and increasing levels of federal government spending on the elderly, government spending on children has been much lower and has largely fallen to individual states. In 2018, 45% of the U.S. federal budget went towards health and retirement benefits for adults through Social Security, Medicare, and Medicaid, 15% went towards defense spending, and 8% went to interest on the federal debt (Peterson Foundation). In comparison, 9% of the federal budget, or \$379 billion "was spent on children, with another \$106 billion provided through tax reductions for families. Those commitments totaled, on average, about \$6,200 per child" (Peterson Foundation). In 2018, federal government spending on children fell to 1.9% of GDP, the lowest rate in a decade, and is expected to decline, which translates into reduced government support for health programs like Medicaid and the Children's Health Insurance Program (CHIP) and nutrition programs such as the Supplemental Nutrition Assistance Program

(SNAP) (Peterson Foundation). The American Academy of Pediatricians therefore argues that improving certain government programs that address poverty is vital for addressing children's health concerns. It advocates for improving access to early childhood education and increasing parents' income by strengthening programs like the earned income tax credit, Supplemental Nutrition Assistance Program, housing subsidies and the Special Supplemental Nutrition Program for Women, Infants, and Children (Jenco).

Poverty and Unequal Access to Health Insurance

One of the main hurdles for children to get healthcare services is obtaining health insurance. About 4.3 million children or approximately 5.5% of children in the United States did not have any health insurance coverage in 2018, an increase of 425,000 (or 0.6 percentage points) from the previous year, according to the U.S. Census Bureau (Berchick et al.). It is important to acknowledge that data on uninsured children only serve as estimates because they may not include all children who have undocumented or migrant status. Statistically, children in families with incomes below or only slightly above the poverty level have been found to be much more likely to be uninsured. In 2018, the uninsured rate for families with income less than 400% of poverty ranged from 6.7% to 7.8%, compared to an uninsured rate of 2.6% of children in families with income over 400% of the poverty line (Berchick and Mykta).

Medicaid and Children's Health Insurance Program (CHIP) serve as public programs when families do not or cannot access private health insurance coverage. Medicaid provides health insurance coverage for children (and adults) with incomes below a certain level while CHIP provides health insurance for children in families with income too high to qualify for Medicaid but who are likely unable to afford private health insurance. CHIP covers pregnant women in some states. CHIP benefits are different in each state but all states provide some type

of comprehensive coverage for children, including routine check-ups, immunizations, doctor visits, and prescriptions (“State Children’s Health Insurance Program”).

State-level variations are significant in terms of health policy, while at the same time federal policy is very important. The Affordable Care Act of 2010 created the opportunity for states to expand Medicaid to cover nearly all low-income American citizens under age 65 (Berchick et al.). Through the ACA, eligibility for children could be extended to 133% of the federal poverty level (FPL). 31 states and the District of Columbia expanded eligibility as part of the ACA. 29 states did not. Uninsured rates dropped sharply after the ACA went into effect. Uninsured rates fell 2.8% in 2013-2014 and another 2.3% in 2014-2015, with a more modest drop of 0.8% in 2015-2017. Uninsured rates were much higher in states that did not expand eligibility as opposed to those – like Pennsylvania – that did (12.4% vs. 6.6%) (Berchick et al.).

There was a slight uptick in uninsured rates of 0.1% noted in 2017-2018 (Berchick et al.). From 2017 to 2018, the percentage of children with public coverage actually fell, but the percentage of children with private health insurance coverage did not statistically change (Berchick and Mykta). Medicaid and CHIP coverage fell for the youngest children (under 6 years old) and for 6-to-11 year-olds, but did not statistically change among 12-to-18 year-olds (Berchick and Mykta). In response to this data revealed in the U.S. Census Bureau’s report, the American Academy of Pediatrics (AAP) made a statement arguing that:

For these kids, no coverage often means no care...No care means fewer preventive screenings to catch conditions before they become severe and costly. No care means more missed school and work days for parents. It means no access to affordable dental coverage, or prenatal services for pregnant mothers. We can do better, and we must (Jenco).

Demographically, in 2018, the highest rates of uninsured children were in the South at 7.7%.

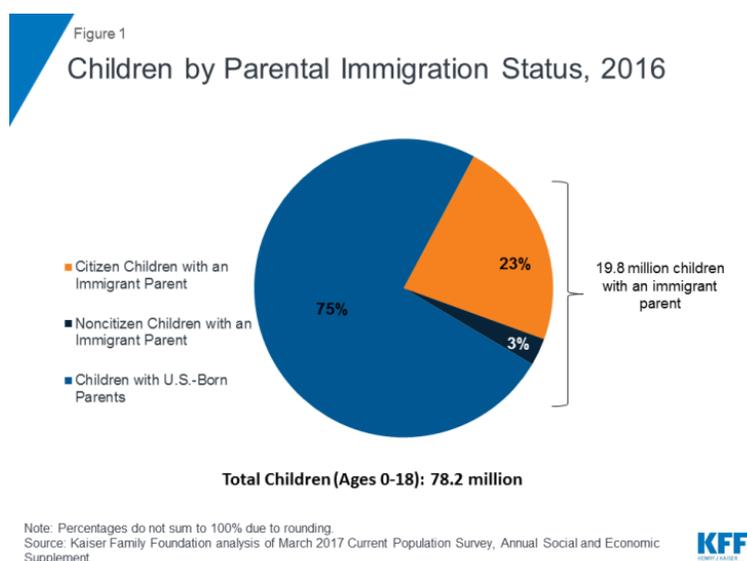
This is important because most spending on children's health falls to states and "state investment in children varies significantly ... although some federal programs use a funding formula that takes state poverty into account, not all do so" (Rosenblum and Blum 24). Although federal expenditures may "mitigate the impact of low spending in states, by no means does federal spending alone equalize opportunity across states" (Rosenblum and Blum 24).

The Effect of Immigration Status on Access to Health Care

While researchers frequently discuss differences in access to health care based on race or socioeconomic status, it is also important to consider parental immigration status¹ for the 78.2 million children living in the United States as of 2016, as shown in Figure 1. Children's life circumstances are greatly shaped by their parents and children have much less control than adults in navigating complicated systems such as the health care system. Figure 1 shows that more than one in every four children living in the United States has at least one immigrant parent and the overwhelming majority of these children were born in the United States themselves. The share of children in U.S. immigrant families has grown considerably, increasing from 13.4% in 1990 to 25.9% in 2018 (Migration Policy Institute).

¹ When labeling immigration status, this body of work will not use the terms 'alien' and 'illegal alien' unless included in a direct quotation. Using the term 'alien' to refer to an immigrant, foreign national, or non-citizen, academics argue, dehumanizes an individual who may be fleeing their country due to violence, poverty, or other form of suffering. Referring to individuals as 'illegal' when crossing the border without proper authorization is utilizing inflammatory rhetoric with political baggage, rather than explaining their behavior. Those described as 'illegal aliens' may actually be in the process of acquiring legal status in some form, usually through family sponsorship or through their work. A significant share of foreign-born individuals has lived in the country for a lengthy period of time and are integral members of the U.S. society and the communities in which they live. The fact that someone was born in another country does not mean that they are not or will never be a full member of our society. In other words, one can be a noncitizen and still have deep roots and strong ties to the United States (Cantor).

Figure 1. Children by Parental Immigration Status, 2016



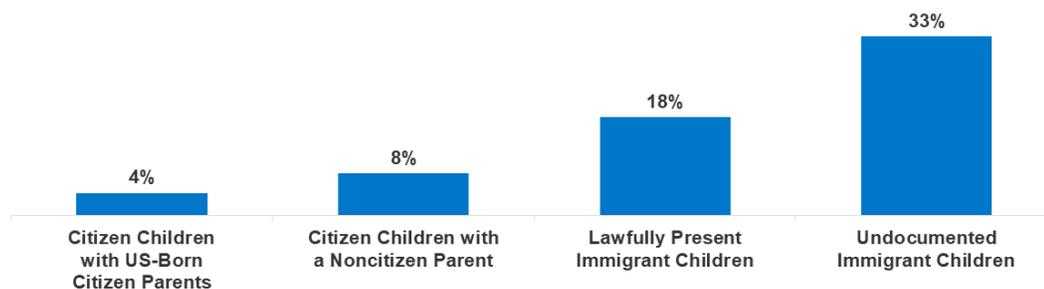
Source: Artiga, Samantha and Anthony Damico. “Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies,” *Kaiser Family Foundation*. 18 Apr. 2018. www.kff.org/disparities-policy/issue-brief/nearly-20-million-children-live-in-immigrant-families-that-could-be-affected-by-evolving-immigration-policies/.

Before examining statistics on the connection between family immigration status and lack of health insurance, we must begin the discussion by evaluating who is legally eligible to participate in health insurance programs. Eligibility for both Medicaid and CHIP depends on immigration status as well as income, and individual states have the authority to expand coverage to more children at their discretion, as discussed below. Federal law requires states to cover certain groups of individuals through Medicaid. At the most basic level, American citizens who are low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups for Medicaid (U.S. Department of Health and Human Services). In comparison to American citizens, immigrants’ eligibility to Medicaid and CHIP is more limited. The 1996 federal welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) restricted and continues to restrict Medicaid eligibility of immigrants (Perreira and Pedroza 146). In terms of non-emergency care, immigrants legally admitted to the United States after August 1996

cannot receive coverage for non-emergencies in their first five years in the country (Perreira and Pedroza 146). “Qualified non-citizens,” which fall within the category of legally admitted immigrants, are generally eligible for coverage through Medicaid and CHIP if they meet their state’s income and residency rules without a waiting period (Peterson Foundation). Qualified non-citizens include refugees, asylees, or lawful permanent residents (LPRs or green card holders) who used to be refugees or asylees (Perreira and Pedroza 146). At the federal level, immigrants without any documentation cannot receive any coverage unless their documentation status changes, and even then, they may be forced to wait an additional five years (Perreira and Pedroza 146).

The data about which children remain uninsured reveal a strong correlation between uninsured status and belonging to an immigrant family. As Figure 2, suggests, citizen children with immigrant parents were more likely to be uninsured than citizen children with U.S.-born parents. We must also recognize that there are citizen-children with U.S.-born parents who are still uninsured and are also experiencing inadequate access to health services, yet immigrant households are both more likely to have minor children and lack health insurance (Gelatt 11). In 2000, a third of all uninsured children lived in immigrant families and by 2010, this figure had risen to 42% (Seiber 201). One of the most striking pieces of data Seiber highlights is the observation that two-thirds (69%) of uninsured children are citizens and 39% are Medicaid eligible (201). This reflects how a child citizen of an immigrant family may be eligible for government healthcare programs but nonetheless face other obstacles to obtaining healthcare.

Figure 2. Uninsured Rates among Children by Immigration Status and Parent Immigration Status, 2018



Note: All percentages shown are statistically significantly different from citizen children with citizen parents at the $p < 0.05$ level. Includes children ages 0-18.

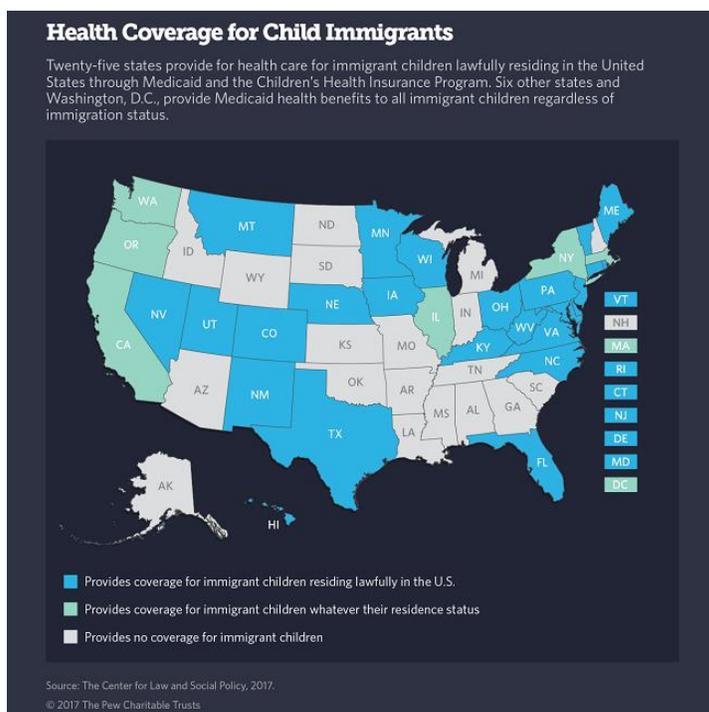
Source: KFF analysis of 2018 American Community Survey (ACS), 1-Year Estimates.



Source: "Health Coverage of Immigrants," *Kaiser Family Foundation*. 18 Mar. 2020. <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/>

Health care coverage for children from immigrant families is also affected by diverging state policies on children immigrant access to Medicaid and CHIP. Figure 3 reflects the state-by-state policies on children's access to Medicaid and CHIP in relation to immigration status in 2017.

Figure 3. Variations in State Health Coverage for Child Immigrants, 2017



Source: Ollove, Michael. "More Immigrant Children in U.S. Illegally to Receive Health Care." *Pew Trusts Stateline*, *Pew Charitable Trusts*, 2017. www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/08/08/more-immigrant-children-in-us-illegally-to-receive-health-care.

As of 2017, California, Oregon, Washington, Illinois, New York, Massachusetts, and Washington, D.C. provided CHIP and Medicaid coverage for immigrant children whatever their residence status (Ollove). Twenty-five states provide healthcare coverage through CHIP and Medicaid to immigrant children lawfully residing within the United States without enforcing a waiting period (Ollove). The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gave states the option to expand eligibility to immigrant children in their first five years of residence (Ollove). It should be acknowledged that the data above reflect access to non-emergency coverage through Medicaid and CHIP. Medicaid does provide payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency), but who do not have an eligible immigration status (Perreira and Perez 146). In emergency situations, health care providers are required to provide care. Hospitals are also bound by the Hill-Burton Act to treat indigent patients if the hospital receives funding through the Act. More than one-half of the hospitals in the United States received construction funds under the Hill-Burton Act and therefore are required to provide some care to indigents (Fallek 3).

Gaps in Care-Seeking Behavior

Distinct populations of people access preventative and emergency care at different rates and deeper examination of those trends reflects inequality in access to preventative care based on access to health insurance, immigration status, and income levels. Health care services often fall into three categories: primary, chronic or emergency care. Primary care is also referred to as preventative care. Chronic conditions may be monitored through a primary doctor, but may also become issues of emergency that require immediate, urgent attention.

