Spring 2012

"Framing" The Polemics of the Intersection of Immigration and Health Care in the United States: an Ethnographic and Theoretical Contribution to a Discussion on the Biopolitics of Exclusion

Morgen M. Alden
University of Pennsylvania

"Framing" The Polemics of the Intersection of Immigration and Health Care in the United States: an Ethnographic and Theoretical Contribution to a Discussion on the Biopolitics of Exclusion

Abstract
The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010 and has slowly been implemented over the past two years. If the President's health care reform legislation continues to move forward we will see tens of millions of Americans gain health insurance and access to medical care at more affordable prices than before, yet due to some of the provisions of the ACA, almost 12 million people living in the United States will see no change to their access to health care. These habitants, most of them employed, come from outside the U.S., and therefore are defined as non-citizens by their immigration status. As a result, all undocumented immigrants and many legal residents will find themselves in a minority of American workers without the same rights and access to basic health needs. Using a multi-faceted approach to study the intersection of immigration and health care, this paper combines ethnographic interviews with immigrant small business owners in West Philadelphia with a literature review of the history of immigration reform and the theories behind the social concepts of political exclusion, framing, structural violence, and biopower. In the conclusion, explanations will be given for the continued biopolitical exclusion of immigrants in the U.S. and suggestions will be supplemented on how this country may be able to change its policy to one day have true universal health care coverage.

Disciplines
Anthropology

‘FRAMING’ THE POLEMICS OF THE INTERSECTION OF IMMIGRATION AND HEALTH CARE IN THE UNITED STATES:

AN ETHNOGRAPIC AND THEORETICAL CONTRIBUTION TO A DISCUSSION ON THE BIOPOLITICS OF EXCLUSION

Morgen M. Alden

A THESIS

in

Anthropology

Submitted to the
Department of Anthropology
University of Pennsylvania

2012

I would like to dedicate this paper to Karolyn and Herman, who gave me the knowledge, the skills, and the courage to go out in the field every day.

Abstract

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010 and has slowly been implemented over the past two years. If the President's health care reform legislation continues to move forward we will see tens of millions of Americans gain health insurance and access to medical care at more affordable prices than before, yet due to some of the provisions of the ACA, almost 12 million people living in the United States will see no change to their access to health care. These habitants, most of them employed, come from outside the U.S., and therefore are defined as non-citizens by their immigration status. As a result, all undocumented immigrants and many legal residents will find themselves in a minority of American workers without the same rights and access to basic health needs. Using a multi-faceted approach to study the intersection of immigration and health care, this paper combines ethnographic interviews with immigrant small business owners in West Philadelphia with a literature review of the history of immigration reform and the theories behind the social concepts of political exclusion, framing, structural violence, and biopower. In the conclusion, explanations will be given for the continued biopolitical exclusion of immigrants in the U.S. and suggestions will be supplemented on how this country may be able to change its policy to one day have true universal health care coverage.

Introduction

The United States is a country that prides itself on the extensity of its civil liberties. Founded by immigrants who left an oppressive regime in Great Britain to find freedom, this country's laws and morals have continued to stand for the protection of its people's rights and their pursuits of happiness. Within the often ambiguous framing of the U.S. Constitution law makers and judiciaries have created and upheld many basic human rights – the right to free speech, the right to congregate, the right to privacy, and the right to have reproductive choice are just a few. Yet such a progressive nation has fallen behind the world's freedom trend when it comes to one very important liberty – the right to health. Not explicitly protected under the Constitution or any law since the United States' foundation, a right to health has been a topic of great debate over recent decades. Since the Nuremburg trials, a universal right to health has been pushed in the international human rights arena, perhaps as a means to prevent future humanitarian disasters. Within the few years of the close of World War II, the first international definition of a right to health had been established through the Declaration of Human Rights (Yamin, 2005), yet the United States found itself in a small minority of countries who chose not to the adopt the right within its own Constitution or legislation. The reasons for such a decision shall be made clear throughout the pages of this paper as I bring us up to date on where the United States stands now in 2012, on the brink of its first universal health care reform in history.

The Patient Protection and Affordable Care Act (PPACA) was signed into law by President Obama on March 23, 2010 and has slowly been implemented over the past two years. If the President's health care reform legislation continues to move forward (pending approval of the constitutionality of its individual mandate by the Supreme Court) we will see tens of millions of Americans gain health insurance and access to medical care at more affordable prices than

before. Because of this, the ACA has been championed as a step forward in an official U.S. declaration of the fundamental right to health for all. Although there may be substantial evidence in support of this claim, we must explore the real totality of what is meant by "universal." Due to some of the provisions of the ACA, almost 12 million people living in the United States will see no change to their access to health care (Sanchez et al., 2011). These habitants, most of them employed, come from outside the U.S., and therefore are defined as non-citizens by their immigration status. As a result, all undocumented immigrants and many legal residents will find themselves in a minority of American workers without the same rights and access to basic health needs.

For an act that has been hailed as " a major first step in setting a strong foundation where finally health care becomes a basic human right for all rather than a privilege for the few," (quoting Representative Barbara Lee, Zietlow, 2011, p. 32) it seems an explanation is needed for why millions of American habitants will be denied coverage. Furthermore, with the United States body politic establishing a further divide between who will gain access and who will not have such a privilege, the goal of this paper is not only to explain the history of health care reform as it relates to immigration, but also to come to terms with how working immigrants in this country have and will continue to navigate our health care system around these political and ethical obstacles.

