FEATURE ARTICLE

Health Care for Our Immigrant Neighbors: The Need for Justice and Hospitality

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Introduction

We are in an exciting and challenging time in U.S. history regarding health care. The same is true regarding policy-making and attitudes toward immigration to the United States. In combination, the two issues are volatile, almost combustible. For instance, many will recall the infamous taunt of "You lie!" that Representative Joe Wilson (R-SC) hurled at President Obama during the 2009 address on health-care reform to a joint session of Congress. This outburst was, of course, in response to the President's assertion that undocumented immigrants would be excluded from any new health-care coverage legislation (which became the Affordable Care Act).

It is very unfortunate that these two issues have become intertwined. There is no intrinsic connection between the two. We believe that insuring and treating all who live within a community would serve all well and should be the norm. Health care is similar to basic education in that it is a basic good and should be delivered to those in need of it without regard to accidental circumstances such as immigration status.[1] To do so benefits the community as a whole and failing to do so harms the community.

It seems that some if not much of our public dialogue regarding the insuring and provision of health care to all has been distorted by uninformed and selfish, perhaps even sinful, attitudes. In this fallen state of affairs, how should Catholic health-care institutions respond? We will argue that Catholic moral anthropology provides a corrective lens through which to view the issue of immigration. This lens focuses us on how we can enable our immigrant neighbors to contribute to the community and foster their full participation. When viewed in this way, Catholic health care is called to a leadership role both in terms of advocacy for more just public policies and also to directly and

humanely, i.e., hospitably, serve immigrant populations in our communities.

Uninformed Stereotypes and Sinful Attitudes Concerning Immigrants

Public policy discourse today is sometimes framed in divisive terms that pre-empt the development of a consensus inclined toward the common good. While this is not true of all who have concerns about immigration reform, it does seem to be the case for some if not many. The latest false dichotomy to gain traction is the rhetoric of "makers v. takers."[2] This rhetoric suggests that some people are intrinsically producers of goods and services, while others are parasites trying to unfairly take what rightfully belongs to the producers. We routinely hear people espouse stereotypes regarding immigrants that are derivative and reflective of this worldview.

- "They take our jobs."
- "They are free loaders," "They come here for welfare," or "for health care," "education," or other "handouts."
- "They won't learn English" or in other ways, refuse to assimilate.
- "They are law breakers and we mustn't reward them."

The conclusion of this kind of thinking is that immigrants are ungrateful thieves, takers who take what does not belong to them. They are the "undeserving" poor.

While such stereotypes might sound like the pet biases of armchair Archie Bunkers, we must realize that they are often the assumptions behind many legislative proposals that have significant traction in our policy-making process. These proposals include a focus on border security, detention, deportation and denying a path to citizenship for undocumented immigrants. (Of course, it is also the case that some of those advancing these and similar proposals are doing so on the basis of other assumptions and legitimate concerns). Furthermore, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, colloquially known as "welfare reform," embraced the premise that immigrants should not be eligible for important benefits until they have been in the U.S. with authorization for at least five years.

These problematic assumptions may have had an impact on health care reform as well. In order to gain passage, the Affordable Care Act's expansion of Medicaid did not change the PRWORA five-year exclusion of immigrants who are here with full governmental authorization. Furthermore, all unauthorized immigrants remain ineligible for federally funded health care, including the new subsides to buy insurance, and are even disqualified from purchasing a full-price health insurance policy with their own money on a federal or state exchange. Even DREAMers (i.e., adult undocumented immigrants who were brought to the U.S. as children) who have received a two-year authorization to work within the United States through the Deferred Action for Childhood Arrivals program of the U.S. Citizenship and Immigration Services are ineligible to so purchase health insurance (see Table A.)

This stereotype-based approach to insurance coverage has several obvious consequences. Chief among them is that immigrants will often continue to be uninsured. As the total

number of the uninsured decreases substantially, immigrants will become a larger portion of the uninsured. As a result, immigrants are increasingly likely to be targeted by inhumane strategies in order to reduce uncompensated costs. Perhaps chief among these are forced "medical repatriation" in which chronically ill or even terminally ill patients are essentially deported against their will by a health care facility as a discharge plan. Similarly, as most hospitals must examine and stabilize any presenting patient before transfer by virtue of the Emergency Medical Treatment and Active Labor Act (EMTALA), some prominent critics such as former Florida Governor Jeb Bush, have proposed that the United States allow states to delineate their own particular limits on EMTALA-related services,[3] potentially closing the ER door as a point of access to care for this population. It is easy to show that on basic principles of the mission and values of health-care institutions, such proposals should be non-starters. Moreover, a view of the human person informed by the richness of the Catholic philosophical and theological traditions would reject, at their roots, the negative assumptions about our immigrant neighbors.