Primary care

In 1978, the International Conference on Primary Health Care held by the World Health Organization and UNICEF defined primary health care as “the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work” (UNICEF et al.). At the fundamental level, primary health care should seek to combat the main health problems in the community by providing “promotive, preventive, curative, and rehabilitative services,” especially in, but not limited to, the areas of maternal and child health; the prevention and control of infectious, nationally common, and locally endemic diseases; treatment of injury; adequate supplies of safe water and basic sanitation; the promotion of food supply and proper nutrition; and the provision of essential drugs (UNICEF et al.). In essence, primary care centers should be the patient’s healthcare home, a place where they should be able to come to seek health information and diagnosis, counseling, and treatment (Durden 181).

Specifically, in the case of evaluating children’s health care access, it is valuable to consider patterns in receiving immunizations since following a routine childhood vaccination schedule brings significant health benefits, reducing hospitalization rates and medical costs; according to one study, routine childhood immunization of children born in 2009 was estimated to have prevented over 40,000 early deaths and 20 million cases of disease (Rossin-Slater 51). Buelow and Van Hook find that taking into account parental nativity reveals that a much larger group of children are at risk for under-immunization than if only the child’s nativity status were taken into account (Buelow and Van Hook 37). Their study’s results suggest that parental nativity, citizenship, and residential duration are all important factors to consider when assessing differences in timely immunization completion among children (Buelow and Van Hook 39). In

efforts to eliminate disparities in immunization completion, public policy makers and health care providers may need to broaden the focus of public immunization outreach programs that target disadvantaged groups, including children of non-citizens and newly arrived immigrants (Buelow and Van Hook 38).

Emergency and chronic care

Because of the gap in insurance coverage and access to preventative care, many children who are undocumented or whose parents are undocumented rely on free or greatly reduced-price care at community health clinics, local health departments and public hospital emergency rooms. Under Section 1867 of the Social Security Act, known as the Emergency Medical Treatment and Labor Act (EMTALA), all Medicare-participating hospitals are required to provide treatment and stabilize emergency medical conditions, including active labor, regardless of the patient's ability to pay and regardless of documentation status. If the hospital is unable to do so, the patient must be transferred to a different facility. The hospitalized individual with the medical emergency can: apply for emergency medical assistance, become a charity care case of the hospital, set up a payment plan with a hospital, or not pay the bill and have it become uncompensated care for the hospital (Durden 184).

Chronic care is defined as including both chronic illness, "the presence of long term disease or symptoms," and impairments, "a physiological, psychological, or anatomical abnormality of bodily structure and function" (Durden 185). Examples of chronic conditions include but are not limited to AIDS, arthritis, cancer, heart disease, diabetes, hearing impairment, and mental retardation. According to Cuello, immigrants who are undocumented have the least access to chronic care. Emergency Medicaid does not cover chronic conditions and although public clinics do provide treatment for chronic conditions, the degree of comprehensive follow-

up that is needed for management of such conditions proves challenging when dealing with patients who do not speak English as their first language and cannot afford much (Durden 185).

Whether insured or not, immigrants are more likely to continue to seek services at Community Health Clinics (CHC) and Local Health Departments (LHD) because of trusted relationships, locations in the community, and enabling services such as language access that they rely on (Ambegaokar 1). Many immigrants are eligible for Medicaid, CHIP or private insurance through the ACA's marketplaces but may be unaware or reluctant to apply for coverage, or may face barriers in the application process and therefore turn to CHCs and LHDs as an alternative to a traditional primary care doctor who expects patients to have health insurance (Ambegaokar 1).

In terms of use of the Emergency Department (ED) as a form of care, studies reflect ambiguous results. Tarrag et al. finds, immigrants, particularly non-citizens, were less likely to use ED services compared to the US-born respondents, consistent over 9 years of study from 2000-2008 (Tarrag et al. 604). McDonnell and Guenther suggest that as emergency departments (EDs) are experiencing increased volumes and crowding problems, crowding is often blamed on uninsured patients, but the role of uninsured children is unclear (McDonnell and Guenther 439). Their study finds that uninsured pediatric patients were not disproportionately represented in the ED population. Moreover, uninsured children were not more likely than insured children to be moderate or frequent ED users (McDonnell and Guenther 437). However, Elizabeth Durden's research reflects that a larger percentage of non-Hispanic white children report a private doctor as their source of regular medical care while other Hispanic and Mexican-American children report higher use of clinic or ED for health services (Durden 753). Her data also reflects that a lower percentage of non-Hispanic whites report the ED as their source of regular medical care

(Durden 753). Her study notices a correlation between a mother's nativity, duration in the United States and citizenship status as indicators of their child's health access. Her results indicate that as groups further acculturate into the US, some of the health disparities dissipate, but not all.

(Durden 756). Durden's decision to place health clinic and ED in the same category may have had an impact on her findings.

Chapter 3. Political and Economic Factors that Impact the Health of Latinx Children

In order to focus this investigation, I will be looking at the health of Latinx children from immigrant families, beginning with an overview of issues that affect Latinx individuals and families throughout the country in this chapter and a more detailed examination of the Latinx community in the Greater Philadelphia region in the next chapter.² It is important to note that in the case of Puerto Rico, while people born Puerto Rico are classified as Latinx but they are U.S. citizens by birth. It is necessary to acknowledge that Latino and Latinx as identifiers are not always used or embraced by people who are from Latin America. Frequently, people born in countries in Latin America identify more closely with their country (or territory as in the case of Puerto Rico) of origin than the overall continent. However, I did not want to limit my research to Latinx immigrants from a particular country because data collection would be more difficult and this would limit the applicability of my conclusions and policy recommendations.

For the 2010 U.S. Census, the Office of Management and Budget (OMB) standards included two minimum categories for data on ethnicity: "Hispanic or Latino" and "Not Hispanic or Latino." It specified that race and Hispanic origin (also known as ethnicity) are two separate and distinct concepts ("About Hispanic Origin"). These standards generally reflect a social definition of race and ethnicity recognized in this country, and they do not conform to any biological, anthropological, or genetic criteria. Persons who report themselves as Hispanic can be

² Originally, the word Hispanic referred to those who are of Spanish-speaking background, which includes the country of Spain, but excludes countries in Latin America such as Brazil and Haiti where Spanish is not the predominant language (Santana). The word Latino comes from the Spanish language and generally refers to those from Latin America. Latino is gendered as are almost all nouns in the Spanish language. Spanish nouns ending in "o" generally are masculine and nouns ending in "a" are generally feminine. Latino is the masculine form of the noun referring to a person from Latin America, and it can be used to refer to one male, groups of males, or groups with both males and females. The "x" in the word Latinx has no gender connotation in Spanish or in English. To be inclusive of people of all genders including non-binary and transgender people and to not emphasize masculinity over other identities, the word Latinx will be used in this body of work, except when referring to government data, which use the term Hispanic.

of any race and are identified as such in data tables. The OMB defines "Hispanic or Latino" as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race ("About Hispanic Origin"). People who identify with the terms "Hispanic" or "Latino" are those who classify themselves in one of the specific Hispanic or Latino categories listed on the decennial census questionnaire and various Census Bureau survey questionnaires – "Mexican, Mexican Am., Chicano" or "Puerto Rican" or "Cuban" – as well as those who indicate that they are "another Hispanic, Latino, or Spanish origin." The 2010 Census question on Hispanic origin included five separate response categories and one area where respondents could write in a specific Hispanic origin group. The first response category was intended for respondents who do not identify as Hispanic. The remaining response categories ("Mexican, Mexican Am., Chicano"; "Puerto Rican"; "Cuban"; and "another Hispanic, Latino, or Spanish origin") and write-in answers can be combined to create the OMB category of Hispanic ("About Hispanic Origin"). Although the OMB does not use the term Latinx, by categorizing individuals as either Hispanic or Latino or Not Hispanic or Latino, the term Latinx can be used interchangeably with the Census's use of Hispanic or Latino.

Studies have shown that immigrant children and native-born children of immigrant parents are more likely to lack health insurance and access to healthcare than native-born children of native-born parents (Calvo and Hawkins 2223). Some studies have shown that differences in utilization rates and access to care existing between Latinx and other minority groups and whites cannot be completely accounted for by low socioeconomic status or other financial barriers (García-Pérez 412). Non-citizen children of Latinx and Asian families have the lowest odds of having visited a doctor at least once in the last year and of having a usually place of care (García-Pérez 415-16). García-Pérez finds that parental nativity and region of birth for

particular groups were important determinants in their study in reducing the probability of a child having one or more visits to the doctor and a usual place of care, regardless of a child's citizenship status. This effect was even stronger for non-citizen children in immigrant families (García-Pérez 417). Children's lack of preventative care is reflected by their lower probability of having visited the doctor at least once a year and lack of care may translate into further higher health costs if a child suffering from a preventable condition is not treated on time because once a condition becomes acute, treatments become more expensive and riskier for the patient (García-Pérez 417). García-Pérez concludes that it is important to incorporate parents of children of immigrants into the formal health system in order to incorporate their children as well. (García-Pérez 417).

Calvo and Hawks find evidence that racial/ethnic minority children from immigrant families in the United States are more likely to report lower quality of healthcare than white children from nonimmigrant families, but that time in the United States increases the perceived quality of care of children from immigrant families. However, some disparities persisted even by the third generation and the indicators of quality of healthcare that contributed to the disparities varied between racial/ethnic groups (Calvo and Hawkins 2231). Regardless of racial/ethnic group and generational status, immigrant and native-born children with two immigrant parents lived most often in poor, uneducated, large families, in which English was not the primary language. Additionally, children of immigrant parents lacked health insurance and a regular place for healthcare more often, and reported excellent health status less frequently than children with native-born parents (Calvo and Hawkins 2225).

Disparities in health care for Latinx children are influenced by a variety of demographic and socioeconomic factors, according to Elizabeth Durden. Prior studies show that mothers make

the most investment in the children's health care and therefore Durden explores how a mother's nativity status and duration of time in the United States affect the healthcare her children receive (Durden 753). Overall, her research reflected that while socioeconomic status does greatly influence the type of regular care a child receives, other factors impact the usual source of health care (Durden 757). When measuring the usual source of health care – a clinic, a doctor's office, Emergency Department (ED) or some other place – Durden finds that children of foreign-born mothers are 71% and 75% more likely to report a clinic or an ED as their usual source of health care (Durden 757). Mexican and other Latinx individuals were much more likely to report an ED or a clinic as a usual place of care than non-Latinx white children (Durden 757). Her results suggested that children of immigrant women with shorter duration in the United States were less likely to use a doctor's office as their primary source of care, and while a mother's duration in the United States reflected less inequalities in access to a usual source of medical care (Durden 757).

Seiber identifies some more logistical hurdles for parents to enroll their children who are eligible for health insurance coverage like in-person applications at multiple locations, lengthy forms, and extensive documentation requirements (Seiber 530). Families of low income or mixed documentation status may not possess all necessary paperwork for applications or flexibility in terms of timing, due to multiple jobs with hourly pay. In order to increase access to care in light of such obstacles, some states have implemented multiple strategies like extending time between renewals of Medicaid, eliminating asset tests for Medicaid applications, and streamlining Medicaid verification requirements (Seiber 531). Still, such logistical challenges continue to exist for families of mixed-documentation status and low-income background. Enrollment disparities in Medicaid between children with undocumented parents and documented parents

may also arise from a “chilling effect” from local immigration attitudes and police agencies' immigration enforcement activities (Seiber 532). An immigrant family with any undocumented family members is unlikely to go to a Medicaid office located in a county government building that also houses a police station when a neighbor was deported after an encounter with local law enforcement (Seiber 532).

Vargas et al. compare healthcare access and utilization between Mexican-born undocumented and documented immigrants who are naturalized citizens or lawful permanent residents. Their findings are based on a large population-based study, the 2007 California Health Interview Survey (CHIS), which reported that undocumented immigrants from Mexico are 27% less likely to have a doctor visit in the previous year and 35% less likely to have a usual source of care compared to documented Mexican immigrants after controlling for confounding variables (Vargas et al. 152). Significant differences existed among Mexican immigrants, with undocumented Mexican immigrants, versus documented Mexican immigrants, facing a lower likelihood of having a doctor visit in the previous year or having a usual source of care. Documented and undocumented immigrants from Mexico faced the same probability of using the Emergency Department (ED), and experiencing delays in accessing drugs and other healthcare services (Vargas et al. 151).

Children of undocumented immigrants face obstacles to access to health care, amongst other difficult life circumstances, that are slightly different than documented or of legal status children with undocumented parents. Benuto et al. define the children of undocumented immigrants, or the “1.5 generation”, as individuals who arrived as children to the U.S. and are the first in the family to navigate growing up in the United States (Benuto et al. 199). Undocumented immigrants are at an increased risk for poverty and mental health and physical

health consequences while simultaneously less likely to have health insurance and access to regular primary care (Benuto et al. 201). While there are also immigration initiatives that provide temporary protections and opportunities to youth, these do not guarantee permanency or full access to opportunities. Because Congress was unable to agree upon a permanent legislative solution and various attempts to pass the Development, Relief, and Education for Alien Minors (DREAM) Act failed, President Barack Obama authorized the Deferred Action for Childhood Arrival (DACA) program in 2012, which gave qualified undocumented minors access to relief from deportation, renewable work permits, and temporary Social Security numbers (Benuto et al. 202). In September of 2017, the Trump administration ordered the Deferred Action for Childhood Arrivals (DACA) program to be rescinded and its protections phased out by March 5, 2018 (Lopez and Mackey).

As of February 14, 2018, the United States Citizenship and Immigration Services (USCIS) no longer accepts new requests for deferred action under DACA and only accepts renewal requests (Benuto et al. 202). DACA increased access to jobs, higher earnings, driver's licenses, health care, and banking (Gonzales et al., 2014), but this was temporary and limited and youth cannot plan for their future in the United States as they are not guaranteed one (Benuto et al. 202) Youth with DACA remain ineligible for Medicaid, CHIP and marketplace plans under the Affordable Care Act (ACA) (Lopez and Mackey). Their primary option for health insurance outside of college and employer-based insurance is to purchase a private health care plan, which may be costly to the individual (Lopez and Mackey). Eliminating DACA completely, however, could bring an end to this form of coverage, which typically comes at higher cost to the individual as there are no tax subsidies (Lopez and Mackey).

Health Care Access and the Fear of Deportation

These enrollment disparities may arise from a “chilling effect” from local immigration attitudes and police agencies' immigration enforcement activities. An immigrant family with any undocumented family members is unlikely to go to a Medicaid office located in a county government building that also houses a police station when a neighbor was deported after an encounter with local law enforcement (Seiber 531).