In its entirety, this paper sets out to cover three main concepts in relation to immigration, health care reform, and a human right to health. These are a brief history of the exclusion of immigrant populations from health rights and access in the U.S., the national and cultural theories behind the politics of exclusion, and finally an ethnographic account of how some immigrants of different residency status have learned to cope with these processes of

marginalization. By taking a multi-faceted approach to the issue of immigration status and health protection, I hope to provide a better understanding of why a country that has long been so progressive in terms of defining rights and providing a new home for foreigners has fallen aback from both these labels when it comes to providing easy and affordable health care for all living and working people within its borders but who are, by legal definition, non-citizens.

Methods

Original ethnographic fieldwork was conducted for the purposes of enhancing my findings on this topic and with the goal of hopefully supplying a point of view to the discussion that is often unheard. Willen (2012) comments, "as non-citizens…[immigrants] around the globe face categorical exclusion both from prevailing social contracts and from the health care systems accessible to citizens and authorized residents" (p. 813). As anthropologists, we are equipped with the right tools to approach complex human problems of inequality and health access disparities from multiple angles. "The anthropological literature has provided meaningful conceptual tools to our understanding of the multi-faceted ways in which both discourses and practices undermine the health claims of vulnerable immigrant groups" (Viladrich, 2011, p. 5). By examining a variety of discourses on the politics of exclusion (Agamben, 1995; Foucault, 1978), the framing of the political and moral debate on immigration using theory developed by Goffman (1986), and an analysis and the structural forces at play in the internalized thoughts and actions of the immigrants in my study, this paper hopes to contribute a holistic view of historical and present views of health care exclusion of immigrant populations in the United States.

Coupled with a review of relevant theoretical literature are the stories and accounts told to me by immigrant workers in a commercial neighborhood in West Philadelphia. As small business owners, many of the immigrants whom I interviewed have invested much of their lives

to working and raising a family in the foreign background of the United States. Their time as residents of this country vary in length from a few years to many decades. As a result, their perspectives on life outside of their work and businesses vary substantially. With regards to health care, I found similar differences to exist, yet I expect these variances in degrees of knowledge about our health care system are not only symptomatic of their time and experience spent in the United States, but are also representative of a larger and more general population of immigrants nationwide, as well. Because of this, I found it useful to broaden my ethnographic reach to immigrant business owners from all types of backgrounds in order to gain the most comprehensive knowledge of this minority group's navigation strategies of the U.S. system.

Why business owners? One of the restricting research principles I placed on how my stories were gathered was my focus on interviewing immigrant small business owners. My reasoning for this is somewhat strategic. Business owners tend to have more invested in the communities in which their business operates. They often become spokesmen and women of their neighborhoods and enclaves because of their economic standing within the community. Because of this, I hypothesized that they would be good contacts with whom to learn about how people of similar ethnic backgrounds, including themselves, operate within our health care system. Immigrant small business owners are also more reachable contacts than the typical immigrant worker in America because of their direct connection to an overt entity. Due to time constraints on my research, finding a population that was readily available and easy to locate was one logistical reason for my choosing to focus on this subgroup.

At the same time, it is important to be reflexive on the disadvantages of such population discrimination within my research. Although immigrant business owners are often well established within a community, their representative status is not always so indicative of how

less privileged individuals and families from their home countries react to the obstacles and constraints on them that our society imposes. When it comes to health care, a business owner may have a larger personal network and knowledge base in order to make informed decisions about treatment and care than an individual from the same country who is only beginning to understand how to survive within a foreign system of bureaucracy and exchange. This must be taken into consideration when reading the accounts of immigrants that have been retold for the purposes of this paper.

At the conclusion of my time gathering stories from one-on-one semi-structured interviews with immigrant business owners, I had about twenty individuals' narratives of how they have come to understand the U.S. health care system. Yet for the purposes of this paper, I have chosen to focus the reader's attention on two accounts at opposite poles of the knowledge experience – one from a Pakistani immigrant who has become a successful entrepreneur with a handful of restaurants and shops under his domain, and one from a recently arrived Vietnamese immigrant who is still grappling with the basics of how to traverse the complexities of primary care, health insurance, and medical treatment options. Their names and other identifying information have been changed in this paper for the purposes of protecting their privacy. These two men's stories will hopefully place a stark contrast on how vast and far reaching the issue of immigrants' exclusion from health care has become. In the end, allowing these immigrants' stories to be heard, in what Hirsch (2003) calls a sort of 'liberation anthropology,' should lead us to help shape public health policy proposals that will respect immigrants' subjectivity and perhaps even their cultural values as Americans, albeit non-citizens.

A Recent History of Immigration Policy as it Parallels Health Care Reform

In order to keep this history short, I have chosen to begin looking at the intersection of immigration and health care reform from the year 1994. In this year, the state of California passed a ballot initiative known as Proposition 187. Viladrich (2011) cites this Proposition as a marker in a "deep shift in the social portrayal of foreigners in the U.S., and raised the tenor of anti-immigrant rhetoric to the pinnacle of conventional wisdom" (p. 2). This act made it lawful to deny unauthorized immigrants from gaining access to health care and public education, in addition to other public services that used to be available to them. It also required health care providers to report to the authorities any suspicious person who may have entered the United States illegally (Berk & Schur, 2001). Although Proposition 187 was later struck down as unconstitutional, the fact that it had gained enough support to be publically voted into law illustrates the American people's (or at least the citizens of California) growing disfavor with immigration, especially by illegal means.

