EDITORIALS

Untangling the Web: Race/Ethnicity, Immigration, and the Nation's Health

According to the 2000 census, people of color (including Hispanics and non-Hispanics who did not identify their race as White) now represent 31% of US residents.[1] The US population is increasingly racially and ethnically diverse owing, in part, to immigration and higher birth rates among minority populations. Today, more than 3 in 4 immigrants (77%) come from Latin America (South America, the Caribbean, and Central America) or Asia.[2] They are racially and ethnically classified in the United States as Latino/Hispanic, Asian, or African American/Black, even though most of them probably would not be classified as such in their country of origin. This represents a shift from past immigrants, who were largely of European descent. Immigrants represent 11% of the US population.[3] While most minority Americans are native born, about 39% of Latinos, 61% of Asians, and 6% of African Americans are immigrants (US Census Bureau, unpublished data, March 2000). On average, almost 60% of immigrants of color have been in the United States longer than 10 years and most are now US citizens (US Census Bureau, unpublished data, March 2000).

Foreign-born residents of color often experience barriers to full participation in society on the basis of race/ethnicity, language, and immigration status. Sensitivities about issues of race in the United States have made it difficult to have open and honest dialogue about the overlapping issues of race/ethnicity, immigration, and access to publicly supported social welfare benefits. Louis Freedberg, in a *Washington Post* op-ed article,[4] describes US policy toward immigrants as "borderline hypocrisy." His article was largely about illegal immigrants, about a quarter of the 30 million immigrants estimated to be in the United States in 2000.[3] Immigrants, regardless of their legal status, are given contradictory messages about the extent to which they are valued in society. On the one hand, there is considerable evidence that the United States encourages immigrants' participation in the labor force, both in lower-skilled positions (e.g., farming and domestic work) and higher-skilled positions (e.g., computer and medical sciences). On the other hand, immigrants' contributions to the economy are not always valued sufficiently to ensure that they are afforded the workplace protections and societal benefits made available to other workers.

A recent poll found that public attitudes about the economic impact of immigrants on society have changed dramatically in the past 5 years.[5] In 1994, 63% of the public saw immigrants as an economic drain on society. In 2000, just 38% held that view. However, the public has a more mixed view about immigrants' impact on American culture. In a March 2001 Gallup survey, 45% of respondents said that the increasing population diversity created by immigrants mostly improves American culture, while 38% said it mostly threatens the culture (the rest had no opinion or volunteered that "both" or "neither" response options were true).[6] Although public attitudes toward immigrants have become more positive in the last decade, contentious public debate about the benefits of the current wave of immigration persists.

PUBLIC POLICIES AND IMMIGRANTS' HEALTH

Over the past decade, there have been several major policy changes that affect immigrants—some more directly than others. The federal government and most states have taken actions to limit immigrants' access to health coverage and care. The most significant policy change was the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which fundamentally changed cash assistance and the treatment of legal immigrants with regard to social welfare programs. Previously, legal permanent residents and other legal immigrants had the same access to public benefits, including Medicaid, as did US citizens. However, welfare reform created a 5-year ban on Medicaid for new immigrants (those arriving after August 1996), and other legislation established a process called "deeming" in which an immigrant's sponsors' financial resources are "deemed" or considered available to the immigrant when financial eligibility for public programs is determined.

Although federal matching Medicaid funds are prohibited, some states have decided to use their own funds to cover new immigrant children in their Medicaid program (13 states) or Children's Health Insurance Program

(CHIP) (9 states).[7] Other states (Rhode Island, New Jersey, and California) have gone much further, covering all otherwise eligible populations (e.g., pregnant women, the disabled, and the elderly) regardless of immigration status. Even for immigrants who remained eligible for federal Medicaid benefits, fear and confusion about participating in public programs create barriers to enrollment and concern about becoming a "public charge" and then becoming ineligible for citizenship. Recent Department of Justice clarifications have reiterated that Medicaid and CHIP coverage are not to be used in "public charge" determinations. Language barriers also represent one of the overlapping issues facing racial/ethnic minority populations, immigrants, and publicly supported health programs. In August 2000, guidance from the Department of Health and Human Services required that entities receiving federal funds, including Medicaid and CHIP, provide assistance for persons with limited English skills. This assistance may help facilitate health coverage and access for immigrants.