Hacker et al. address the perspectives of medical care providers on the impact of Immigration and Customs Enforcement (ICE) activity on immigrant health. Deportation fear has been associated with poorer self-perceived health and activity limitation following raids by ICE officers responsible for detaining and deporting individuals who violate immigration statutes (Hacker et al. 652). Deportation fear has also been associated with emotional distress for both documented and undocumented immigrants (Hacker et al. 652). ICE activities were found to negatively impact immigrant health from the perspective of primary care providers (PCPs) and emergency medicine providers (EMPs) who care for immigrant patients from Everett, a city with the fourth largest concentration of immigrants in Massachusetts (Hacker et al. 653). Their results concluded that deportation fear led to interrupted care and deportation fear also created perceived barriers to access. Over 40% of responses referred to “stress,” “fear,” and “anxiety” in their patients resulting from the threat of deportation (Hacker et al. 655). Concerns about ICE and deportation were also seen as obstacles to health care access. Patients feared that providing any documentation for insurance enrollment purposes would risk exposure (Hacker et al. 656). ICE presence in the community led to increased fear of deportation, not only among undocumented immigrants, but also among their U.S. citizen children and networks of families and friends. This pervasive fear led to health care avoidance, stress, and anxiety, all of which have profound effects on physical and mental health (Hacker et al. 660). Stressful experiences have been found

to adversely affect children's neurological and biological development, thereby adversely influencing their physical and mental health, as well as their cognitive, social, and emotional development (Thompson 42).

Primary care providers were far more likely than EMP's to identify negative effects of ICE on their patients (Hacker et al. 660). Hacker et al. raise several questions: are PCPs better at eliciting this information than EMPs or are immigrant patients more likely to reveal this information to PCPs? Primary care providers are well-trained in taking social histories and are thus well positioned to identify and address social factors related to health and improve health disparities. In contrast, EMPs are focused on urgent issues and may not obtain this type of information. So too, while many immigrants utilize emergency departments for care, it may be a difficult environment to discuss social and behavioral stressors given the acuity of the visit and the issues of flow within emergency departments. Overall, the establishment of patient-doctor trust is critical for the communication of sensitive information. While this relationship is valued in both primary care and emergency departments, it may be expressed to and by patients differently in the two settings. Circumstances such as privacy, time availability, and other contextual factors, are likely to influence what a patient will share, where and when (Hacker et al. 661).

Fear can result in care avoidance since authorities are perceived as threats for exposure of immigration status. Flight behaviors such as frequent moves also make it hard to contact patients to insure that recommendations on health conditions are met, leading to exacerbation of chronic conditions such as diabetes and hypertension. In other situations, the deportation of a single member can cause undue financial strain, tipping the balance of an already susceptible family and affecting children. This phenomenon has been noted following large-scale immigration

raids. More importantly, this chronic fear affects trust in “the system”—including the “health care system”—and ultimately can lead to social isolation and impact the social cohesion of neighborhoods and communities. Thus, the health of the already vulnerable immigrant population is placed at further risk (Hacker et al. 661).

33% of providers did not know their patients’ immigration status and more than half the providers did not identify a negative impact of immigration enforcement on their patients. Taking care of undocumented immigrants was highly correlated with reporting negative effects, as would be expected. Hacker et al. express concern over the number of providers who were unaware of their patients’ immigration status. Hacker et al. speculate that providers may have patient-doctor communication issues and the urgency of a patient’s visit may limit communication. It is also possible that the providers may actively avoid the question of documentation status so as to create a more welcoming atmosphere for the patient.

Health Care Access and the Public Charge Rule

Concerns about immigrants’ access to health care have been further increased by a public charge rule promulgated by the U.S. Department of Homeland Security on Feb. 24, 2020 that makes it more difficult for immigrants to obtain legal status if they use public benefits through Medicaid and the Supplemental Nutrition Assistance Program (SNAP). The new rule affects people applying for green cards and visas from within the United States, through a process known as “adjustment of status” (“The Public Charge Rule Explained”). Under this rule, persons labeled as potential public charges can be denied legal entry to the United States. They can also be prevented from adjusting their status from a nonimmigrant visa category (e.g., a student or work visa) to legal permanent resident status (Perreira et al. 901). Current guidelines define a public charge as a person who is primarily dependent on the government for more than half of

personal income. In evaluating whether a person is likely to become a public charge, immigration officials previously took account of factors such as age, health, financial status, education, and skills. The use of cash assistance for income maintenance (e.g., Supplemental Security Income or Temporary Assistance for Needy Families) and government-funded long-term care were considered in making these determinations. Other noncash benefits such as health and nutrition programs were specifically excluded from consideration, and use of cash-assistance benefits by the immigrant's dependents is not currently factored in (Perreira et al. 901).

The Trump administration substantially expanded the definition of a public charge to include any immigrant who "uses or receives one or more public benefits." Not just cash assistance but nearly all public benefits from federal, state, or local governments would be considered in public-charge determinations, including nonemergency Medicaid, the Children's Health Insurance Program (CHIP), and subsidized health insurance through the marketplaces created by the ACA (Perreira et al. 902). The public charge rule affects legal immigrants, as well as persons living in "mixed-status" families (those in which some members are citizens and others are not) and persons living abroad who wish to immigrate to the United States (Perreira et al. 902). Although several categories of immigrants (e.g., refugees, asylees, and immigrants with temporary protected status) are exempt from public-charge rules, confusion regarding applicability could deter even exempted immigrants from applying for essential benefits.

The new policy is predicted to have a chilling effect on lawfully present immigrants' use of public programs (Perreira et al. 902), discouraging immigrants from accessing health benefits for fear that doing so will render them a "public charge" and threaten their eligibility for legal permanent resident status and, eventually, citizenship. Research also suggests that the regulation could result in lower rates of health care utilization and poorer health among some immigrants

and their dependents. Lower rates of insurance coverage would reduce the use of prenatal and postnatal care and could therefore lead to higher rates of low birth weight, infant mortality, and maternal morbidity. They might well also result in forgone preventative care such as well-child visits, routine checkups, immunizations, and cancer screenings (Perreira et al. 903). Finally, for health care providers such as federally qualified health centers and public hospitals, the expanded public-charge rule could lead to more patients lacking health coverage and higher costs from uncompensated care. It could also create confusion among patients from immigrant families and jeopardize progress that has been made in improving access to health care among language-minority populations. If immigrants are to understand the crucial implications of the new rule, summaries of the changes and cautions would need to be disseminated through websites, public-service announcements, hotlines, and community outreach. In communicating with immigrant patients, health care providers, too, may need to explain the potential implications of the new rule (Perreira et al. 903).

Chapter 4. The Greater Philadelphia Latinx Immigrant Population as a Case Study

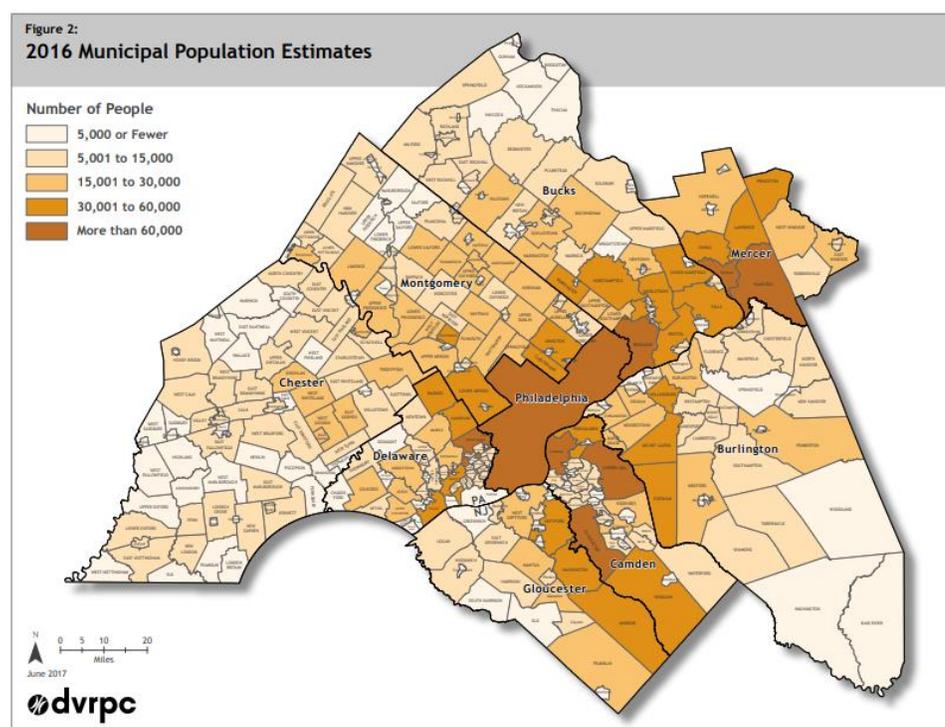
This chapter examines Latinx communities within the 11-county region of Philadelphia, also known as the Delaware Valley Region. Greater Philadelphia was identified by the Brookings Institution in a 2008 report as a “re-emerging immigrant gateway” region (“Philadelphia Immigrants”). The Delaware Valley Region or Greater Philadelphia encompasses Philadelphia County as well as parts of Montgomery, Bucks and Chester counties of Pennsylvania; Burlington, Camden, Gloucester, and Salem counties in New Jersey; and New Castle County in Delaware, and Cecil County in Maryland (“Population Estimates, DVRPC”).

The 2010 U.S. Census found that 190,000 people in Philadelphia County—12.3% of its total population—are Latinx (“Latinx Philadelphia Fact Sheet”). In July 2018, the census estimate for the population rose to 14.1% (“Latinx Philadelphia Fact Sheet”). The immigrant population of the city of Philadelphia makes up nearly 15% of city residents and nearly 76,000 children under age 18, or about one in four city children are immigrants (“Philadelphia Immigrants”). Of Philadelphia County’s Latinx population, about 120,000 people are Puerto Rican or of Puerto Rican descent, about 15,000 people are Mexican or of Mexican descent, about 4,000 people are Cuban or of Cuban descent, and about 45,000 people are of other Hispanic descent (“Latinx Philadelphia Fact Sheet”). In 2016, the city had more than 232,000 residents who were born abroad, who may also be referred to as immigrants (“Philadelphia Immigrants”). More than a quarter of all Philadelphians in recent years—estimated at around 390,000 residents—were either immigrants or U.S. natives with immigrant parents, together comprising a population with significant potential to shape the city (“Philadelphia Immigrants”).

The Latinx populations within Montgomery County and Chester County reflect similar trends (see Figure 4). Within Montgomery County, 2018 Census estimates find that of the total

population of around 828,000, approximately 44,104 residents are Hispanic or Latino (“Hispanic or Latino Origin by Specific Region”). Of those Hispanic residents, about 12,800 are Mexican and about Puerto Rican 12,100, with the remaining percentage identifying with other countries within Latin America. In 2018, Chester County had an estimated total population of close to 517,000 people, and close to 38,000 are Hispanic or Latino. Of the Latinx population, Mexicans amount to around 21,000 and Puerto Ricans total to more than 8,100 (“Hispanic or Latino Origin by Specific Origin”).

Figure 4. 2016 Municipal Population Estimates



Source: “Population Estimates, 2010- 2016, DVRPC's 28-County Extended Data Services Area. *Data Bulletin 100*, Delaware Valley Regional Planning Commission, 2017, www.dvrpc.org/Reports/DB100.pdf.

In terms of the status of immigrants across the 11-county metropolitan region, including the city, there were approximately 160,000 unauthorized immigrants (“Philadelphia Immigrants”). An estimated 50,000 undocumented immigrants reside in Philadelphia County, which accounts for about one in four foreign-born residents. More undocumented immigrants

live in Philadelphia than in any of the largest Northeast American cities, except New York City, according to research conducted in 2018 by the Pew Research Center (“Philadelphia Immigrants”). According to the City of Philadelphia’s own website, Philadelphia describes itself as a “Welcoming City” and notes that the city and region now have a higher proportion of immigrants than the nation as a whole for the first time since the 1980s (Waters). The report concluded that immigrants have become a major demographic force in Philadelphia in recent years, helping drive its population growth and altering the economic and social landscape in ways that pose both opportunities and challenges for the city. Philadelphia identifies its policy as a “Welcoming City” and became a sanctuary city in 2014, preventing city employees, including police officers, from holding someone in custody longer than they otherwise would solely because of their non-citizen status, and limiting the amount of information shared with the Department of Homeland Security about individuals released from custody, unless they were violent felons or the federal government had issued a warrant (Irby). Despite opposition from Republicans in Congress and in the state legislature and a threat from officials in the Trump administration to cut federal funding to sanctuary cities, Philadelphia has maintained its policy based on research that between officers and immigrant communities is essential to reducing crime and helping victims (Waters).

Existing Studies on Health Care Services for Latinx Immigrants in Greater Philadelphia

Based on Census Bureau data, in 2017, the population of uninsured in Pennsylvania was 692,000; in 2018, uninsured numbered 699,000 or 5.5% of population (Berchick et al.). A portion of the uninsured population in Pennsylvania are Latinx immigrant families. Within Greater Philadelphia, members of Latinx immigrant families face various obstacles to access health insurance and health services, as noted by several existing studies. Access to health care

services, as discussed previously, is affected by health insurance access as well as other care-seeking behaviors. Jennifer Atlas finds that in all three areas of health care—primary care, emergency care, and chronic care—there are shortages of services and barriers that prevent Mexican immigrants in Philadelphia from fully accessing the existing healthcare services and programs available to them (Atlas 192). Inaccurate demographic data on the Mexican population in Philadelphia and past national legislation hindering immigrants' access to public welfare benefits have created, exacerbated, and sometimes even justify such a shortage of services (Atlas 193). Community building efforts are in the early level of development in the Mexican immigrant community within Philadelphia (Atlas 193).

Michele Berger describes how some community building efforts are growing within the Greater Philadelphia Region, in Kennett Square, a borough of Chester County. In 2018, there were more than 50 farms in Kennett Square, producing 570 million pounds of mushrooms (Berger). Work on mushroom farms requires heavy lifting and significant manual labor, often on hands and knees, and the work is indoors, which means it can happen year-round (Berger). Laborers may be paid by crop yield rather than by the hour and they may work seven days a week to maximize their take-home pay (Berger). Many migrant workers in the United States will not live to age 50, a life expectancy that falls far short of life expectancy age of 78 for the population as a whole, according to the Centers for Disease Control and Prevention (Berger). Berger highlights the participation of health services outreach to Latinx migrant workers of the mushroom farms in Kennett Square. *Cultivando Juntos* or “Cultivating Together,” a 10-week community-based curriculum, created by University of Pennsylvania students José Maciel and Antonio Renteria, aims to bring a range of subjects like nutrition and sleep directly to the Kennett Square farmworkers. Its work reinforces checkups and health classes already provided

monthly by a local federally qualified health center called *La Comunidad Hispana* (LCH) (Berger). Their pilot will be launched at South Mill Mushrooms farm upon the Penn students' graduation in May 2020 and will be followed by similar interventions at eight more farms. The work done by LCH and Penn students aims to close the health outcome disparities and bridge the gap in access to health care services in Kennett Square.