Two years later, in August of 1996, President Clinton signed into law a bill known as the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA) (Public Law 104—193, 1996). Put simply, the law divided immigrants into two general groups – qualified and nonqualified foreigners. Citizenship then came to be seen as a necessary condition for any social entitlement in the U.S. (Viladrich, 2011). Under the new law, even those immigrants who had entered the country legally were not eligible for public benefits like Medicaid until they could prove at least five years of residency within the country.

PRWORA was meant to deter immigrants from coming the United States on the pretense that they would be able to "take advantage" of our country's welfare system, but in reality,

PRWORA did much more than that. Viladrich (2011) writes, "Although undocumented immigrants had never been beneficiaries of means-tested programs prior to PRWORA, this bill clearly spelled out their ineligibility by making states, not the federal government, explicitly accountable for the financial and logistic burden of providing services to them" (p. 2). What is interesting about PRWORA is that it did nothing to change access to health care and benefits for the population of undocumented immigrants, with which the public had the most resentment. What changed was how *legal* immigrants were treated upon entry into the United States. For the first five years of their residency (if not longer), these legal residents were treated as unwelcome foreigners. The discourse constructed through PRWORA is aptly described by Viladrich (2011) when she wrote the following:

> Under the metaphor of the U.S. as a "welfare magnet," PRWORA aimed at discouraging immigrants from coming to this country for the purpose of taking advantage of America's tax dollars…The notion of immigrants' undeservedness was now brought to fame with thousands of legal immigrants losing means-tested benefits and health coverage, including Medicaid. Unauthorized foreigners were then constructed as lawbreakers in both moral and judicial terms (p. 2).

Through this legislation, we can begin to see a national discourse forming around anti-immigration, and whether it is legal or illegal in nature. The Act's exclusionary principles clearly place immigrants in the 'other' category of non-citizenship, therefore validating the denial of access to basic social needs and health care in order to preserve these resources for needy low-income American *citizens*.

This binary between citizens and immigrants is part of a system of biopolitics (Foucault, 1978) in our country surrounding who has a privilege or a right to health. A parallel polarity that seems to exist here is that between *bios* and *zoë*, terms used by Agamben in *Homo Sacer* to distinguish between lives that are valued and lives that are not (1995). *Bios* refers to "the

qualified life of the citizen" (emphasis added), while *zoë* represents "the bare, anonymous life that is as such taken into the sovereign ban" (Agamben, 1995). In using this analogy, we can think of immigrants as part of a group of the "Other," in our country. In defining the Other within the context of the state, we often recognize the Other's existence, but the need to care for this alternate face is not so obvious.

Another arguably important historical moment in the progress of xenophobic public sentiment in the U.S. came on September 11, 2001. Some analysts attribute growing public concerns about illegal immigration to fears about terrorism after 9/11 (Ku & Pervez, 2010). Ku and Pervez write that this "broad public sentiment about immigration, coupled with intense anti-immigrant beliefs of a small but vocal segment of the electorate, led many politicians to support anti-immigrant policies, or at least to be cautious about being perceived as pro-immigrant" (2010, p. 10).

This led to further legislation passed in Congress that was designed to curb immigrant rights and freedoms. In 2005, Congress passed the Deficit Reduction Act or DRA (Public Law 109—171), which requires state Medicaid offices to gain proof of citizenship and identity from eligible citizens who have applied for assistance. Ku and Pervez (2010) point out that this policy was framed as a means of eliminating fraud in the Medicaid system from undocumented immigrants who were managing to gain access to health benefits, yet in the year before this law was enacted, the Centers for Medicare and Medicaid Services (CMS) reported that there was no significant fraud of this type currently present in the system. Even so, the proposal to initiate this new rule into the Medicaid system was pushed forward by two Republicans from Georgia, Representatives Nathan Deal and Charles Norwood. How were these two Congressmen successful at pushing through a law for which there was no evidence that it was needed? Ku and

Pervez (2010) describe Norwood and Deal's political tactics as "obfuscation," or "pitting groups of beneficiaries against one another, in this case citizens versus immigrants. Framing the proposal as punishment for undocumented aliens obscured the facts in two ways. First, the amendment did not apply to those who apply to Medicaid as *immigrants*" (p. 8). Only those immigrants who would attempt to apply for Medicaid coverage as *citizens* would no longer be able to do so under this new legislation. In fact, before DRA, undocumented immigrants were already ineligible for Medicaid. "Second, it distorted the findings of [the report confirmed by CMS in the previous year]" (Ku & Pervez, 2010, p. 9). In other words, the Congressmen made it look like undocumented immigrants vying for citizens' Medicaid was more of an issue than it really was. Ku and Pervez (2010) add, "the symbolic framing used by Deal and Norwood was strong enough to draw support from conservatives and to deter moderate and liberal members of Congress from opposing it too vigorously…Neither evidence of a problem nor evidence that the proposed solution would work was viewed as necessary because the symbols were strong enough to override these flaws in the argument" (p. 9).