The debate over immigration issues is occurring in legislatures across the country as well as the courts. Recently, 2 court cases affecting New York immigrants have further complicated the health policy picture for immigrants. One federal district court case, *Lewis v City of New York* (2001 WL 540657 [2nd Cir, May 22, 2001]), reversed earlier rulings that had forced the state to provide prenatal care benefits to undocumented women who meet the income-eligibility criteria for Medicaid. Another case, *Aliessa v Novello* (2001 WL 605188 [NY State Supreme Court, June 5, 2001]), decided by the state supreme court, found that barring legal immigrants' access to Medicaid violated equal protection clauses of the New York and US constitutions. The latter case, while only affecting New York immigrants, has potential implications in other states.

Recent concerns about racial/ethnic health disparities have resulted in a number of public and private sector efforts to better understand and address the multiple factors that contribute to the poorer health outcomes of minority Americans. A sizable share of immigrants of color work in low-wage jobs or in small businesses that offer either no health coverage or unaffordable coverage. Restricting access to public sources of coverage therefore places many low-income immigrants at a disadvantage in obtaining health care—especially preventive and primary care. When immigrants are ill or injured and uninsured, their health and the nation's well-being are placed at risk. Efforts to reduce health disparities will need to better assess and understand the intersecting role of race/ethnicity and immigration status in shaping health behaviors, opportunities for healthy living, and health care access.

THE FACTS: PERCEPTION VS REALITY

Many of the recent public policies regarding immigrants' participation in health and welfare programs are not grounded in facts about the population. Misperceptions about immigrants' legal status, role in the economy, and impact on the health system contribute to anti-immigrant stereotypes and counterproductive public policies. Clarifying the facts should help to reduce the backlash that has occurred through misinformation.

Legal Status

Most immigrants (85%) enter the United States legally,[8] and most foreign-born persons (72%) are currently here legally.[3] Furthermore, 3 of every 10 immigrants are naturalized US citizens.[3] Of the 28% of undocumented immigrants,[3] 4 of 10 enter the country with a student, tourist, business, or other type of visa and become "illegal" when they stay after the visa expires.[8]

Many immigrants who have not yet become naturalized want to do so. A national survey of Latino adults conducted by the *Washington Post*, the Kaiser Family Foundation, and Harvard University found that the vast majority (85%) of foreign-born Latinos were either citizens, applying to be citizens, or planning to apply to be citizens.[9] Only 12% said that they did not plan to become citizens. The main obstacle to naturalization cited by Latino immigrants was the requirement that they speak, read, and write English.

US policies make clear distinctions between citizens and noncitizens; however, in reality, many families are not one or the other but a combination of the two. For example, 9% of US families with children are mixed-status families (i.e., at least 1 member is not a US citizen), and most immigrant families (85%) include children who are US citizens by virtue of being born in the United States.[10] Policies aimed at noncitizens can create confusion among mixed-status families, leading to a "spillover" effect on the citizen children that, in effect, discourages the seeking of Medicaid or CHIP coverage to which they are legally entitled.

Economic and Fiscal Impact

A panel commissioned by the National Research Council found that "immigration benefits the US economy overall, and has little negative effect on the income and job opportunities of most native-born Americans."[11] The authors estimated that immigrants add as much as $10 billion to the economy each year. They conclude that the majority of immigrants and their descendants will pay $80 000 more in taxes than they use in government services over their lifetimes and that they do not reduce the wages of native-born Americans. In addition, the Social Security Administration estimates that undocumented workers paid over $20 billion in Social Security taxes from 1990 to 1998 and most likely will never receive any benefits.[12]

The economic benefits from immigration are shared by all Americans; however, a few states (and local governments) disproportionately bear the responsibility for immigrants' social welfare needs. Roughly two thirds of taxes collected from immigrants go to the federal government, but about two thirds to three fourths of expenditures for immigrants are at the state and local level.[13] This reality is largely due to policy choices restricting federal payments to social programs that benefit immigrants and other low-income people.