In this body of work, I endeavor to discuss the economic, political, and social factors that impact the health access of Latinx children of immigrant families within neighborhoods of Montgomery, Chester, and Philadelphia counties in the Greater Philadelphia Region. The review of contributing factors will be followed by descriptions of a few case studies of community efforts to bridge the gap in access.

Addressing Linguistic Barriers

Work done by the Georgetown University Health Policy Institute highlights various factors that contribute to unequal access to health care in the United States, including English language proficiency. Emily Ihara, from the Georgetown University Health Policy institute, referring to work by Fiscella et al., notes that Spanish-speaking Latinx individuals are less likely than Whites to visit a physician or mental health provider, or receive preventative care, such as a mammography exam or influenza vaccination. Health service use may also be affected by the availability of interpreters. According to Collins et al., among non-English speakers who needed an interpreter during a health care visit, less than half (48 %) report that they always or usually had one (Ihara). The type of interpretation service provided to patients is an important factor in the level of satisfaction. In a study comparing various methods of interpretation, patients who use professional interpreters are equally as satisfied with the overall health care visit as patients who use bilingual providers. Patients who use family interpreters or non-professional interpreters,

such as nurses, clerks, and technicians are less satisfied with their visit. Racial and ethnic minorities are also more likely to have lower levels of literacy, often due to cultural and language barriers and differing educational opportunities. Low literacy may affect patients' ability to read and understand instructions on prescription or medicine bottles, health educational materials, and insurance forms, for example (Ihara).

Avila and Bramlett conducted a study to estimate Hispanic/non-Hispanic (nH)-white health disparities and assess the extent to which disparities can be explained by immigrant status and household primary language. They calculated disparities for various health indicators between Hispanic and nH-white children, and used logistic regression to adjust them for socio-economic and demographic characteristics, primary language spoken in the household, and the child's immigrant status. Controlling for language and immigrant status greatly reduces health disparities, although it does not completely eliminate all disparities showing poorer outcomes for Hispanic children. English-speaking and nonimmigrant Hispanic children are more similar to non-Hispanic white children than are Hispanic children in non-English speaking households or immigrant children. Hispanic/non-Hispanic white health disparities among children are largely driven by that portion of the Hispanic population that is either newly-arrived to this country or does not speak primarily English in the household (Avila and Bramlett 415).

Prior studies suggest that patient language barriers reduced the probability of follow up appointment after an initial visit to a hospital emergency department (Kalist 102). Fiscella et al. (2002) rejected the hypothesis that, in general, the poor health outcomes of Hispanics stem from cultural differences. They claim that the disparities in health between non-Hispanic whites and Hispanics result solely from language barriers, not ethnicity (Kalist 102). Pippins et al. find an association between language proficiency and utilization of preventative health care by Mexican

Americans (Pippins et al. 1020). Their study suggests that among insured Latinos, those with low English language proficiency have more negative experiences of primary care than their English language proficient counterparts, with decreased access (longer wait times and greater difficulty obtaining information or advice by phone) and less continuity (Pippins et al. 1022). Their findings are in keeping with past work demonstrating an association between low English proficiency and less timeliness of care, as well as poorer communication with providers and less helpful staff (Pippins et al. 1022).

Limited English Proficiency (LEP) status has been associated with fewer physician visits and fewer preventative services, even when controlling for other factors, whereas provision of interpreter services has been associated with increased receipt of services (Pérez-Stable 1010). Lack of regular source of care and longer waits in the waiting room were associated with LEP status. Thus, monolingual Spanish-speaking patients may be less assertive and less able to communicate their needs to either obtain regular medical care or to be seen in a timely manner at a physician's office (Pérez-Stable 1009). Pérez-Stable highlights the debate about whether medical professionals should be incentivized to learn Spanish for LEP patients or if LEP persons should "learn English: to improve communications with their clinics (Pérez-Stable 1010). The reality is that health systems are often unable to meet the demand for interpretation; patients often rely on their limited language abilities or ad hoc interpreters as professional interpreters may not be available according to Pérez-Stable (Pérez-Stable 1010). Clinicians often use their own limited language skills to bridge the gap and the quality of clinic communication may be compromised (Pérez-Stable 1010).

Some employers are hiring full time interpreters or utilizing non-medical bilingual staff to provide interpretation services. Other employers are seeking more bilingual medical

professionals (Kalist 103). LEP requirements stem from the Title VI of the 1964 Civil Rights Act and Executive Order 13166 (signed by President Clinton in 2000) (Kalist 103). In 1994, U.S. Congress mandated that the Office of Minority Health (OMH) address the issue of language barriers in the provision of health care (Kalist 103). LEP requirements apply to all recipients of federal financial assistance from the U.S. Dept. of Health and Human Services, such as hospitals, nursing homes, managed care organizations and physicians (Kalist 104). Failure to provide translation services, both oral and written, may result in tort liability, potentially requiring health-care providers to reimburse patients for the harm caused by lack of such services (Kalist 104).

Employers may have incentives to hire bilingual staff in order to meet LEP requirements (Kalist 104). American Medical Association (AMA) argues LEP requirements place an undue financial burden on physicians since it is common for a physician's cost of providing interpreter services to exceed Medicaid's reimbursement from the patient's office visit. It can be difficult to have interpreters in rural areas, who often have to travel from far away (Kalist 112). The American Nurses Association supports the requirements. Some nursing programs have already recognized the value of bilingualism and are offering courses in Medical Spanish (Kalist 115). David Kalist studies the effect of bilingualism on registered nurses' (RNs) wages. His findings suggest that some RNs command slight wage premiums, but it is also likely that in areas with large Spanish-speaking populations, when there is a larger supply of bilingual employees and professional interpreters, the language premium decreases (Kalist 115). Kalist recommends more research to be done in investigating the value of bilingualism in nursing as the Spanish speaking patient population continues to increase in the United States (Kalist 115).

Providing interpreters and employing bilingual employees can be seen as one method to approach providing culturally competent care. Patients' values, beliefs, and behaviors about

health and well-being are shaped by various factors such as race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation. Cultural competence in health care is broadly defined as the ability of providers and organizations to understand and integrate these factors into the delivery and structure of the health care system (Ihara). The goal of culturally competent health care services is to provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency or literacy. Common strategies for improving the patient-provider interaction and institutionalizing changes in the health care system include specific services offered, staffing choices, and other aspects of health care provision. In terms of patient services, health care facilities can provide interpreter services and provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials (Ihara). Within health promotion tools, cultural-specific attitudes and values can be incorporated in order to appeal to the perspectives of patients (Ihara). When it comes to the people involved in culturally competent health care, clinics can recruit and retain staff who look like their patients in terms of ethnicity and/or race (Ihara). This can provide greater potential for trust and open communication between staff and patients, which can lead to better patient outcomes.

When training staff, increasing their cultural awareness, knowledge, and skills can be incredibly beneficial. Staff training in culturally competent health care strategies is on the rise, and Ihara's study finds that training approaches that teach facts about specific groups are best combined with cross-cultural skill-based approaches that can be universally applied (Ihara). Teaching facts about specific groups may lead to stereotyping and may ignore variation within a group, however. For example, the assumption that all Latino patients share similar health beliefs

and behaviors ignores important differences between and within groups. Latinos could include first-generation immigrants from Guatemala and sixth-generation Mexican Americans in Texas. Even among Mexican Americans, differences such as generation, level of acculturation, citizenship or refugee status, circumstances of immigration, and the proportion of life spent in the U.S. are important to recognize (Ihara). That is why it is necessary to apply cross-cultural skill-based approaches because skills such as communication and medical history-taking techniques can be applied to a wide diversity of clientele. Curiosity, empathy, respect, and humility are some basic attitudes that have the potential to help the clinical relationship and to yield useful information about the patient's individual beliefs and preferences. An approach that focuses on inquiry, reflection, and analysis throughout the care process is most useful for acknowledging that culture is just one of many factors that influence an individual's health beliefs and practices (Ihara).

There are increasingly more state and federal guidelines that encourage or mandate greater responsiveness of health systems to the growing population diversity. Also, many health systems are finding that developing and implementing cultural competence strategies, including interpreter services, are a good business practice to increase the interest and participation of both providers and patients in their health plans among racial and ethnic minority populations (Ihara).

Addressing Bureaucratic Barriers

Researchers also identify other hurdles for parents to enroll their children who are eligible for health insurance coverage, including in-person applications at multiple locations, lengthy forms, and extensive documentation requirements (Ross and Hill 2003) (Seiber 204). States have implemented multiple strategies to facilitate enrollment in Medicaid, including expanding coverage to parents, extending time between renewals, eliminating asset tests, and streamlining

verification requirements (Kronebusch and Elbel 2004; Wolfe and Scrivner 2005; Sommers 2006; Summer and Mann 2006) (Seiber 204). Seiber also highlights that some states have sizeable refugee populations who may have moved to the United States after living their entire lives in tribal societies where health insurance and the Medicaid bureaucracy could be very alien concepts (Seiber 204). By anticipating some immigrant patients may lack comfortability navigating the health sector and training staff how to interact with such individuals, medical facilities can take another step towards providing culturally competent care.

There is evidence to suggest that non-medical staff play a particularly consequential role in shaping the experiences of undocumented immigrants. Frontline bureaucrats, such as receptionists and staff, are often the first people that prospective patients encounter when they try to schedule an appointment (Armenta and Sarabia 1). These workers can either connect immigrants to rights and entitlements, or exclude them through their roles as gatekeepers (Lipsky, 1980; Marrow, 2009; Maynard- Moody and Musheno, 2003) (Armenta and Sarabia 2). Thus, frontline workers can block access to doctors by withholding information, requiring particular kinds of documentation to access services (such as proof of income or residence), or lying about the availability of appointments (Deeb-Sossa and Bickham Mendez, 2008), they can act as brokers that help immigrants navigate health care institutions (López-Sanders, 2017), and they can bend the rules to ensure that undocumented immigrants receive medical services to which they may not technically be entitled (Marrow, 2009, 2012a,2012b) (Armenta and Sarabia 3).

Within the Latino community, the use of promotoras, also known as peer educators, is becoming increasingly popular. Promotoras are generally ordinary people from hard-to-reach populations who act as bridges between their community and the complicated world of health

care. When peer educators have similar cultural backgrounds, identify as the same ethnicity, or come from the same income level of patients, patients can develop greater trust in the information that they are provided. They can also form stronger connections with peer educators than they possibly would with some of the medical professionals. They learn about health care principles from doctors or non-profit groups, and share their knowledge with their communities. The peer education model is not only cost-effective, but also has been shown to be more effective in terms of reaching populations who find the information more credible coming from someone with a familiar background (Ihara).

Chapter 5. Interview Compilation and Analysis

In addition to drawing information from published sources, I conducted interviews to understand the goals, policies and challenges for organizations directly involved in providing health care to underserved communities. I chose to perform interviews with several non-profit staff members in the Greater Philadelphia area in order to gain insight from people who work on the ground on Latinx immigrant children's access to health care. I recognize that interviews offer "an important and distinct means of understanding contemporary political actions and outcomes" (Mosley 5). Using interview analysis, a researcher can interact directly with individuals and organizations on the front lines of this issue and assess the accuracy of general theories. Furthermore, interviewing allows researchers to test the applicability of research findings that are focused on different or broader populations. Interviews often serve as an essential tool for "making sense of political phenomena. Interviews allow scholars to interact directly with the individuals, or some of the individuals, who populate our theoretical models" (Mosley 2).

In March and April of 2020, I conducted extensive phone interviews with staff at two health clinics and one community outreach center that are located in Greater Philadelphia in order to get insight from those working directly with local Latinx immigrant families. This allowed me to go past hypothesizing about the challenges of providing adequate health care to Latinx families in the Greater Philadelphia area; it allowed me to actually investigate how area health care providers deal with these challenges. In short, these interviews gave a "direct window" into the issue (Mosley 4). I ensured minimal risk to participants by not including their real names. With regard to interview participants, all potentially had clients with undocumented status and thus maintaining participants' anonymity was important in order to protect their clients' vulnerable

position. Here, I identify participants by their job title and their organization type. I do not identify their organizations by proper name in order to further protect their clients and volunteer identities. I chose to interview leaders of organizations in a position to provide insights on the political, economic and social factors that affect the gap in access to healthcare for immigrant children and families. Interviewees were paid staff in leadership positions of their organizations who had worked for more than five years with their respective non-profit. The sampling was purposive rather than random for both theoretical and practical reasons. By interviewing individuals from organizations directly involved in providing health care for Latinx individuals and families in the local community, I was able to get rich information from interviewees with appropriate knowledge and experience. I also chose whom to interview out of practical considerations of accessibility. Since interviews took place over the phone, rather than in person, I spoke with people who had access to a phone and available time to interview. The interviews were aimed to synthesize some of this literature to generate an understanding of what gaps exist for access to healthcare services in the Greater Philadelphia Area. The interviews also shed light on how political, economic and social factors affect how local organizations seek to fill these gaps in care and how staff of these organizations view the sustainability and effectiveness of their work in the societal context in which they provide their services. I designed open-ended questions to allow interviewees to speak to topics such as what needs their organization serves, the characteristics of the population they serve, how the organization connects with the community and the clients it serves, what types of knowledge and support they provide to clients who are under/uninsured and/or undocumented, what obstacles the organizations face in delivering their services, how they recruit and maintain staff, volunteers and funding, and the overall mission and atmosphere of their organizations. As needed, I supplemented open-ended

questions with more targeted questions like “How are children specifically affected?” “What role do interpreters play in your organization?” and “Why does your organization not ask about immigration status of your clients?”. Interview answers proved to be consistent with the additional information I draw upon from some of their public brochures and information, demonstrating the validity of my qualitative interview data. To ensure reliability of interviews, I took electronic notes during the interviews and then completed comprehensive notes directly after each interview concluded. The interviews were not conducted back-to-back, but occurred several days apart.

Both health clinics included in this study work within the Greater Philadelphia Area and admit patients free of charge while operating as non-profit entities that rely on a small number of paid staff and many generous volunteers. They serve uninsured adults and children, mostly Latinx and from immigrant families. The clinics offer interpretation services, primary care and specialty care as well as low-cost and/or free prescriptions for medications and referrals to other health care facilities when necessary. Both clinics are built upon the belief that everyone should have a right to health care, no matter their income or insurance coverage or other barrier. I will differentiate between the two clinics by calling them the Nurse’s Center and the Health Clinic. The Nurse’s Center is a smaller facility, offers fewer hours, has a smaller staff and was founded by a Registered Nurse (RN). The Health Clinic is a larger facility, offers more extensive hours, has a larger staff and was founded by a physician and a minister. The Nurse’s Center provides primary care services, pediatrics, women’s health services, and nutrition counseling as well as lab tests. The Health Clinic provides primary care services, pediatrics, gynecology, professional counseling services, cardiology, internal medicine, allergy services, orthopedics and lab tests.