In the end, the proposal was passed through Congress into law, and the act proved to be a complete disaster. Many states reported a decrease in numbers of eligible citizens applying for Medicaid due to the fact that many low-income Americans often have trouble locating their birth certificates, Social Security cards, or other proof of citizenship (Ku & Pervez, 2010). In addition, CMS suspects that many more eligible children became uninsured as a result of DRA.

We can see from Ku and Pervez (2010) how symbolic framing in political discourse can have powerful effects of persuasion when it comes to passing laws. This issue seems to be very relevant when discussing the exclusion of immigrants from health care and other social services. Although it is doubtful that symbolic framing, alone, has been the cause of ostracizing

noncitizens from rights discourses in the United States, it is certainly something to keep in mind as an influential factor among others.

Goffman (1986) is credited with developing the concept of framing to define conceptual structures that work to organize discourses and narratives around patterns of selection. Viladrich writes, "Framing takes place in three states beginning with frame building which creates specific definitions and positions on a particular topic; frame setting…that involves the selection and dissemination of specific frames; and framing effect, or the impact on segmented audiences" (2011, p. 3). Goffman's concept of framing is a useful one for understanding how negative frames concerning immigration and are disseminated through the public, media, and political channels. Conservative and xenophobic ideologies in the U.S. have built several frames to structure the immigration debate and to advocate for a policies of exclusion. For example, one such frame, as defined by Viladrich (2011), is a policing frame. This frame building develops the belief that laws should be enacted to protect American citizens from the dangers of foreigners. Based on the idea that immigrants represent a pubic hazard to others, this frame contributes to the moral justification of keeping immigrant populations isolated and excluded from the rest of the legitimate American population. In the case of health care reform, this exclusion takes the path of purposeful non-inclusion of undocumented immigrants and many legal residents from gaining access to more affordable means of health care and insurance, which have been outlined in the Affordable Care Act through the establishment of the health insurance exchanges. Under the ACA, these immigrant groups will be barred from participating, thus making it likely that they will remain uninsured while millions of Americans become covered.

The article by Ku and Pervez on the Deficit Reduction Act (2010) infers an even more active practice of frame building – one that I would argue could be defined as a punishment

frame. In the case of the DRA legislation, conservative Congressmen took an active stance in order to stop what they saw to be the breaking of the law by immigrants who were masking their identity as citizens in order to gain better access to welfare and Medicaid options. As a result, they framed this legislation as a means of "punishing" illegal immigrants from taking advantage of social services meant for U.S. citizens. Yet, this example also illustrates well how the dissemination of a frame can restrict our gaze from the larger picture. Ku and Pervez (2010) aptly point to the fact that there was statistical evidence from the CMS that concluded that immigrants' misuse of the welfare system was in fact a falsity. In fact, there were only rare instances of fraud within the Medicaid system, and these cases could not be attributed to immigrants trying to take advantage of social benefits. The framing used by Congressmen Deal and Norwood obscures this fact, choosing instead to focus other policy makers' attention on painting immigrants as the 'bad guys.' Such a frame gained traction within the political arena because of a proliferation in anti-immigration sentiment in the months after 9/11. As I mentioned earlier, regardless of whether a politician was anti-immigration or not, it was better not to viewed as supporting a pro-immigration policy. Therefore, framing an act on deficit reduction as an issue on immigration helped it to pass through Congress with ease.

Even including these provisions in a bill titled the Deficit Reduction Act, frames the situation in a negative light. Immigrants are arguably placed in the position of contributing to the cause of the deficit, and therefore must be stopped in order to reduce the misuse of state and federal funds. Willen (2012) discusses in an article on framing the debate around immigration as one of "deservingness" that these sorts of policy framings that we see exemplified in the case of the DRA legislation often are inextricably tied to "misrepresentations and distortions that contradict conclusions substantiated by economic and epidemiological research" (p. 815). What

is also important to note is how such framings – regardless of their foundational truth – contribute to the enacting of policy and public sentiment that can be detrimental to the lives of the excluded. I hope to bring to light how these politics of exclusion police the behaviors and health of some immigrants in later sections.

Public Influence on Policy (In)action

Another persuasive factor that needs mentioning before discussing how immigration and health care reform frames have impacted the lives of working immigrants in the U.S. is how public thoughts and often misperceptions about immigration can have a direct influence on public policy. With regards to choosing to decide to exclude immigrants from access to affordable health care options, Willen (2012) writes:

> Concepts of deservingness and undeservingness do not, of course, emerge in a vacuum. Rather, they are shaped by political, economic, social and cultural context as well as personal values and commitments… Questions of 'who deserves what' are pivotal, if implicit, throughout the political process. They shape the discourse and practice of legislators and policy makers…health care institutions…the media…and ordinary citizens (p. 814).

Sanchez, Sanchez-Youngman, Murphy, Goodin, Santos, and Valdez write in their article on public sentiment concerning extending health coverage to undocumented immigrants in New Mexico, "understanding the public views of including immigrants is a crucial dimension of health reform policy formation because the public's attitudes and feelings toward this group are likely to continue to influence the implementation of health reform policies at the state and national level" (2011, p. 684). Zietlow (2011) agrees, arguing that progressive change is best accomplished first by advocacy on behalf of the people, themselves. Many laws, including the

ACA can be regarded as products of democratic constitutionalism, or the "process through which the popular advocacy of fundamental rights succeeds as those rights are incorporated into law" (Zietlow, 2011, p. 6). As we saw in the case with the DRA legislation, anti-immigration sentiment from the public contributed to Congressional support of a law to further divide the rights of citizens from immigrants (Ku & Pervez, 2010). Perhaps if there were more support of immigrants being included as beneficiaries of social services, such a law would never have been passed or even voted upon, and yet there seems to be a dearth of frame building that would advocate for such inclusion. In the next section, I hope to illustrate how confusion and misinformed data has contributed to the general American public's negatively reactionary stance towards immigration and health.