Most immigrants are in working families. Even though they are almost as likely as citizens to have a full-time worker in their family (82% vs 85%), noncitizen families are much more likely than citizen families to be poor (29% vs 16%).[14] They also are much more likely to work for a small business or to work in agricultural, labor, or repair industries than are citizens. Almost half of noncitizens

(47%) work in agricultural, labor or cleaning, or craft positions, compared with about one quarter (28%) of citizens.[14]

Health Coverage and Access

Recent policy actions have adversely affected immigrants' ability to obtain health coverage and thus access to care. Immigrants made up 22% (9.2 million) of the 42 million uninsured in 1999.[15] However, recent immigrants (noncitizens who had lived in the United States for less than 5 years) were a smaller proportion (6%, or 2.4 million) of the nation's uninsured.[15] Moreover, recent immigrants have not been the major factor in the growth of the numbers of uninsured from 1994 to 1998, despite their higher rates of being uninsured.[16] Nonetheless, lack of health insurance coverage is a major issue facing immigrant populations. Low-income immigrants are twice as likely to be uninsured as low-income citizens. Almost 59% of the 9.8 million low-income noncitizens had no health insurance in 1999, and only 15% received Medicaid. In contrast, about 30% of low-income citizens were uninsured, and about 28% had Medicaid.[14]

Race/ethnicity combine with economic circumstances in determining the likelihood of health coverage for noncitizens. For example, in 1997, Latino noncitizen children were twice as likely to be uninsured as White noncitizen children (56% vs 25%). In contrast, Asian noncitizen children and White noncitizen children have similar rates of being uninsured (23% vs 25%).[17] These findings are consistent with the economic circumstances of foreign-born Latinos, who generally work in lower-paying industries and are poorer, on average, than foreign-born Europeans or foreign-born Asians.[18]

Despite perceptions that immigrants overburden the US health system, there are several studies that suggest otherwise. In fact, noncitizen immigrants receive less medical and dental care than native citizens even after differences in income, employment, and health status are accounted for.[17,19] Even though noncitizens often have no regular source of care, they are less likely to go to emergency rooms than citizens. In addition, noncitizen children on average have fewer medical, dental, and mental health visits than citizen children.[19]

THINKING FORWARD

Efforts to exclude immigrants from publicly supported sources of health coverage and care may reflect any number of factors, including misperceptions about immigrants as well as federal–state disputes over who should bear the primary responsibility for meeting the social welfare needs of low-income residents. Legislation, with bipartisan support, has been introduced in this session of Congress to address some of the gaps created by the welfare reform law. The legislation includes provisions that would restore Medicaid and CHIP to pregnant women and children who are eligible legal immigrants, regardless of when they entered this country. These bills reflect changing public attitudes, efforts to remedy inequities created by recent law, and a desire to provide fiscal relief for states.

Teasing out the extent to which racial/ethnic stereotypes are shaping public attitudes and policies regarding immigrants is an important first step to developing more rational and inclusive policies. Similarly, understanding the extent to which racial/ethnic health disparities are related to immigration or citizenship status should help in developing more targeted interventions to reduce these disparities. This discussion is important for forthrightly addressing the issues rather than creating separate boxes—for immigrant populations and for racial/ethnic minority populations—without understanding the intersection of the two. Attention to these issues is essential not just for immigrants' health but also for our nation's health. ■

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Sex, Lies, and Silence: Reproductive Health in a Hostile Environment

In this issue of the Journal, Radha Jagannathan has provided us with a methodologically elegant assessment of the degree to which low-income New Jersey women underreported abortions.[1] By comparing self-report with Medicaid claims, she is able to compare rates of underreporting by race/ethnicity and other social and behavioral characteristics. Such an analysis is of great help to those of us who seek to characterize various populations' behaviors so that we can design public health interventions.