It is important to note that the Clinic and the Nurse's Center are both subject to the Health Insurance Portability and Accountability Act (HIPAA), which provides federal government standards and requirements for maintaining and transmitting health information. HIPAA defines and protects information that identifies a patient. HIPAA is relevant when considering how Latinx families can feel comfortable to come to these facilities and feel safe and protected. HIPAA is based on the concept that patients and families have a right to privacy and a right to know how their information is used and with whom their information is being shared. They can restrict use and disclosure of health information and limit the amount and kinds of information that can be released about them. All volunteers and staff at the clinic have a legal and ethical duty to maintain confidentiality and are bound to regard all patient information (including identity, diagnosis and condition, etc.) as strictly confidential. The value of both health clinics cannot be overstated. The organizations provide essential care to individuals who may not be able to find care anywhere else in their community.

The third case study, the community outreach center, is just one of many like it in the area that serves as a bridge from the locals to the medical professional world. It also provides key services that involve addressing social determinants of health, like access to education and food. Interviewing a staff person from a community outreach center emphasizes how the right to health and healthcare does not just begin and end with getting a doctor's care. The community outreach center gives further understanding of the populations that are in need of support and often may fall through the gaps, especially those who are English language learners (ELLs).

Case Study #1: Nurse's Center

To get a view inside the work and practices of the Nurse's Center, I spoke with one of their clinical coordinators. The clinical coordinator described some of the characteristics of their

patient population and identified a variety of issues that the staff and volunteers at the Center seek to address when it comes to providing care. Founded over 20 years ago, the Nurse's Center has a strong connection to its community yet still faces challenges. Patients often find out about the Center's medical services through the free community lunches provided by the church associated with the Center. The Center itself has a food pantry and encourages patients to take what they need. They have many returning patients who know the staff and long-time volunteers well.

The Center aims to provide a point of entry into the healthcare system, advance the health of the community, decrease use of emergency healthcare services, empower individuals to be responsible and engaged with their own healthcare, and provide holistic care with an emphasis on diet, lifestyle and health maintenance education. Its services include periodic health screenings for adults, children and women's health, physical exams, follow-up care and medicine, lab tests and referrals. The Center only serves those who do not have health insurance. It cannot serve those with insurance or provide them with medications prescribed by another doctor. Those who have health insurance who come to the Center are referred to other medical facilities in the area, such as La Comunidad Hispana (LCH), a nonprofit Federally Qualified Health Center that accepts patients with and without insurance, charging sliding scale fees based on income and family size ("About Us – Mission and Vision"). Patients may and frequently do contribute monetary donations to the Center, but the care they receive is free. Most patients are low income and if employed, do not receive health insurance through their jobs. The clinical coordinator informed me that many of the adults work in the mushroom fields in Kennett Square or in other manual labor jobs in the area, like landscaping. According to the clinical coordinator, many male adult patients work more than one job and still live below the poverty line. Their

most common diagnoses are diabetes, hypertension, hyperlipidemia, and obesity. To overcome significant financial difficulties of their patients, the Center stocks many generic prescriptions on site and provides them to patients who require them. If there is a medication that is not typically stocked, for example, medication for an eye infection, the patient is given a prescription that has the Center's logo on it. The clinical director explained that the local pharmacy where the patient is sent to fill the prescription understands that the pharmacy should bill the Center and not the patient. The Center also provides referrals to other health facilities when the patient requires more intensive care or lab testing that it cannot perform. The Center itself relies on volunteer service with over 45 volunteers providing three or more hours of service each month. The funds to support the Center come from the church associated with it, the surrounding community, United Way, Catholic Social Services, and one especially generous and passionate believer in the Center's mission who is a parishioner of the church.

The majority of patients, both children and adults, are Spanish-speaking and of immigrant background. The coordinator estimated that 90-95% of the patients are Latinx, many of whom are Mexican. All staff and volunteers know and abide by the policy of not asking about a patient's immigration status. As the clinical coordinator explained, "It's not relevant. There's no reason to ask and we don't need to know that. We don't want to create fear. We are here to take care of their health care needs, not report them to ICE." The coordinator also observed that patients typically do not bring up immigration status or the effects of immigrant background when speaking with the staff and volunteers. Because of the high volume of Spanish-speaking only patients, the Center employs three paid interpreters. The online website for the Center also has information provided in Spanish and often the instructions on how to take a certain medication are provided in Spanish to the patient. One interpreter may work alongside the front

desk and handle phone calls and those arriving for appointments, and the other two will be paired with an RN or NP who is communicating with a patient. The interpreters also assist with patient intake and help make the process of filling out new patient paperwork more efficient and smooth. The volunteers and staff are mostly English speakers, while there have been a few bilingual (Spanish and English-speaking) volunteers in the past. Those providing care do attempt to follow what the patient says and may occasionally use a few words of Spanish when communicating with the patient. Volunteers and staff have picked up bits and pieces of Spanish from their time at the Center, but they do express immense gratitude for the interpreters. The facility itself is small and limited in terms of the number of people it can physically accommodate and it offers limited hours, thus restricting its ability to serve more patients at more times. The Nurse's Center, however, by offering its services completely free of charge, with no sliding scale according to income, stands out from some of the other clinics in the area. Some visitors to the clinic insist that the fees at other clinics are too high, even though they adjust for income. The clinical coordinator admitted they did not understand the exact details of such occasional complaints, but could recall multiple instances when such issues arose. Other patients who do have insurance note the persisting obstacles to obtaining medication and care affordably.

The Nurse's Center faces high costs behind the scenes, and lab and pharmacy costs are the two most expensive items on the budget. The Center's online website highlights the need for donations and states that obtaining medications remains a challenge for patients and the Nurse's Center itself. The Center, like other non-profits, must continue to fundraise each year. The clinical coordinator admitted that the pediatric nurse and women's health nurse practitioner are both limited in their time commitments. The pediatric nurse is often swamped around back-to-school time when parents need their kids to be seen in order to fill out school medical paperwork.

Family health nurse practitioners will see children, but some only see children under 13 years old based on their own comfort level and expertise. Volunteer NPs and RNs also have other jobs and do their best to come consistently but sometimes have to limit their commitment. The Center faces the challenge of filling gaps in their volunteer base, when volunteers move on or face time commitments that limit their ability to serve for the Center.

What can be clearly seen is that the Nurse's Center's services are needed and relied upon by the community, and the staff believe in the work that they do and the foundations of the Center. On its website, the Center affirms its values and contributions, stating, "Founded, staffed, and led by nurses, we are committed to nurturing the physical and emotional health of our patients and respecting the sanctity of life. Belief that healthcare is a basic human right inspires and directs our efforts."

Case Study #2: Health Clinic

Turning to the other non-profit clinic included in this study, the Health Clinic's mission, according to its volunteer manual, is to "to provide quality health care services to the uninsured and underserved in an atmosphere that fosters dignity and respect for our patients. It is our privilege to do so." To get a view inside the work and practices of the Health Clinic, I spoke with two of their staff, their volunteer manager and their business office manager. They provided me with the volunteer manual, which they have all incoming volunteers review to understand the work and background of the Health Clinic. The Health Clinic serves patients who do not have insurance. The people who come to them do not qualify for Medicare or Medicaid. For a family/household of four individuals, the federal poverty level is \$26,200 annually ("Poverty Guidelines"). Patients who come to the Health Clinic often have an income that is just over the requirement based upon 150% or 200% of the federal poverty level guidelines. The volunteer

coordinator and business manager both emphasized the Health Clinic's status as a *free clinic*. When patients walk through the door, they get asked if they have insurance, and if they do not, for whatever reason, the Clinic can see them free of charge. The Clinic did provide the caveat that it sees those with non-urgent care needs, and it directed people to go to the closest hospital for emergency needs. When discharged from the hospital, the patient can come see someone at the Clinic. The Clinic gets about 150 to 200 patients during an average week. Its adult population is much larger than its pediatric population. The manager and coordinator speculate that a lot of children who come to the Clinic are on CHIP. However, they still will see children and continue to have children come in. A few weeks before our interview, the manager and coordinator recalled that two newborns had been brought into the Clinic to be seen. Upon receiving care, patients are asked if they would like to contribute to their care and the Clinic accepts donations, but it does not require them. People generally give something, according to both of my interviewees who described patients as "extremely grateful."

In their volunteer guidebook, the Clinic acknowledges the role that pride, stress and homelessness play in the lives of some of their patients. The guidebook discloses to its volunteers that patients may be dealing with a loss of pride when seeking charity medical care. The guidebook recognizes the pattern that many who come to the Clinic have suffered unfortunate symptoms for weeks, months, and even years before receiving care. The guidebook even goes as far to say that "Most of our patients truly do not have any other resource for medical care except the emergency room, and no other resource for dental care." Stress is another point the handbook addresses. Many of those who come the Clinic engage in the day-to-day survival associated with unemployment and poverty and therefore experience high levels of stress. Some patients work multiple jobs and still live under the federal poverty level with

numerous family members to support in their household. Their health issues may be severely compounded by stress. Stress related to immigration status and ICE raids may also compound health issues. Some of the Clinic's patients are homeless and may not have a regular place to sleep or have a regular diet. As a result, they may not be receiving the rest and nutrition they need to recuperate and the volunteers are made aware that "it may take longer to bring about the desired health care results."

The Clinic can provide for such a large body of patients with high need partially due to the fact that they have a very small staff and large volunteer base. Their 11-member staff team oversees the work of over 140 volunteers. The majority of their specialists are volunteers. All volunteers are asked for four hours weekly for a minimum period of six months, and per year, the Clinic benefits from over 12,000 volunteer hours. The Americares Foundation provides some medications to the Clinic at discounted prices so they can distribute them to patients free of charge. The Clinic also provides patients cards to get discounts at pharmacies for certain medications. Their development director has also been working to raise awareness about the work of the Clinic and increase its corporate fundraising funds. The Clinic relies on its endowment and corporate funders, and it shares newsletters and volunteer stories to donors so people can know what an impact they are making.

In addition to socio-economic status, the manager and coordinator explained how the Clinic's population is largely Latinx, many of Mexican background, and a lot are undocumented but "We don't know the numbers for sure because we don't ask." Patients just have to provide a picture ID. When prompted about the subject of ICE, the interviewees replied that the fear and concern about ICE goes mostly unspoken. There was a large push about the importance of the

census and the Clinic worked to build an initiative to have patients to fill it out without fear because it “could be tremendous benefit to them but they fear for themselves and their families.”

To address language barrier concerns, the Clinic has a full-time interpreter who answers phone calls and patients can make an appointment through her. There are also three other long-time volunteer interpreters, two of whom go into patient rooms. Other volunteers help in the lab and in the front desk area with interpreting. The manager and coordinator highlighted that to help with patient-doctor interactions, interpreters need to be certified medical interpreters in Spanish, which means they need to know medical terminology in Spanish, not just general Spanish vocabulary. There is also a device at the front desk that can serve as an interpreter, if patients want to ask the front desk for a referral or they need paperwork, but usually it is not used because there is almost always someone at the front desk who can interpret and help the patient. Patients are actually encouraged to bring their own interpreter if possible, and most do. If patients do not have a contact who speaks English or if they do not want a close family member who might serve as their interpreter to know about the private issue or condition, they are welcome to utilize the interpreters on site. In some instances, a child may interpret for the parents, but the Clinic tries to discourage having a child interpret unless it is very general information. Although a lot of the children who come to the clinic speak English, the Clinic would prefer for an adult to serve as an interpreter.

The volunteer handbook includes a section on language barriers. It advises volunteers to look and speak directly to the patient even when an interpreter is present, look for signs of comprehension difficulties and verify that patients understand what is being said. The Clinic educates its volunteers by informing them that many patients may speak English well enough for conversation but may need extra time and help understanding medical instructions. Moreover,

patients who utilize an interpreter may also understand and/or speak some English but may be more comfortable, when in a medical setting, with interpretation into their native language. The guidebook writes that when interpretation is successful, the intended message and its meaning are appropriately conveyed. It also emphasizes that volunteers should speak in normal, clear conversational tones, be on the lookout for a patient's non-verbal cues and ask open-ended questions rather than those which evoke yes/no answers.

The Clinic has a strong tie to the community and seeks to uphold its good reputation. Patients hear about the Clinic through word of mouth and through other non-profits in the area. The Clinic goes beyond providing just appointments with a medical provider. It is affiliated with a food bank and offers fresh produce once a week. It provides English learning classes, pregnancy classes, and information on CHIP through pamphlets as well as in-person consultation. It is actually currently functioning at capacity and physically cannot get any bigger. It also cannot expand its patient base much wider and must concentrate its efforts on just the greater urban area where it is located. Those who reside in the county and want to come to the Clinic but live farther away are referred to sites closer to their homes. The Clinic does not have the staff or physical capacity to help everyone in the county, according to the business manager. To keep up its volunteer base, the Clinic recruits new volunteers through the site called Volunteer Match, local church bulletins, and through associates of current or former volunteers at the Clinic. There is a fairly high turnover rate, and no one could really nail down the number of volunteers on any given day because it is ever changing. Volunteers also have their own medical issues and some days are harder to staff than others. The main push is to draw volunteers from the immediate region because people from farther away may want to come in but the commute time can be a serious hindrance. Most volunteers work from 8:45 to 12pm or 1pm to

4pm or some for a whole day, depending if their aim is to give two shifts a week. The volunteer coordinator and business manager also emphasized that patients really do try to give when they can. The business manager recalled a patient who paid \$6 the prior week all in change and added that the practice manager “really knows the patients” and she won’t let people “over donate when they are having a hard time.” The practice manager occasionally might approach patients and ask them again if they want to give and directly refer to the number of times they have come in and the types of care they have received. The business office also keeps track of trends, noting who patients see, when they come in, and what they give in donations. What the patients give, however, does not nearly compare to the endowment and corporate supporters. While the Health Clinic cannot and does not charge a fee for no shows and lab costs are very steep, it can rely on a steady stream of funds to support its services.

Both interviewees described the staff and volunteers as “very dedicated, from all different backgrounds,” explaining how many come in weekly and “give up their time and their talent.” Coming into the Health Clinic is something volunteers “look forward to” and “can’t put into words” but is a “very big part of their lives.” The volunteer coordinator emphasized the dedication that the founders had to treating everyone equally regardless of where they are from, their legal status, their income and their belief was that everyone should have health care. They also added that the physicians love the Health Clinic because they can practice what they love without red tape and time constraints. She referred to one doctor especially who “really loves his craft and enjoys not having to deal with all the paperwork.”