A Catholic Social Justice Response: Moral Anthropology & Policy

In several different teaching documents, Pope John Paul II and the Conferences of Catholic Bishops of both the United States and Mexico outlined the knowledge and attitudes that Christians should bring to discussions about immigration.[4] There is no shortage of studies to show that the attitudes described earlier are uninformed and empirically wrong.[5] But empirical studies are often received or rejected based on the predispositions and view of human nature that the listener holds. Furthermore, human motivations are not mere whims that can easily be influenced by studies and surveys. In any case, a Catholic view of human nature provides an alternative perspective to the one described above and ought to inform the imaginations of Catholics as they assess the immigration laws of the United States and urge reform.

The Catholic view of human beings that emerged in the 20th century highlights a number of key features of human nature. In many ways, these features are and should be obvious to common sense and observation. Human nature is manifest in our experience, not something hidden and esoteric. The following are some of those elements relevant to this discussion.

Catholics believe in the intrinsic value of each person. We sometimes refer to this as human dignity in its original Latin meaning of "worth." So, while governments have a right to promote secure borders, they cannot simply disregard the effects of such policies on human beings who are not their citizens.

On a Catholic view of human nature, people are laboring creatures. We work. We work in order that by our labor we might provide sustenance for ourselves and our families. But we also work as an expression of creative natures. Thus, Catholic social teaching speaks of the dignity of labor. There is not a distinction between makers and takers in Catholic moral anthropology. We are all inclined to be makers. In addition, the relationship between a worker and an employer is not sacrosanct and inviolable. If that relationship does not respect the dignity

of labor by enabling the worker to earn a living wage and to have sufficient leisure to restore his body and to engage in social activity such as raising a family, the government, by virtue of its duty to promote the common good, should promote more just arrangements.[6]

Based on this view of human nature, Catholic social teaching simply rejects anti-immigrant sentiment. We must respect our neighbors and their cultures. We cannot hide behind a self-righteousness premised on a false sense of cultural superiority. The magisterium has made clear that culture is an important part of human nature and a way in which our relationship to God and each other is mediated.[7] Thus, we must not demand a forced homogenization of our neighbors into our cultural norms.

Implications for Health Care Facilities and Health Care

Respecting human nature has a variety of implications both for the clinical delivery of health care and for our role as a ministry that advocates for the underserved. The view of human nature that Catholic social teaching highlights requires that institutions respond to human need. The *Ethical and Religious Directives* are clear about this: "A Catholic health care institutional service is a community that provides health care to those in need of it. This service must be animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church."[8] Those needs require that we be welcoming institutions that care for our community and its members.

Catholic health-care institutions must present themselves as welcoming places, places of hospitality.[9] Hospitality is rooted in our moral mission and also our pragmatism. Hospitals want the sick to present while their illnesses are in a treatable stage and early enough to minimize the spread of contagion in the community. Practices such as forced medical repatriation must be renounced because they undermine such goals.[10] Hospitality requires promoting practices that are culturally welcoming and medically efficacious. The next section provides examples of how this imperative applies to the new market opportunities brought to us by the Affordable Care Act.

With respect to advocacy, Catholic health care must support other Church ministries in advocating for humane and comprehensive immigration reform.[11] A Catholic view of human nature enables us to look beyond a selfish view of health insurance as a benefit that immigrants are trying to steal. We are able to view health insurance as a community good that fosters the effective participation of all in the community. Federal subsidies to assist a person to purchase insurance enable the person to make a monetary contribution to the health care system according to their means. Even providing Medicaid fosters a kind of participation as the insured person is then better able to take responsibility for her health and to be a more productive member of the community.[12] For these reasons, it would seem that linking health insurance and health care to immigration status is simply a mistake.

Of course, immigrant populations are currently uninsured at high rates and will remain so despite the implementation of the Affordable Care Act. In this current milieu, how should our health systems respond to the immediate need in a hospitable manner?

Practicing Cultural and Medical Hospitality: Mission-Based Care for Immigrants

Our mission to care for the poor and the disenfranchised sometimes doesn't discriminate. However, we must not simply view underserved populations as a mission-based burden to be borne stoically. We must also consider the opportunities. Outreach to select patient populations can meet the maxim of "doing well while doing good." Immigrant populations are growing in the United States and, in many markets, represent the majority of market growth. These populations are critical to our local economies as well. In 2008, the Selig Center for Economic Growth at the University of Georgia indicated that the Latino population in Illinois represented $41 billion in purchasing power. Hospitals and other health care organizations can garner new market share, newly insured patients and new revenues by reaching out to immigrant populations. That is the "doing well" part. They can also provide care in a culturally sensitive and mission driven way by thinking about the ways to better accommodate immigrant patients. And that is "doing good."