Myths, Sentiments, and Realities of Immigration in the United States: Examining the facts and immigrants' own accounts

The most recent census estimates that about 12 percent of the U.S. population is comprised of immigrants with varying degrees of citizenship status (Stimpson et al., 2010), and the number is continuing to grow. Between 1999 and 2006, it is believed that approximately eight and a half million people moved to the United States from abroad (Stimpson et al., 2010). At rates like this, it is understandable why immigration continues to be such a polemical topic in politics and the national media. Yet it is important to distinguish the truth about immigration in the U.S. from the trepidations that many Americans feel about their foreign-born neighbors and coworkers. We will come to see that the public fears about immigration are often not founded in fact; therefore, it is worth discussing these falsities in greater detail to ascertain why so many Americans come to accept them as reality.

One of the most popular arguments against immigration in the United States is based upon the assumption that immigrants cost the U.S. and American taxpayers lots of money (Dolgin & Dieterich, 2010). As a result, it is believed that our economy suffers from immigration. Yet, many studies have shown this to be false (Gardner, 2004; Kullgren, 2003; Viladrich, 2011; Ku & Pervez, 2010; Galarneu, 2011). Most immigrants, although possibly educated and qualified for specialized careers in their home countries, do not have the resources to find well-paid and advanced jobs when they move to the U.S. As a result, many are forced to work in low-wage jobs in industries that provide few if any benefits. These jobs include the work of migrant laborers in the agricultural industry, construction, house cleaning, and childcare. Many of the wages produced by these jobs are not enough for most families to survive, which is why they are often passed over or refused by Americans who are looking for work. Despite their low-income status, these jobs are necessary for the rest of the American economy to run smoothly. Immigrant workers in these fields help to make that possible.

In addition to providing the U.S. with a cheap labor market, most immigrants pay taxes, whether on income or through other means (Schneider, 1999). These taxes help support the continuation of public benefits like Medicare and Medicaid, social security, and welfare – services that many immigrants are not eligible for. In this sense, one could argue that immigrants often give more to the U.S. government and economy than they receive.

Finally, we must not forget that immigrants are also consumers in our economy, like all other Americans. The goods and services they buy and the money they spend contribute to the wealth of functioning of our country. Although such contributions are difficult to quantify, it is important to match them up against the argument made that immigrants contribute only to economic losses and the U.S. deficit. A research study done by the Pew Hispanic Center

(Forbes.com, 2007) on the economic impact of immigration in the U.S. concluded that there is no definitive evidence that immigrants affect the economy negatively overall. As I have begun to point out, there are simply too many variables to account for when considering immigrants' effects on employment, spending, and tax contributions to the U.S. government.

In addition to the general economic arguments made against immigration, many opponents have made points about the drain of medical costs and services that go toward immigrants and their families. A popular myth in the United States is that undocumented and legal immigrants siphon public health services like Medicaid away from American citizens that need them the most (Viladrich, 2011; Schneider, 1999). This is often cited when looking at uninsured or low-income immigrants' use of emergency medical services, which are much more expensive than the average doctor's visit to a primary care provider. When immigrants who are uninsured or who are not eligible for Medicaid cannot pay for these emergency room visits, the payments eventually get picked up by the state and indirectly through Americans' tax dollars. This is why some of the American public has accused immigrants for driving up health care costs in our health care system. Yet what this argument fails to acknowledge is *why* many immigrants – both undocumented and legal residents – have no other choice but to turn to emergency rooms in hospitals to treat conditions that have become exacerbated because of a lack of preventative and primary medical care.

The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 was one positive step in the direction of a more inclusive public health strategy in that it required U.S. hospitals to treat patients in emergency medical conditions regardless of their ability to pay for the treatment, yet once the patient is considered to be in a 'stable' medical condition, then the hospital can discharge him or her at any time. Provisions like EMTALA have undoubtedly

saved millions of low-income Americans and uninsured immigrants' lives since being passed into law, but it has also played a critical part in structuring our system of care. Many immigrants who are without health insurance or other means of paying for medical expenses will forego important preventative health care measures or routine annual check-ups because the financial costs are too high and they are not emergency treatments that hospitals are obligated to administer.

In some ways, EMTALA has framed a discourse on when and a right to health begins and ends. The federal government has deemed that life-threatening conditions are worth saving at all costs – therefore everyone, regardless of their ability to pay, has a right to emergency health care – but even once you may be admitted to a hospital because of an emergency medical condition, you may just as quickly be asked to leave if the doctors decide your state of health is no longer life-threatening and they discover that you are uninsured or cannot pay for further treatment. Thus, an immigrant or uninsured American's 'right to health' ends when they are no longer seen as being on the verge of possible death. In this frame, EMTALA defines *when* lives are worth saving, yet it does nothing to protect lives from reaching the point of needing to be saved. Vaccines, annual check-ups, health screenings, and other valuable preventative measures that help save lives in the future are not health benefits that are covered within a right to health framing under EMTALA. As a result, the only place that many immigrants without insurance or a means to pay end up visiting for medical care is the emergency room. This experience of limited health rights came into reality for me when I met a Vietnamese business owner named Mr. Trang.