Case Study #3: Family Center

In the third interview I conducted, I spoke with the Executive Director/CEO of the Family Center, a community service agency that provides access to resources and programs and

describes itself as a “connector” in the human services network, facilitating access to health and educational services for English-language learners from early childhood to adulthood. The executive director described how the Family Center has been around for more than 40 years and one of its informational flyers used in fundraising campaigns describes it as “a safe haven for Spanish speakers in the area.” The informational flyer provided by the executive director greatly amplified the information provided during the interview. The executive director characterized the Family Center’s client population as low-income Latinos, many Puerto Rican and Mexican, who are residents of Montgomery County and surrounding areas. Families who come to the Family Center are often of mixed status, where some family members have documentation while others may not. Families are very low income, earning no more than \$25,000 a year per household and therefore below the \$26,200 poverty threshold set by the U.S. Department of Health and Human Services, for a family/household of 4 people (“Poverty Guidelines”). The Family Center’s resources and programs cover education, health, food, employment, housing and social services, especially for those with limited English. It offers services under three umbrellas: education, social services and health and wellness. Its staff is made up of two administrators, eight positions within the education department, five positions within the social services department and four positions in the health and wellness department. Some staff members serve in multiple positions. The Family Center also draws upon a large volunteer base, especially for its educational programs.

When it comes to providing for Spanish-speaking clients, all three departments of the Family Center combine to create strong communication pathways and English language learning opportunities. The informational flyer outlines the three departments in great detail. The Education Department encompasses pre-school educations for English Language Learners

(ELLs), adult basic education classes on English and civic engagement, parenting classes, after-school programs, and college prep programs. The executive director explained how staff within the Education Department are English speakers or bilingual, and are encouraged to speak mainly English with adults and children who participate in their programs. The executive director further informed me that the Social Services Department Health and Wellness Department staff are Spanish speakers who can communicate directly with English Language Learners (ELLs) and rarely is an interpreter necessary.

The role of immigration status or documentation status of Family Center clients shows up in various ways. The executive director estimated that less than 1% of the children in the after-school program do not have citizenship, but as mentioned earlier, most families are of mixed status. When asked about the subject of ICE and deportation, the executive director acknowledged that many Family Center's clients and participants suffer from "major stress and trauma from the fear that any day a family member could disappear." The Family Center does offer immigration consultations and case management along with immigration education/information workshops. It does not ask clients to reveal their status, according to the executive director, but it does conduct advocacy work so people are informed about options to vote, how to register to vote and how and why they should participate in the census.

When addressing access to health services, which can be especially challenging for low-income families and those who may not be familiar with the U.S. bureaucracy, the Social Services Department and the Health and Wellness Department work together to serve the community. The Health and Wellness staff provide benefits acquisition assistance to support individuals and families in obtaining insurance and access to health services as well as health literacy education. The health literacy education comes in the form of relevant preventative

health and chronic disease management classes and individual support including health information and health screenings to at risk adults. The mothers in the Family Literacy program learn how to manage these challenges in English as part of the Family Literacy program. The Health Literacy curriculum covers everything from learning parts of the body, identifying illnesses, contacting health professionals, filling out medical history forms, following instructions, and communicating with health professionals. The mothers also learn about the purposes and side effects of medications, how to read a prescription and how to administer different medications and dosages. Other topics include nutrition, exercise, and the importance of a healthy diet, especially in relationship to avoiding common conditions such as hypertension and diabetes. Lead poisoning, safety in the home, dental care, and other related topics are also covered. A bilingual pediatrician comes throughout the year to discuss different topics and illnesses related to children, and answers questions from the mothers. Health education is provided through informational sessions, food demonstrations and physical activities like Zumba and yoga classes.

The Social Services Department assists individuals and families to resolve housing, food insecurity and utilities concerns through case management. It also offers programs and workshops for larger groups and has helped thousands receive health insurance, primary care, dental care and other health services. It also provides referrals for mental health services and support groups. Other referrals connect individuals with income support, job and training opportunities. It has senior services to serve the aging population as well as fatherhood program to educate fathers of children in the after-school program.

The Family Center is well known throughout the surrounding area. Data on its website include annual statistics that provide a quantitative overview of its work and the large population

it serves. The after-school program hosts about 140 children. Within the Social Services Department, more than 3,000 individuals receive referrals or information yearly and more than 1,000 clients receive case management services yearly. Through the Health and Wellness Department, more than 800 applications for health insurance are submitted yearly and annual health fairs and clinics help over 300 individuals. The Family Center actually does not have to conduct much outreach at this point because it could actually end up with more clients than it could handle if it increases awareness. It recognizes that the services it provides are highly needed and consistently rely on donations, grants, and other fundraising avenues.

Interview Analysis

Strong connections between the three interviews underline the amount of need present amongst Latinx immigrant families and children in the Greater Philadelphia Area. All three organizations serve low-income, immigrant or recently immigrated families from Mexico and other Latin American countries and they generally have mixed-documentation status and/or mixed levels of English language proficiency. The organizations also serve Puerto Rican families with mixed levels of English language proficiency. In order to increase access to healthcare services in the Greater Philadelphia Area for low-income, English Language Learners (ELL) and Limited English Proficiency (LEP) families, especially for those with mixed-documentation status, all three organizations utilize various techniques. The Nurse's Center, the Health Clinic and the Family Center provide their services free of charge to the populations they serve. All three organizations are all built upon holistic approaches to health care and provide services such as food and education in addition to either providing or connecting clients with direct medical care. The Nurse's Center and the Health Clinic both use interpreters, and the Family Center employs many bilingual and Spanish-speaking staff. The Nurse's Center, the

Health Clinic and the Family Center do not ask questions about documentation status, but are aware of the large percentage of undocumented individuals they serve and seek to create welcoming, supportive, inclusive, non-fear inducing spaces.

Several general themes emerge from the three case studies that connect with current scholarly work. First, low-income status is one of the largest influences on health care access for Latinx individuals and families, explaining why they rely on non-profit centers that offer free or heavily subsidized medical services. When considering all three case studies, each served clients of low-income background. Individuals and families with minimal financial means relied on the non-profit centers to access health care. This finding coincides with a multitude of research studies, including work done by Fallek and Benuto et al., which find that undocumented immigrants are more likely to live in poverty while simultaneously being less likely to have health insurance and access to regular primary care. This double dose of vulnerability increases the need for non-profits like these case studies to continue the work they do. Typically, low paying jobs provide workers with very limited or no health insurance coverage at all. Furthermore, seeking medical care has its tradeoffs in terms of finances. Parents have to take off work in order to take themselves or their children to see a medical professional. Medications, along with seeing a professional, can be costly, especially for those without insurance. In order to afford housing and food costs, families often have to sacrifice spending money in the area of preventative health care services when their budgets are limited. This can lead families to postpone seeing any type of medical professional until an emergency situation arrives, in which case, treatment can be very costly. Children and youth who come from low-income families also experience pressures to join the workforce, which can affect their long-term economic well-being and access to health care. Joining the workforce earlier often translates into not pursuing higher education. Benuto et

al. writes that “this single factor of lack of access to higher education can affect the trajectory of an undocumented youth's life; they are more vulnerable to living in poverty, being exposed to dangerous or labor intensive employment, having no access to health insurance, and more” (Benuto et al. 199).

Second, legal status is an obstacle to accessing health care for many Latinx families, causing undocumented individuals and mixed-status families to delay seeking health care and turn to non-profit centers that do not ask questions. The fact that families of mixed-status turn to non-profit centers that do not ask questions is a well-documented trend beyond this study. Hacker et al. find that deportation fear affects both documented and undocumented populations. An immigrant family with any undocumented family members is unlikely to go to a Medicaid office located in a county government building that also houses a police station when a neighbor was deported after an encounter with local law enforcement (Seiber 532). Whether insured or not, immigrants are more likely to continue to seek services at Community Health Clinics (CHC) and Local Health Departments (LHD) because of trusted relationships, locations in the community, and enabling services such as language access that they rely on (Ambegaokar 1). Durden’s case study of Philadelphia children accessing medical care finds that Mexican and other Latinx families compared with non-Latinx white children were much more likely to report an ED or a clinic as a usual place of care (Durden 757). Enrollment disparities between children with undocumented parents and documented parents may also arise from a “chilling effect” from local immigration attitudes and police agencies' immigration enforcement activities (Seiber 532).

Third, trained, culturally sensitive interpreters are key to providing quality health care. The Health Clinic and the Nurse’s Center both employed and relied on volunteers to provide interpreter services. The Family Center consistently employs native Spanish speakers and

bilingual speakers to work with clients. Clearly, sympathetic interpreters are key to providing quality health care. Limited English Proficiency (LEP) status has been associated with fewer physician visits and receipt of fewer preventative services, even when controlling for other factors, whereas provision of interpreter services has been associated with increased receipt of services (Pérez-Stable 1010). A recent study by Pippins et al. suggests that among insured Latinos, those with low English language proficiency have more negative experiences of primary care than their English language proficient counterparts, with decreased access (longer wait times and greater difficulty obtaining information or advice by phone) and less continuity (Pippins et al. 1022). Their findings are in keeping with past work demonstrating an association between low English proficiency and less timeliness of care, as well as poorer communication with providers and less helpful staff (Pippins et al. 1022).

Many health systems are finding that developing and implementing cultural competence strategies are a good business practice to increase the interest and participation of both providers and patients in their health plans among racial and ethnic minority populations (Ihara). Tucker et al. highlighted people skills and language as two of the key elements to culturally sensitive health care according to the patient perspective (Tucker et al. 866). The importance of language goes beyond knowing basic Spanish vocabulary when working with Spanish-speaking ELLs. Technical medical language competency is also necessary to facilitate clinical encounters between doctors and patients as well as the appointment desk, advice lines, medical billing, and other written materials (Ihara). Physicians relying on interpreters must also demonstrate effective communication skills for successful health encounters, which includes eye contact with the patient, not the interpreter. In her cultural guide for health care providers serving Latinx patients, Chong highlights the importance of other culturally effective communication skills. Shaking a

patient's hand at the start and end of a medical appointment and expressing interest in the well-being of patient's family are other methods to establish trust and more open communication between Latinx patients and medical professionals (Chong 125). Studies support that effective utilization of interpreters and culturally competent care, through empathy, friendliness, time allotted and courtesy, have had positive associations with patient health outcomes (Tucker et al. 867).

Fourth, lack of resources and emotional stress compound health problems. The health problems that patients experience who come to the Health Clinic, the Nurse's Center and the Family center are all compounded by lack of resources and emotional stress. As noted previously, some of the hurdles that prevent parents from enrolling their children who are eligible for health insurance coverage can include in-person applications at multiple locations, lengthy forms, and extensive documentation requirements (Ross and Hill 2003) (Seiber 204). This lack of resources or difficulty in accessing resources can make it less likely for patients to receive timely care. Frontline bureaucrats, such as receptionists and staff, can connect immigrants to rights and entitlements and they can act as brokers who help immigrants navigate health care institutions (Armenta and Sarabia 1). They can provide and serve as greatly needed resources to clients like those of the case studies.

Hacker et al. find that the deportation of a single member can cause undue financial strain, tipping the balance of an already susceptible family and affecting children. This phenomenon has been noted following large-scale immigration raids (Hacker et al. 661). The chronic fear affects trust in "the system"—including the "health care system"—and ultimately can lead to social isolation and impact the social cohesion of neighborhoods and communities. Thus, the health of the already vulnerable immigrant population is placed at further risk (Hacker

et al. 661). This directly connects to the trauma and stress the Family Center CEO referred to that clients of the Family Center experience. Hacker et al. find that over 40% of their responses from patients referred to “stress,” “fear,” and “anxiety” resulting from the threat of deportation (Hacker et al. 655). While volunteers and staff at the Health Center and the Nurse’s Center are trained to anticipate certain stressors amongst their patient population, they also are not always aware of the documentation status of their clients. Other studies find similar trends in medical staff being in the dark about patients’ immigration status. Hacker et al. finds that in Everett, Massachusetts, 33% of providers surveyed did not know their patients’ immigration status. The number of providers who were unaware of their patients’ immigration status is notable and is a matter of concern. It is unknown whether this is due to patient-doctor communication issues, urgency of visit, or lack of provider knowledge (Hacker et al. 661).

Fifth, a holistic approach to health, inclusion of education and nutritional programs, is vital. Beyond strategic interactions between patients and doctors, receptionists, and interpreters, health and wellness should be approached from a holistic perspective through the incorporation of education and nutritional programs. All three case studies offered educational opportunities for patients. At the fundamental level, primary health care should seek to combat the main health problems in the community by providing “promotive, preventive, curative, and rehabilitative services,” especially in, but not limited to, the areas of maternal and child health; the prevention and control of infectious, nationally common, and locally endemic diseases; treatment of injury; adequate supplies of safe water and basic sanitation; the promotion of food supply and proper nutrition; and the provision of essential drugs (UNICEF et al.). The American Pediatric Academy argues that improving certain government programs that address poverty (like the earned income tax credit, Supplemental Nutrition Assistance Program, housing subsidies and the

Special Supplemental Nutrition Program for Women, Infants, and Children) can further this goal of addressing children's health concerns (Jenco). The nutritional and educational programs, like the ones provided by the Family Center, can create a bridge to direct health care services like doctor appointments. Ihara advocates for more promotoras in the community to engage with vulnerable but hard-to-reach communities, like undocumented and mixed-status families. Ihara describes promotoras as generally ordinary people from hard-to-reach populations who act as bridges between their community and the complicated world of health care. Promotoras distribute knowledge about health care principles that they learn from doctors or non-profit groups and share their knowledge with their communities. The peer education model is not only cost-effective, but also has been shown to be more effective in terms of reaching populations who find the information more credible coming from someone with a familiar background (Ihara).

Finally, non-profit organizations that provide health care and other social services to members of the local Latinx community face an ongoing challenge to serve all those who need and/or want their services and to continue attracting necessary volunteers and funding. Non-profit organizations, like the Family Center, the Health Clinic and the Nurse's Center that provide health care and other social services to their local Latinx community, face an ongoing challenge to serve all those who need and/or want their services and to continue attracting necessary volunteers and funding. One of the reasons the clinics are experiencing such high demand is they have established trust with their patient base and are less limited than Emergency Departments in their time constraints. Hacker et al. identify primary care providers as well positioned to identify and address social factors related to health and improve health disparities due to their training in taking social histories. Hacker et al. also highlight that Emergency

Departments are focused on urgent issues and may not obtain information about social and behavioral stressors due to high flow of patients in Emergency Departments and the urgency of that patient's visit. However, all three organizations mentioned their limited capacity and how they cannot serve as many clients as they would like. They rely on the ability to refer people to other facilities and both the Health Clinic and the Nurse's Center mention La Comunidad Hispana as one such option. As discussed previously, in the Kennett Square area, the local federally qualified health center called La Comunidad Hispana (LCH) provides checkups and health classes. It is supported by a program Cultivando Juntos or "Cultivating Together" facilitated by Penn students (Berger).