While the ACA's coverage expansions will not apply to undocumented immigrants, access for other immigrant patients will improve with the ACA, e.g., immigrants eligible for subsidies in the exchanges, including those recently arrived who are excluded from Medicaid because of the five year bar. There will undoubtedly be additional conversations about caring for our immigrant patients. Thus hospitals and other health care facilities are compelled to think about the practical approaches they can take to provide mission-based care for these varied patients.

Many hospitals have already done substantial work around caring for the varied populations of patients who seek care from them. According to the website for New York-Presbyterian Hospital, "New York-Presbyterian offers an extensive language assistance program for its patients, including more than 58 onsite interpreters and other interpretation services available for up to 120 languages. In 2005, the Hospital provided more than 115,000 interpretations in 72 different languages all cost-free to the patient."[13] That is impressive. For the majority of hospitals, the interpretation needs of patients are aggregated into a few languages. But, in addition to language assistance, hospitals and other health care organizations need to be sensitive to the cultural and religious beliefs of patients who seek services there as well. Administrators in faith-based institutions are called to care for the whole person--body, mind and spirit, and so, in Catholic health care, we are called to provide for the diverse needs of our immigrant patients. Outlined here are several practical steps hospitals and other health care facilities can take to ensure awareness of and responsiveness to immigrant patients' needs.

1. Self and Institutional Education
    a. What are the demographics of your patient population?

b. What about the demographics of your service area?
c. What are the subgroups within those demographics, i.e., Mexican, South American, Cuban, etc.?
d. What do administrators and staff need to know about these cultures?

2. Response to What Is Learned
   a. **Language:** Consider what medical interpretation services are needed on site, via phone or through Skype-like technology. Also, consider using iPad or smart tablet apps that can translate non-clinical information such as directions to navigate through the facility. One example of such an app is iTranslate which can provide written or spoken translation from an iPad.

   b. **Religious Beliefs:** The fact that different religions have food and modesty beliefs needs to be taken into account. Ensure that a varied menu is available to accommodate vegetarian or other nutrition needs. Also, consider the possibility of enhancing hospital gown privacy with pants and head covering caps for patients whose religion or culture requires additional modesty.

   c. **Cultural beliefs:** It is critical to be aware of and responsive, to the degree possible, to cultural norms. Some cultures have strong superstitions about illness, some are sensitive to the gender of the patient and the caregiver, and some include the entire family in the care process. While it is not always possible to accommodate all norms, being aware of them can assist staff in being more sensitive when providing care to patients.

   d. **Clinical needs:** Data available from the Centers for Disease Control (CDC) provides a roadmap for needs of populations. For example, among Latino patients, women are 2.3 times more likely to have no or late prenatal care. Diabetes occurs 1.6 times more frequently among Latino patients, and Latina patients are 1.6 times more likely to have cervical cancer.

      Knowing the population disease trends will assist in developing clinical programs that are responsive to your patient demographics.

3. Some Additional Steps
    a. Recruit hospital staff who are reflective of the population of patients being served.
    b. Provide diversity training and practice to facility staff as well as to the medical staff.
    c. Consider hiring a diversity leader.
    d. Ensure that facilities are language friendly—signage, interpretation services (medically certified) and non-medical interpretation options.
    e. Provide culturally sensitive hospital gowns.
    f. Provide a menu that respects religious and cultural choices.
    g. Have a chaplain staff that is reflective of various beliefs or that is well versed in the nuances of various religions.
    h. Develop strong community relationships with churches, cultural organizations, and Federally Qualified Health Centers who can support your patient population.
    i. Create clinical programs responsive to population needs
    j. Develop Patient Financial Services expertise on Medicaid eligibility, exchange enrollment, etc.
    k. Help ensure that immigrants receive good information about the ACA and possible benefits they might be able to receive, and help them to enroll where they are eligible.

Many of the steps that need to be taken are not difficult or terribly costly, though some will require longer term planning and additional expenditures. But sensitivity training for staff and education of medical staffs are free and can begin now.

With or without the Affordable Care Act, our Catholic health care calling creates an urgency to care for these new and growing populations. It may be that not all hospitals can afford interpreters, or new signs, but education, awareness and calling will find us leading the way to welcome our immigrant brothers and sisters with hospitality and a commitment to changing policies and structures that do not adequately serve their health needs.

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Table A. Eligibility of Access to New Coverage Vehicles of the Affordable Care Act

Immigration Status	Individual policy purchase on exchanges	Individual policy purchase on exchange with premium subsidy	Medicaid Coverage
Authorized > 5 years	Yes	Yes	Yes
Authorized < 5 years	Yes	Yes	No
Undocumented	No	No	No
DREAMers with DACA status	No	No	No