The accuracy of self-report is always a matter of concern to public health researchers, as we recognize that memory, misunderstanding, and a host of other factors affect respondents' answers. A body of literature addresses the degree to which people are particularly hesitant to report behaviors considered "socially undesirable." To understand why so many New Jersey women did not report abortions, we have to locate Jagannathan's study in its context. This context comprises a wide-ranging effort to denigrate sexual activity outside of marriage and to constrict access to reproductive health information and services.

As we are all too well aware, abortion has been at the heart of a political and cultural storm for the 3 decades it has been legally available in the United States—a particularly deadly, ugly storm at that. It has left dead in its wake Dr David Gunn, Dr John Bayard Britton, Dr Bernard Slepian, James Barrett, Shannon Lowney, and Leanne Nichols. At least 6 other people have been shot and seriously wounded.[2] Dr George Tiller now wears a bulletproof vest to work. Many women seeking abortions have also faced harassment, interference, and intimidation at abortion clinics. Since 1977, there have been more than 45 000 reported cases of picketing, 400 cases of stalking, 150 cases of arson, and 40 bombings.[2]

All of this is old news. The New Jersey story, however, gives us a lens through which to view recent twists in this anti–reproductive choice maelstrom. Dr Jagannathan's work took place as part of an evaluation of the New Jersey Family Cap program. This program, called the Family Development Program, began in 1993 when New Jersey received a waiver from the federal government to try "innovative" approaches with its welfare program, on condition that the program be set up in an experimental design and formally evaluated. One component of New Jersey's Family Development Program that was evaluated was the Family Cap policy that was intended to reduce births to welfare recipients by denying a stipend to any subsequently born child (quaintly referred to as an "afterborn" child). Importantly, legislators sought to achieve this reduction in births without an increase in abortion. The evaluation in New Jersey demonstrated a decline in births and an increase in family planning utilization but also an increase in abortion, especially for those recently enrolled.

The Family Cap was one of a series of measures that states were allowed to impose (either by waiver prior to 1996 or without waiver after the 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act, known as "welfare reform") that were intended to control and constrain the sexual activity and fertility of poor women, goals articulated explicitly in the preamble to the bill.[3] Other notable state provisions include conditioning receipt of cash benefits on identification of the child's father and attendance at family planning counseling and requiring women who have had "capped" children to return to work earlier after delivery than is required of mothers of "noncapped" children. Two components of the federal bill are directed at the general population and not exclusively at welfare recipients: block grants to the states for abstinence-only education programs, which must advocate sexual abstinence outside marriage and must delineate the harm to society, the mother, and the child allegedly caused by out-of-wedlock births; and annual bonus funds to the 5 states whose out-of-wedlock birth rates declined the most without increased abortion rates.

Since George W. Bush assumed the presidency, the storm has intensified. One of his first acts was to reimpose the Global Gag Rule, which restricts foreign nongovernmental organizations that receive US family planning funds from using their own, non-US funds for providing legal abortion services, lobbying for abortion law reform, or providing accurate medical counseling or referrals regarding abortion.[4] The Bush administration has opposed coverage of contraceptive care for federal employees, has recently decided to refuse waivers to states wishing to extend Medicaid coverage for family planning, has endorsed the Unborn Victims of Violence Act, and has proposed to extend Child Health Plus Program (CHIP) coverage for prenatal care on behalf of the fetus, rather than to the pregnant woman as

proposed in a competing bill.[5] Pro-choice advocates believe these last 2 acts are backdoor efforts to establish fetal personhood under the law. In concert with the promulgation of abstinence education, there has been an effort to depict condoms as ineffective in protecting against sexually transmitted diseases (STDs). This disinformation campaign has included demands that warning labels be put on condoms, that the director of the Centers for Disease Control and Prevention (CDC) resign because of the CDC's promotion of safe-sex programs, and that federal funds be withdrawn from supporting all such programs. Although a recent report by the Department of Health and Human Services concluded that condoms have been proven effective at preventing transmission of HIV and gonorrhea but that data were insufficient regarding other pathogens, there are indeed data demonstrating that condoms offer significant protection against chlamydia, herpes, and human papillomavirus as well.[6,7]