Mr. Trang's story. The stark effects of the poor structure of our nation's health care system and legislation like EMTALA are embodied in the lives of Mr. Trang and his family. Mr.

Trang moved to the United States from Vietnam fifteen years ago. Like many immigrants, he has moved around a lot over the years, settling in Philadelphia in 2006. Two years ago, he opened a restaurant in West Philadelphia, which is where he spends most of his time working now. Despite living in the U.S. for more than a decade, Mr. Trang's English is very limited. Greetings are about all that he can understand and respond to, and his wife is in the same constrained position. An excerpt from my field notes on the first day I met Mr. Trang and his family is as follows:

> *The restaurant has what one could call the bare minimums. Chairs, tables, a TV whose satellite has not been connected in the corner, a fridge full of sodas and water, and a hostess stand with a cash register. When I walk up to the hostess stand, an older woman begins calling in Vietnamese for her young daughter to come over. Her daughter is the only one in the restaurant who can speak English. I later learn that she is in the 4th grade and comes to the restaurant after school to waitress and answer the phones. She translates for me as I ask her father if he would be willing to sit with me and answer some questions. He consents, so I make plans to come back tomorrow evening. These plans are also facilitated by his daughter's translations back and forth between us.*

Mr. Trang's interview was conducted entirely through the translation of his eldest daughter, who is only ten years old. I spoke with her for a little while when her father had to stop the interview to go on a delivery. Mr. Trang's daughter, Xiwei, explained to me how she was on her spring break, but had only been allocated two days in the week by her parents for playing with friends.

"What do you do during the rest of week"? I asked.

"My parents need me here to help in the restaurant." Xiwei replied nonchalantly. I tried to detect a hint of disappointment at having to spend her week off from school in her family's restaurant, but there was none. Xiwei was used to spending all her free time there. As the eldest

child and the only one whose English was extensive enough to handle calls and orders from customers, Xiwei was the most vital part of the family's entire business operation. Mr. Trang did not hire any outside employees; it was a business completely dependent upon the labor of family members, which is quite common among many small businesses owned by immigrants. Family and ethnic solidarity is often very important for immigrants, which may be one of the reasons why Mr. Trang chose not to hire outside help.

Xiwei and her younger siblings are enrolled in the state's Medicaid for children program – CHIP. As U.S. citizens, Xiwei and her siblings are covered under the health insurance program funded by the state and federal government for children of low-income families. This coverage is fairly extensive and provides more care than Medicare and some Medicaid programs for adults. Such coverage should have ensured that Mr. Trang would have been able to take his children to a pediatrician or primary care physician on a regular basis in order to make sure they stay healthy. This was not the case. When asked what happens when his children become ill, Mr. Trang responded that he takes them to the hospital. When I followed up with a question about whether or not his children saw a primary care physician or a pediatrician, Mr. Trang was slightly confused. Either he did not think such a doctor was necessary, or, as I am more inclined to think, Mr. Trang was unaware of how to find a primary care doctor. Due to his poor English-speaking skills, Mr. Trang's navigation of our health care system had not developed enough in order to find a way to provide primary and preventative care to his children. With no primary care doctor to speak of, Mr. Trang found himself in the same position as many other immigrants and low-income Americans with family members on Medicaid. When his children would come down with a fever or a bad cold, he would take them directly to the emergency room. Of course,

CHIP would cover any kind of all-purpose care for a sick child, but instead, the coverage was only being used to pay for expensive hospital ER visits.

In addition, Mr. Trang admits that he and his wife have no health insurance.

"Why?" I ask.

"Because I am young and healthy." He smiles.

Mr. Trang's answer was logical. Many young Americans forgo the cost of paying for health insurance that they think they will rarely ever use. Yet, I could not help but wonder if there were other reasons for Mr. Trang's uninsured status. Surely, if he had managed to navigate enough of the bureaucratic system to enroll his children in the CHIP program without understanding hardly any English, he could have done the same for himself and his wife in the Medicaid program, assuming that they would qualify and that he was aware of the Medicaid program for adults with dependent children. Although we did not discuss the sensitive issue of Mr. Trang's immigration status, I wondered if the mixed citizenship statuses of him and his children was enough for Mr. Trang to try to avoid the government system when possible.

In one study, Berk and Schur (2001) examined the effect fear had on immigrants' use of medical services, regardless of their citizenship status or legal standing. They found that across the board, a large percentage of immigrants agreed that fear of deportation or legal consequences concerning their immigration status deterred them from seeking medical treatment when it was needed (Berk & Schur, 2001). Studies have also shown that immigrants overall consume less health care relative to their share of the population than American citizens (Viladrich, 2011; Stimpson et al., 2010). Under PRWORA legislation from 1996, all undocumented immigrants and many legal residents are barred from applying for government assistance to pay for medical care. Many social scientists have suggested that this has drastically reduced immigrants' access

to primary health care and preventative services (Viladrich, 2011; Kullgren, 2003), which leaves them with few other options than to seek emergency treatment once conditions have worsened. These medical costs at emergency treatment centers are undeniably more expensive than the preventative measures that could have been taken to help many immigrants avoid the hospital setting. As a result of this evidence, a counter argument and framing to the belief that we should not provide access to health care for immigrants because they would take away health services from needy Americans is that it may be much more cost effective to include them as eligible members of public health benefits (Kullgren, 2003). Keeping immigrants excluded from access to health care may be more costly in the long run. Under the ACA, the individual mandate clause is also based on evidence that widening the pool of health insurance applicants will lower health care insurance for all. If the 12 million immigrants who will be barred from entering the new health insurance exchanges were required, like all American citizens, to have health insurance, costs of health care would assuredly drop even more.