These interviews with staff from the Family Center, the Nurse's Center, and the Health Clinic provide insight into the inner workings of non-profit organizations in the Greater Philadelphia Area that serve Latinx immigrant families. The interviews support findings within other scholarly work on Latinx children immigrants access to health services. Children of Latinx immigrant families in the Greater Philadelphia Region face obstacles to receiving preventative, nonemergency care from primary physicians, and their families may turn to community health clinics, because of lack of insurance, fears of deportation and concerns about barriers to effective communication with medical professionals because of limited English proficiency. Communities are attempting to provide welcoming spaces for health care access for Latinx immigrant children and families. The Family Center, the Nurse's Center, and the Health Clinic continue to experience high demand and cannot serve as many clients as they would like. The work of these organizations to eliminate barriers to health care related to income, immigration status, and English proficiency serve as strong examples for others to follow.

Chapter 6. Implications

While non-profit clinics and community outreach centers are attempting to fill the gaps that exist due to current state and national healthcare policies, inequitable access to healthcare services for children of Latinx immigrant families still exists. For there to be equal access to healthcare services for all children in the Greater Philadelphia Area, regardless of native language, immigration status, or socioeconomic class, it will take major policy changes. Upon evaluation of the information drawn from scholarly literature and interviews conducted in this study, I propose three policy suggestions along with further areas for policy development to address the inequitable state of healthcare access. On the local level, non-profit organizations should tap into more local partnerships and conduct more specialized training to have more medical interpreters competent in Spanish and English. On the state level, the Pennsylvania legislature can take the step that other states, like Massachusetts, have taken and extend CHIP and Medicaid coverage to all children of any immigration status. Non-profit organizations are struggling to meet the rising level of need and demand for their services from people who are uninsured. Greater numbers of insured children can expand their families' options to seek primary care physicians. On the national level, it is highly advisable that the public charge rule, which went into effect February 2020, be revoked so as to create a more conducive environment for immigrant families and their children to enroll in programs such as CHIP and Medicaid. We must also begin to evaluate how to encourage all medical professionals to embrace the holistic approach to providing health care services, through education, nutrition and fitness programs, and networking with social services.

(1) Local level: Increasing Availability of Bilingual Medical Interpreters

Given the fact that more than 25 million Americans speak English “less than very well,” according to the U.S. Census Bureau, and more than 60 million speak a language other than English at home (Juckett and Unger), there must be greater numbers of medical interpreters and bilingual medical professionals competent in Spanish and English readily available and trained in culturally competent care. Local community connections can foster greater availability of interpreters. Despite widely recognized need for interpreters, the reality is that health systems are often unable to meet the demand for interpretation. This includes clinics, primary care physicians and emergency rooms. Patients often rely on their limited language abilities or ad hoc interpreters as professional interpreters may not be available (Pérez-Stable 1010). Clinicians often use their own limited language skills to bridge the gap and the quality of clinic communication may be compromised (Pérez-Stable 1010).

According to the Patient’s Bill of Rights, which is part of the Consumer Bill of Rights and Responsibilities that was adopted by the U.S. Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1998 (HealthSource), patients who do not speak English should have access, where possible, to an interpreter (Youdelman 271). Patients who are covered by programs like Medicaid and those who receive health insurance subsidies created under the Affordable Care Act and CHIP that rely on federal funding are also legally entitled to have access to interpreters. Following the passage of the 1964 Civil Rights Act, which prohibits discrimination based on race, color or national origin in all programs or activities receiving federal funding, the courts made it explicit that “discrimination based on national origin included the failure to provide language services to non-English speakers” (Ollove). The Clinton administration extended the reach of the law not just to programs that received federal funds but

to federal programs themselves, and the Obama administration issued instructions informing medical providers how to comply with the law, yet the Trump administration has proposed to either weaken or eliminate those requirements (Ollove). At the state level, Pennsylvania's Bureau of Professional and Occupational Affairs supplies translated signs of patients' rights to health care practitioners who treat non-English speaking Medicare beneficiaries, which they are required to post (Youdelman 270). Pennsylvania law also holds that "When it is substantiated that the regular patient population of the hospital contains a foreign language speaking population for whom the language barrier constitutes a service disadvantage, the hospital should have a roster of bilingual personnel or volunteers, or both, and post bilingual signs and have other printed materials, such as hospital handbooks, medical care instructions and follow-up care, readily available" (Youdelman 271).

In addition to the legal obligation to provide culturally and linguistically appropriate care, scholarly studies have overwhelmingly found that language barriers in health care for Latinx patients have significant detrimental effects on "quality of care, including misdiagnosis, prescribing inappropriate medications, lack of patient information leading to poor compliance, lack of follow-up, and a decrease in preventive services" (Juckett and Unger). Another study reporting similar findings states that "quality of care is compromised when LEP patients need but do not get interpreters. LEP patients' quality of care is inferior, and more interpreter errors occur with untrained ad hoc interpreters. Inadequate interpreter services can have serious consequences for patients with mental disorders." (Flores 255). Patients with limited English proficiency are much more likely to have adverse effects from drug complications, poor understanding of diagnoses, low health literacy, and a greater risk of being misunderstood by their physicians (Juckett and Unger). To address this gap in quality of care, "Trained professional interpreters and

bilingual health care providers positively affect LEP patients' satisfaction, quality of care, and outcomes. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when LEP patients have access to trained professional interpreters or bilingual providers" (Flores 255).

Language barriers are a particular problem for Latinx patients, given that about 61% of the foreign-born population in the United States from Latin America and the Caribbean speaks English "less than very well" and 40% do not speak English well or at all (Gambino et al. 6-7). Individuals from countries with large resident populations in the United States are more likely to have lower English-speaking ability, which affects residents born in Latin American countries. 47% of Mexicans, 45% of Dominicans, 49% of Guatemalans, 43% of Cubans, 48% of Hondurans and 45% of Salvadorans report that they do not speak English well or not at all (Gambino et al. 8). Despite the need for and benefits of medical interpreters, wide gaps continue to persist in making interpretive services available. Even though federal civil rights policy obligates health care providers to provide language assistance, the federal government does not provide funding to reimburse the costs of interpretation and only a handful of states reimburse medical providers for interpreter services (Ku and Flores).

To increase the presence and availability of interpreters, at the community level, health clinics can build volunteer interpreter networks in addition to paying interpreters. The Nurse's Center and the Health Clinic provide a strong example for other clinics, emergency rooms and primary care offices to follow. Both facilities recruit volunteer interpreters (in addition to paid interpreters) from various community connections. The Health Clinic has a large retiree volunteer base, and the Nurse's center relies on the local affiliated church. The Nurse's Center also recruits volunteer nurses from a nursing program at a local college. Facilities that offer

health care services and serve Latinx populations that are English Language Learners (ELL) have a variety of pools to source interpreters from. In areas where there is a sizeable population of ELL, there are often bilingual speakers as well. Employing locals would be a great form of connecting the community to the health care system and building more trust. Furthermore, college and high school students interested in Spanish language acquisition could be given concrete opportunities to apply their education through volunteer interpreting. For example, La Comunidad Hispana has established connections with area colleges and universities, offering service learning opportunities for students interested in careers in medicine and public health as well as social work. Such partnerships could be expanded to include Spanish language learners. Members of religious and faith organizations may also be motivated to serve as unpaid interpreters as a way to practice their beliefs in generosity and giving back to the community. The Nurse's Center pools from of its volunteer RNs from parishioners of the affiliated church and other health facilities like it can work to draw in greater numbers of Spanish-speaking volunteers to serve as interpreters as well. Community Health Clinics (CHC) and Local Health Departments (LHD) that offer translation and interpretation services, not only improve the quality of care and health outcomes for their patients, but can also connect eligible immigrants to affordable care options (Ambegaokar 4).

The interpreters who are recruited will also need to have certain skills such as medical vocabulary and learn how to interact with patients in a culturally appropriate manner so that they convey concern and respect while interpreting. They should have an awareness of specific stressors for immigrant and low-income families. Not only interpreters but physicians, front-desk attendants and other staff within medical facilities play a role in providing culturally competent care. For example, physicians relying on interpreters must demonstrate effective communication

skills for successful health encounters, which includes eye contact with the patient, not the interpreter (Ihara). Hacker et al. suggest numerous actions medical providers should take in addressing such fears and anxieties in order to provide proper care to patients. Providers should be encouraged to: 1) Consider how the current climate of immigration enforcement and the resulting deportation fear might affect their patients' health and health access. 2) Understand the realities of access to health care and various entitlements in their area. 3) Ensure that the clinical environment is seen as safe. This could be accomplished with visual cues (notifications that explain confidentiality rules), by office staff, or by the providers themselves. 4) Utilize strategies that clarify security within the health care system that might involve communication with places frequented by immigrants, such as churches, ethnic grocery stores and restaurants, and social service agencies (Hacker et al. 662). Understanding how individuals are coping with this uncertainty and how this affects their financial stability can assist the provider in treatment planning. Are they coping at all? How is stress impacting their relationships and their daily lives? Furthermore, to understand the realities of immigrants' lives, short training programs have been shown to improve pediatric residents' knowledge (Hacker et al.).

Latinx patients also have cultural values and backgrounds that staff and medical professionals should become familiar with. Ethnicity shapes peoples' perceptions of health and trust of health professionals, along with immigration status. Culturally competent care also involves development of culturally appropriate body language, including handshakes, and verbal expressions of empathy, connection and willingness to spend time, rather than rush, a patient during a medical appointment (Ihara). *The Latino Patient: A Cultural Guide for Health Care Providers* by Nilda Chong is just one of many options professionals working within the medical

environment have when expanding their understanding and appreciation for culturally competent care for Latinx patients.

(2) State level: Expanding Health Insurance Coverage to All

Expanded health insurance coverage has been shown to have economic and health benefits to those who gain health insurance, lowering mortality rates and improving education and employment outcomes. For hospital systems, which are charged with providing care regardless of insurance coverage, “Conversely, high rates of uninsurance have considerable financial implications... and adversely impact community access to quality health care for local residents even if they are insured” (McConville et al.). The COVID-19 crisis further demonstrates the detrimental impact that lack of health insurance and inaccessibility of safe, affordable health care have on public health more broadly. While hospital emergency departments and the kind of community health clinics discussed in Chapter 5 provide a safety net for uninsured and low-income individuals regardless of immigration status and ability to pay, these resources “are not equivalent to having comprehensive health insurance” (McConville et al.). Hospital emergency departments experience overflow and overcrowding and due to limits of space, budgets, time and personnel, donation and charity based clinics can only serve so many people.

At the federal level, health insurance coverage through Medicaid and CHIP are available to eligible “qualified” immigrants who entered the U.S. before August 22, 1996, and those who have held a “qualified” status for five years or longer. Refugees, asylees, veterans, and active duty military and their spouses and children can get Medicaid or CHIP without a five-year waiting period (National Immigration Law Center). Other “qualified” immigrants who have not fulfilled the five-year waiting period, young adults with DACA status and undocumented

immigrants are not eligible under federal policy for Medicaid or CHIP (Lopez and Mackey). Documented immigrants, who are residents of states that opted into the Affordable Care Act, may purchase private health coverage through the state health insurance exchange. This does not apply, however, to young adults with DACA status or other undocumented immigrants who are not eligible to purchase health insurance through the ACA (Lopez and Mackey).

Policymakers in states like Massachusetts, California and several other states have taken action to address this problem, extending benefits to undocumented immigrants. As discussed in Chapter 2, as of 2017, six states plus Washington DC had inclusive health care policies for immigrant children. The six states include Illinois, Oregon, Washington, New York, Massachusetts and California (Pew Charitable Trusts). In Illinois, all children under 300% FPL, regardless of immigration status, can get coverage through the All Kids program, an Illinois specific program (National Immigration Law Center 2). Oregon allocates state funds to cover all children regardless of immigration status (National Immigration Law Center 4). In Washington, regardless of their immigration status, children in households with income below 215% FPL are eligible for CHIP and Medicaid without a share of cost. Children in families earning between 215% and 317% FPL, regardless of immigration status, are also eligible for CHIP and Medicaid, but monthly premiums are required (National Immigration Law Center 5). In Massachusetts, all children, regardless of immigration status or income, are eligible for primary and preventative care through the Children's Medical Security Plan (CMSP) (National Immigration Law Center 3). Massachusetts additionally allocates federal funds to provide full-scope medical services for pregnant women up to 200% of the federal poverty level, regardless of their immigration status (National Immigration Law Center 3).

Before 1996, some “unqualified” immigrants were served by benefit programs under federal policy based on the eligibility category called “permanently residing in the U.S. under color of law” (PRUCOL). PRUCOL is not an immigration status, but a benefit eligibility category that has been interpreted differently depending on the benefit program and the region (Broder et al. 2). PRUCOL applies to individuals who are neither U.S. citizens nor lawfully admitted for permanent residence; i.e., those who entered the United States either: lawfully in a status other than lawful permanent residence; or unlawfully (“Permanent Residence under Color of Law (PRUCOL)”). Generally, PRUCOL means that the Dept. of Homeland Security (DHS) is aware of a person’s presence in the United States but has no plans to deport or remove him or her from the country. A few states continue to provide services to immigrants meeting the PRUCOL definition using state or local funds (Broder et al. 2).

In New York, “Qualified” immigrants and PRUCOLs are eligible for CHIP and Medicaid, along with all lawfully residing children and pregnant women. In addition, prenatal care is available regardless of immigration status. Moreover, all children, regardless of immigration status, are covered under the state Child Health Plus program (National Immigration Law Center 4). Arthur Fried utilizes New York’s PRUCOL policy as an effective method to avoid hospital overcrowding. Hospitals must admit patients for emergency care, including undocumented individuals (Fallek 3), as discussed in Chapter 2. Fried highlights how hospitals can be overwhelmed by ‘permanent residents’ who have no insurance or other way to pay for the long-term care they do need, and without a safe place to which discharge is available for these patients, hospitals must continue to provide for their care (Fried). However, when undocumented individuals fall under the umbrella of PRUCOLs and therefore can have health insurance, once their need for acute care in a hospital has been addressed, they can be discharged from the

hospital to another medical professional facility, and that hospital does not have to continue to provide for their care (Fried).

In Massachusetts, “qualified,” lawfully present, and PRUCOL immigrant children under 19 years old are eligible for Medicaid and CHIP up to 300% federal poverty level (FPL). Also, “Qualified,” lawfully present and PRUCOL 19- and 20-year-olds are eligible up to 150% FPL (National Immigration Law Center 3). In California, PRUCOLs can receive Medicaid and CHIP (National Immigration Law Center 1). PRUCOLs are eligible for California state health care, Medi-Cal (McConville et al.).