There are many vantage points from which to disagree with these measures; those people concerned with poverty and equity, with women's rights and human rights, and with the separation of church and state have all expressed grave concern.[8,9] These measures also have adverse consequences for public health. They lead to increased morbidity and mortality, to attacks on providers, to reduced access to care, and to silence instead of informed discussion. Elsewhere, I and my colleagues have reviewed evaluations of the welfare-associated policies listed above and concluded that evidence of efficacy is lacking.[10] The Campaign to Prevent Teen Pregnancy has scrutinized programs attempting to reduce teen pregnancy and concluded that the most successful such program is comprehensive in nature—including sex education, provision of contraception, and job and skill development—and that, to date, the evidence does not support the abstinence-only approach.[11]

Others have critiqued the gag rule and pointed to the public health damage wreaked by impeding access to family planning for women in countries in which maternal mortality and severe morbidity and infant mortality are serious risks.[12] Efforts to disparage condoms bring the disinformation campaign and its harm to public health back home. Not only does the United States have one of the highest rates of unintended pregnancy in the developed world, but we also have a recurrent and persistent problem with STDs.[13] Importantly, we have seen a rise in condom use by young people in the last decade, attributed in part to fear of HIV infection. Since young women, particularly young Black women, are at increasing and disproportionate risk of heterosexually acquired HIV infection, it seems the height of public health irresponsibility to disparage and discourage an important means of self-protection.[14]

The attempt to provide health insurance for prenatal care to the fetus and not the woman not only reveals overt hostility to her as a human being of worth and dignity, but also cannot attain its purported goal of advancing fetal and infant health. Fetuses reside within women and neonates depend on them. Women's health problems, if not treated, can have long-term trajectories, affecting the ability to conceive, carry to term, and care for infants as well as the well-being of the women. Only a handful of studies have addressed this interaction, but these have demonstrated the obvious: just as maternal problems can be a marker of risk of infant problems, neonatal ill health can be a marker of risk of maternal problems. Efforts to limit care to the prenatal period alone have not been successful in preventing preterm delivery, the major current contributor to infant mortality and serious morbidity in the United States. Women whose health problems (hypertension, glucose intolerance, etc.) go untreated continue to suffer from these conditions and thus have recurrent problem pregnancies as well as worsening health conditions.[15]

The violence surrounding abortion not only has made women reluctant to report having them but also has affected the number of clinicians willing to provide them. This, together with denial of Medicaid reimbursement by most states, has seriously reduced access. Information and access are further curtailed by abstinence-only education. Twenty-nine of 46 jurisdictions (44 states, the District of Columbia, and Puerto Rico) report prohibiting the provision of information regarding contraception, even in response to a direct question, and 10 prohibit information about providers of STD and HIV services.[16]

How can one make sense of policies designed to curtail births, abortions, contraception, and sex information? These varied policies have in common the single-minded belief that sex should be only for procreation within legal marriage. This notion conflicts with the post–World War II reality that fertility has declined dramatically, age at marriage and first birth has risen, and divorce and out-of-wedlock childbearing have increased. These patterns appeared first in the developed world, but many developing countries show similar profiles.[9] The fact that the train has left the station, so to speak, regarding this yearning for an idealized nuclear marital family does not of course mean that its proponents will give up their efforts. It does, however, add an additional line of argument for those of us who believe that these policies cannot be efficacious and actually aggravate important public health problems and obstruct efforts to remedy them.

It is important for public health researchers and program planners to understand why people are hesitant to acknowledge their own actions. Underreporting happens in a context. In the case of Jagannathan's study, the context is both that of New Jersey's Family Cap and, simultaneously, the nationwide controversies about sex and reproduction. Public health advocates must refuse disinformation and the imposition of silence. The health of the public requires information and discussion. ■

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