As we can see from Mr. Trang's story, another way in which preventing immigrants from having access to health care does harm is by indirectly excluding many U.S. citizens who are the children of immigrants from proper medical care. Although the U.S.-born children of immigrant families are eligible for coverage under programs like CHIP, the mixed eligibility standards of the family often result in many children missing annual check-ups and other precautionary and preventative health care treatments (Viladrich, 2011; Hirota et al., 2006; Zuckerman et al., 2011). The difficult process by which all eligible Americans must apply for Medicaid can often deter someone from applying and therefore gaining access to affordable treatment. Ku and Pervez (2010) point out that many low-income U.S. citizens or long-term legal residents, who would be eligible for Medicaid, do not apply because they do not have copies of their birth certificates,

social security number information, or other necessary documents to prove eligibility. Legislation like PRWORA, which mandates proof of citizenship or eligibility status, has only made the process of providing medical insurance aid to many low-income Americans even more cumbersome and challenging, thus discouraging many people from seeking the benefits for which they are eligible.

Another argument that proponents of the exclusion of immigrants from universal health care fail to regard is the public health's duty and interest in providing basic medical care for everyone. Kullgren (2003) writes, "The consequences of [immigrants'] health burdens and barriers to accessing services extend beyond the individual to the entire community. The agricultural and food service settings in which many undocumented immigrants work, for example, can facilitate the spread of communicable diseases to other segments of the population" (pp. 1630-31). From a public health standpoint, it is arguably in everyone's best interest for medical services – especially preventative ones – to extend to all corners of the population. If not, the excluded populations may continue to pose a health threat to those who are protected. Galarneau (2011) succinctly argues, "any individual's health depends in part on the health of others" (p. 426). Later she quotes a health director on public health's interest in providing universal access to health care when she writes, "to have a healthy community, we can't have a subset of people who don't have access to health care" (Galarneau, 2011, p. 426). Again, we begin to see the theme emerge that it may be more disastrous to continue to exclude immigrants from health care coverage than to include them under a universal system.

Despite all of this evidence that excluding immigrants from public health assistance programs can actually cost the U.S. more money and can do harm to eligible Americans' health and well being, the American framing of the narrative of immigrants as welfare stealers

(Viladrich, 2011) continues to exist. Many Americans believe that one of the reasons immigrants come to the United States is to take advantage of our health coverage options (Galarneu, 2001), so barring them from access to health care should deter them from wanting to immigrate in the first place. This was arguably the reasoning behind the DRA legislation. Yet, we have seen this to be blatantly false. There is evidence that immigrants contribute more to the U.S. than they take from it. They are consumers of smaller portions of health care than American citizens, many of them are employed and pay taxes, and their ineligibility is often making it more difficult for children and other eligible adults to gain access to services like Medicaid. In 2009, Congressman Joe Wilson famously called President Obama a liar when the president-elect said that undocumented immigrants would not be included under his universal health care reform plan. The congressman was of course, wrong. Yet, it is statements like these that incite public anxiety over a willingness to accept immigrants as members of U.S. society and worthy of its health benefits (Ku & Pervez, 2010). Until the American public is aware that the supposed threats immigrants pose to their country are nonexistent, there will continue to be opposition to the inclusion of this minority under health care reform.

Yet, perhaps the issue is less about raising public awareness to the benefits of immigration to our economy, and more about how the *framing* of immigration needs to be changed. Framing groups of immigrants as "illegal," "illegal aliens," "undocumented," and "illegals" implies that they resorted to 'criminal' means of arriving in the U.S. Lakoff and Ferguson (2006) discuss the consequences of using the "illegal" frame when they write:

> "Illegal," used as an adjective in "illegal immigrants" and "illegal aliens," or simply as a noun in "illegals" defines the immigrants as criminals, as if they were inherently bad people. In conservative doctrine, those who break laws must be punished — or all law and order will break down. Failure to punish is immoral. "Illegal alien" not only stresses criminality, but stresses otherness. As we are a

> nation of immigrants, we can at least empathize with immigrants, illegal or not. "Aliens," in popular culture suggests nonhuman beings invading from outer space — completely foreign, not one of us, intent on taking over our land and our way of life by gradually insinuating themselves among us. Along these lines, the word "invasion" is used by the Minutemen and right-wing bloggers to discuss the wave of people crossing the border. Right-wing language experts intent on keeping them out suggest using the world "aliens" whenever possible. These are NOT neutral terms. Imagine calling businessmen who once cheated on their taxes "illegal businessmen." Imagine calling people who have driven over the speed limit "illegal drivers" (p. 3).