California adopted universal health care access for all children regardless of immigration status in 2016 (Williams et al.). In 2017, California’s state Medicaid program covered 86% of eligible undocumented children, and “Close to half were new enrollees, while the rest were transitioned from a more limited version of Medicaid that only paid for emergency treatment” (Williams et al.) In 2019, after the state extended health care coverage to young adults ages 19 to 25 regardless of status in an effort to further drive down their uninsured rate, an estimated 97 percent of California children had health coverage (Williams et al.).

It would be in Pennsylvania’s best interests to adopt the same policies as other states that have extended benefits to all children immigrants, regardless of immigration status. Pennsylvania is currently allocating some of its federal funding to offer Medicaid and CHIP coverage to lawfully residing children and pregnant women, *regardless of their date of entry into the U.S.* (National Immigration Law Center 4). Pennsylvania offers more inclusive coverage than the federal standard, but it is not doing enough. Pennsylvania policy does not include undocumented children or DACA individuals as eligible for Medicaid or CHIP. It could utilize methods of any of the six states along with Washington D.C., to extend health care coverage. By extending

Medicaid and CHIP eligibility to all children immigrants, regardless of immigration status, the state of Pennsylvania can increase accessibility of safe, affordable health care, increase its number of insured children, increase utilization of primary care physicians, reduce hospital overcrowding, and produce an environment that is conducive to overall better public health.

(3) Federal level: Ending the Public Charge Rule

Growing research suggests that “recent changes to immigration policy are contributing to growing fears among immigrant families about their and their children participating in Medicaid and CHIP” (Kaiser Family Foundation). Changes to public charge policy that allow federal officials to “newly consider use of certain non-cash programs, including Medicaid for non-pregnant adults, when determining whether to provide certain individuals a green card or entry into the U.S. are leading to growing fears that will likely lead to coverage declines” (Kaiser Family Foundation). Coverage declines would have “important implications” for the health and well-being of families and the health care system (Kaiser Family Foundation).

Considering the overwhelmingly harmful effects from this new public charge rule anticipated by experts in the public health and public policy fields, the public charge rule needs to be revoked. As mentioned in Chapter 3, the new public charge rule under U.S. Department of Homeland Security’s took effect on Feb. 24, 2020. U.S. Citizenship and Immigration Services (USCIS), justifies this change on their website, citing that “self-sufficiency has long been a basic principle of U.S. immigration law since our nation’s earliest immigration statutes” (“Public Charge”). USCIS further elaborates that “Since the 1800s, Congress has put into statute that aliens are inadmissible to the United States if they are unable to care for themselves without becoming public charges. Since 1996, federal laws have stated that aliens generally must be self-sufficient” (“Public Charge”). The Center on Budget and Policy Priorities anticipates that this

policy will lead some “immigrants to forgo health coverage or nutrition assistance for themselves or for their infants, preschoolers, and school-age children and families to forgo tax credits like the Earned Income Tax Credit (EITC) for which they are eligible” (Parrott et al.) The harm would be particularly acute for pregnant women and young children — and the young children affected would typically be *citizen* children — who may lose access to benefits that would lead to better long-term outcomes, including better health, greater educational attainment, and brighter future earnings prospects. The impacts for these children can start before birth, when the lack of prenatal care and nutrition assistance for their mothers could affect their birth and early health outcomes, and extend decades into the future, diminishing their opportunity to thrive in tangible and entirely preventable ways (Parrott et al.). The incentives to forgo such government programs can have serious consequences for the health of many. Pregnant women who decline to enroll in Medicaid lose access to pregnancy-related services, and families that choose not to enroll babies and young children in Medicaid or CHIP lose access to health coverage. Furthermore, school-age children could go to school without the health coverage and food assistance they need to succeed. This may lead to higher rates of poor birth outcomes, including higher rates of infant and maternal mortality, as well as poorer health, education, and financial outcomes for children of all ages (Parrott et al.). Research from Perreira et al. suggests that the regulation could result in forgone preventative care such as well-child visits, routine checkups, immunizations, and cancer screenings among some immigrants and their dependents. (Perreira et al. 903).

Children who are eligible for Medicaid do better in school, on average, and miss fewer school days due to illness or injury. They are also likelier to finish high school, attend college, and graduate from college. And they earn more as adults and experience fewer emergency room

visits and hospitalizations, research shows. Eligible children could miss out on SNAP, which also produces long-term benefits for children. Research on the early days of the SNAP program shows that children who received food stamps (as SNAP was previously known) had greater rates of high school completion and a lower incidence of heart disease, stunted growth, and obesity as adults. In addition, eligible legal immigrant families with one or more adults working at low pay may forgo the Earned Income Tax Credit or Child Tax Credit for which they are otherwise eligible. Children in immigrant families that forgo these credits — including citizen children — would face more poverty and hardship immediately and weaker prospects in the labor market in the future. Without these tax credits, they would be less likely to do well in school, finish high school, and go on to college (Parrott et al.). The rule would likely have other adverse effects as well — for example, on the financial health and viability of many hospitals, due to the significant increase it would produce in people who lack health insurance and come to emergency rooms for their medical care. For health care providers such as federally qualified health centers and public hospitals, the expanded public-charge rule could lead to more patients lacking health coverage and higher costs from uncompensated care (Perreira et al. 903).

Perreira et al. anticipate that the new public charge rule will be harmful to lawfully present immigrants, persons living in “mixed-status” families (those in which some members are citizens and others are not) and persons living abroad who wish to immigrate to the United States (902). In addition, although several categories of immigrants (e.g., refugees, asylees, and immigrants with temporary protected status) are exempt from public-charge rules, confusion regarding applicability could deter even exempted immigrants from applying for essential benefits. The new policies would have a chilling effect on lawfully present immigrants’ use of public programs (Perreira et al. 902).

Concerns about the negative effects of the public charge rule have increased as a result of the COVID-19 crisis. Although US Citizenship and Immigration Services (USCIS) recently clarified that “coronavirus testing will not count towards public charge determinations, immigrants are likely to remain skeptical” (Duncan and Horton). Unveiled April 3, 2020, the Coronavirus Immigrant Families Protection Act, would “extend COVID-19 testing and treatment to undocumented immigrants, provide \$100 million to the CDC for linguistically appropriate outreach on the coronavirus, allow immigrants to access relief funds with ITIN numbers, further limit ICE activity, and suspend the public charge rule” (Duncan and Horton). Nonetheless, even though USCIS has explicitly encouraged immigrants to receive care and as testing and treatment for COVID-19 has been explicitly excluded from the public charge rule, “many immigrants had already acted to limit their interactions with medical institutions and their reliance on public assistance” (Duncan and Horton). Even when COVID-19 is no longer an urgent healthcare crisis, there are other practical reasons to provide healthcare access to all. Other infectious diseases like tuberculosis and influenza continue to affect people living in the United States. Because some diseases can be transmitted fairly easily and quickly between individuals, peoples’ health are tied to everyone in their community, regardless of immigration status. Furthermore, citizens and immigrants, when accessing emergency health services, can all suffer harmful consequences from situations like hospital overflow. Access to insurance leads to more patients utilizing primary care professionals, rather than emergency departments, and addressing health conditions sooner versus later. When it comes to hospital flow and infectious disease spread, our health interdependence cannot be denied.

Providing health care access for children specifically allows them to mature into healthy, productive members of the community in their future years. Pew Charitable Trusts Report of

2014 concluded that immigrants have become a major demographic force in Philadelphia in recent years, helping drive its population growth and altering the economic and social landscape in ways that pose both opportunities and challenges for the city (Waters). Healthy people can be healthy workers, who can contribute productively to the economy and the community. In regards to tax revenue, undocumented immigrants pay approximately 8% of their income in state and local taxes according to the 2017 report by the Institute on Taxation and Economic Policy (Institute on Taxation and Economic Policy). In Pennsylvania, an estimated \$135 million in state and local taxes were noted to have been paid by undocumented immigrants (Institute on Taxation and Economic Policy). Economic revenue through taxation is being generated through undocumented as well as documented immigrants in the United States. By investing in the health of these immigrants from the time they are born, states can work towards creating even more productive adult members of their community.

Health care services cannot just be for emergency situations. Embracing the holistic approach to providing health care services, through education, nutrition and fitness programs, and networking with social services, can assist in keeping down long-term costs and giving people autonomy and control over their own health. At the core, no one should be limited by their health from fully participating in life. With a healthy body and mind, a person has greater freedom to reach for dreams and goals. People from low-income backgrounds already must battle structural disadvantages in order to attain economic stability. Immigrants and non-immigrants alike aspire for such economic stability. Health is an essential foundation for securing basic necessities and realizing a dignified, fully human life. From both a pragmatic and moral standpoint, local, state, and national policy should provide greater equality of access to health care for Latinx children of mixed-status immigrant families of diverse income backgrounds.

Conclusion

We must stop and ask ourselves and our policymakers why not all children have a primary care physician or health insurance in the United States. The Greater Philadelphia Area is no exception. Children of immigrant families in the Greater Philadelphia Area are in fact more likely to face greater obstacles to receiving health care than children of non-immigrant families. Latinx immigrant children's parents often opt to get care their children care from community health clinics rather than primary care physicians out of fear of the threat of deportation. We have created fear-inducing institutional structures that allow a parent's documentation status to impact their citizen-child's health care access. Moreover, we have permitted policies that limited a child's capacity to access health care services due to low income status. Despite the international human right to health and legal statutes such as the Patient Bill of Rights, children of limited English proficiency continue to experience lower quality of care and inconsistent access to interpretation services in health care facilities. In the end, low income status, documentation status and level of English proficiency should not affect a child's potential to grow up to be a healthy, strong individual.

The discussion of the story of Jessica Santillan does not serve as the most representative case of Latinx children's access to health care, but it does raise some the questions that we need to be asking today. In 2003, though Jessica herself was of undocumented status, she received health care services through her mother's employer health insurance and private charity. Many children of Latinx immigrant families in the United States do not receive coverage through their parents' health insurance plans. Furthermore, Jessica received an organ transplant to treat her congenital heart problem. The most pressing need for Latinx immigrant children is in fact, access to basic preventative health care services, not specialized, intensive surgeries.

We should not be asking why children from families with mixed immigration status should receive the same access to health care services as other children, but rather we should be asking why do they not. The right to health and health care access is a legally, morally and pragmatically supported international right. In 2018, 4.3 million children or approximately 5.5% of children in the United States did not have any health insurance coverage (Jenco). The children who lack health insurance often receive less quality care, less preventative care, and as the American Academy of Pediatrics argues, “We can do better, and we must (Jenco). Children of immigrant families, even citizen-children, are less likely to have CHIP, Medicaid or another form of insurance, or a primary care physician than children of non-immigrant families. Immigrant children are also more likely to seek emergency care or care through a community clinic than care through a primary care physician. Latinx immigrant families, specifically, face obstacles to health care due to federal and state policies. The Greater Philadelphia Area has a sizeable Latinx immigrant population and serves as a relevant case study for on-the-ground understanding of Latinx immigrant families’ access to health care. Some members of the Latinx immigrant population within the Greater Philadelphia Area access health services through non-profit organizations that do not ask questions about documentation status and serve those who are low income and/or lack insurance. The interviews I conducted with staff of three non-profit organizations that serve Latinx immigrant children and families revealed the high level of demand the organizations experience and serve as role models for adopting strategies to most effectively engage with Latinx families. Scholarly work and my own interviews provide support for the argument that limited English proficiency, anxieties over documentation status and deportation, and low income status contribute to the gap in access to health care services that Latinx immigrant children experience.

To work to close the gap in access to health care services that Latinx immigrant children experience, non-profit organizations in the Greater Philadelphia should tap into more local partnerships and conduct more specialized training to have more medical interpreters competent in Spanish and English. However, these organizations are struggling to meet the rising level of need and demand for their services from uninsured immigrants. Greater numbers of insured children can expand their options beyond non-profit organizations to primary care physicians. The Pennsylvania legislature can take the step that other states, like Massachusetts and California, have taken and extend CHIP and Medicaid coverage to all children of any immigration status. On the national level, the new public charge rule, which went into effect February 2020, should be eliminated in order to create a more conducive environment for immigrant families and their children to enroll in programs such as CHIP and Medicaid. Overall, health care providers can develop more methods to approach health holistically by providing health care services, through education, nutrition and fitness programs, and networking with social services and take advantage of the long-term benefits holistic health care provides.

Because this study was limited to a few interview sessions, it would be greatly beneficial for more qualitative accounts to be collected from other non-profit organization staff members in the Greater Philadelphia area and the state of Pennsylvania generally. Discussion of health clinics that serve clients with insurance would also broaden the knowledge about how local organizations seek to support low-income families, who may be insured, but still face financial challenges. Analysis of health clinics in states along the southern border, such as Texas and New Mexico, could also provide greater understanding of health care experiences of Latinx children immigrants. These states experience higher volumes of Latinx children, including undocumented Latinx children, and the work of their law enforcement and medical professionals overlap related

to border crossing, detainment of immigrants, and other activities that stem from their location on the United States and Mexico border. It would be of additional insight to consider how the experiences of unaccompanied minor Latinx immigrants compare to Latinx child immigrants who migrate with their families. Because these findings suggest that parents', especially mothers', documentation status and English proficiency shape their children's health experiences, children immigrants who are unaccompanied may experience different obstacles than accompanied children immigrants. The impact of income level, English proficiency and documentation status for health access for child immigrants of other nationalities may differ in comparison with Latinx children immigrants. Further studies could investigate how Asian, European, or African children immigrants encounter health care access in the United States.

In closing, public awareness must increase in regards to obstacles to health care access that some children encounter in the United States and the consequences that stem from such challenges. Hurdles that Latinx children immigrants face when seeking health care in the Greater Philadelphia Area, as well as other parts of the country, are harming their own chances for good health, as well as affecting other public health phenomena. Ensuring all children have access to health insurance and regular primary care can result in positive health outcomes for all children as well as prevention of greater spreading of transmittable diseases and more sustainable, preventative, holistic health care practices. At a more basic level, the right to health and health care access is a basic necessity required to exercise other foundational human rights. Children did not choose nor create their life circumstances, and yet they can encounter gaps in access to health care based on their parents' immigration status, income and language proficiency. Lack of access to adequate preventative health care from a very young age limits an individual's ability to flourish as a human being and to grow up to be a healthy, free adult. Healthier individuals can

live more fully human lives and contribute more meaningfully to their communities, and access to meaningful, preventative health care can improve health outcomes. Policymakers have and should accept the opportunity to amend the structures in place in order to limit the harmful impact that families' low income level, undocumented immigration status, and low English language proficiency can have on their children's health care access.

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