Lakoff and Ferguson (2006) also make the valid argument that framing 'illegal' immigration as a criminal behavior prevents us from seeing the positive effects this group can have on our economy that we discussed earlier. Their point about using an "alien" frame as a means of othering is an important one to linger on, as well. Othering dehumanizes. When 'citizens' become synonymous with 'humans' and 'illegal aliens' imply 'nonhumans' it becomes easier to justify the exclusionary politics of leaving immigrants out of health care reform that is designed to help *citizens* gain better access to affordable health care.

What would a counter frame to this conservative American ideology look like? Think about how our policy might be different if it reflected a frame that classified immigrants as "economic refugees" (Lakoff and Ferguson, 2006)? If we look at the causes of immigration to the United States within a larger context of neoliberalism and global labor exchanges, how might we come to understand the immigrant's condition differently? Viladrich (2011) also brings into question what a public health framing might look like. If we view immigrants coming from all over the world as vectors of disease, then should it not be in our best interest to vaccinate them, routinely check their health, and ensure that they're healthy too? These hypotheticals are great at showing how framing restricts what the public – and therefore the policy makers – choose to see. Viewing Mr. Trang's story from the frame of a hard working businessman whose children are

American citizens and who contributes to the American economy makes justification of his possible exclusion from health care reform significantly more difficult. From the standpoint of who deserves what, how we frame the immigration debate has been shown to drastically affect public narratives of whose moral worth and deservedness of access to health care is valued the most within biopolitical frameworks of exclusion (Willen, 2012; Fassin, 2001).

Foucauldian Biopower and the Other

One cannot talk about the biopolitics of exclusion without invoking Foucault. The French social theorist wrote, "Since the classical age, the West has undergone a very profound transformation of [the] mechanisms of power…a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them" (Foucault, 1978, p. 79). With this shift in power came a focus on the upholding and protection of lives within the state that may be threatened by outside forces such as disease, war, or societal extinction. What is now at stake for the sovereign state is "the biological existence of a population" (Foucault, 1978, p. 80). From this belief naturally comes the legitimization of any action – including violence – by the state to rid the sovereignty of any potential harm. This modern state has the power to not only foster life but also to disallow other lives to the point of death, if need be (Foucault, 1978). In the context of health care reform and framing access as a matter of deservingness, excluding some immigrant groups from participating within the health insurance exchanges and from the individual mandate under the ACA could be interpreted as a way in which the state has drawn a line between those lives worth saving and keeping healthy, and those lives that are negligible. Such a biopolitics of exclusion fits within the framework of dichotomizing American habitants as citizens and non-citizens. Willen (2011) urges us not to overlook the denial of immigrants to biolegitimacy in the U.S. and

other first world countries. The subtle and overt ways in which the biopower of the state operates are constantly at play when we examine who is pushed to the fringes of society – who has access to health benefits and who is forced to find other means to stay healthy. The Medicaid's system of making enrollment a difficult and tedious process and legislation like PRWORA and DRA are tools of the state's biopower that work to scare and exclude immigrants from gaining access to health benefits, regardless of their eligibility status. Mr. Trang's story shows that those who do not have the knowledge base, or are directly excluded from access to health care, are obligated to construct their own counter-biopolitics in order to survive. As we have seen, looking at immigrants' struggle obtaining health care opportunities that are naturally afforded to American citizens within a Foucauldian frame positions them in the role of the Other – one whose life is not worth protecting and must be excluded in order to better protect the lives of those who are American citizens. Still, we must not forget that even the Other can exert agency within a system that is unfavorable to him. My second immigrant's story is one illustrative of successful counter-biopolitics that can ensue once one knows how to navigate within the U.S. health care system.

Learning to Circumvent Exclusion: The Foucauldian exception?

Other immigrants, although familiar with the politics of exclusion in the U.S. healthcare system, have found other means around the controls of state-sponsored biopower within an informal setting. Sunil Singh is a Pakistani business owner is the proud owner of a handful of shops all over West Philadelphia. Throughout his twenty-six years living in the U.S., Sunil has lived all over the country. He has settled in the Philadelphia area to raise his children, all of whom were born here, and are therefore American citizens like the children of Mr. Trang. As a businessman, Mr. Singh constructed the answers to the questions I asked him in economic terms.

At times throughout our discussion, he seemed preoccupied with thoughts about money, class, and even power. Often comparing and contrasting the state of Lahore with Philadelphia, Mr. Singh's story was somewhat exemplary of so many immigrants' American dream. Sunil's success in business and the stories he was able to tell me about how his status among his friends and family changed back in Pakistan since he has made a living in the U.S. showed me that he was confident with how he had found niche within the American system to build himself a comfortable and happy lifestyle. Unlike in the story of Mr. Trang, Mr. Singh and his entire immediate family living with him in the U.S. had health insurance. That said, Mr. Singh's view of health insurance was different from that of many Americans. To him, health insurance was not a means to pay for all of one's health care. Instead he viewed health insurance as a safety net. Insurance was there to cover catastrophic medical costs if and when they arise. Just as Mr. Trang viewed going to see a doctor as only something done in emergency situations, Mr. Singh viewed health insurance – a commodity he surely lived without for many years before he became an established businessman – as a safeguard against emergencies.

Yet, unlike Mr. Trang and many uninsured immigrants, Mr. Singh and his family did not forgo other medical visits like annual physician visits and seasonal vaccines. In order to pay for these medical costs, Mr. Singh had positioned himself within what is often called an ethnic enclave. Founded on dual labor market theory, which stresses the occurrence of "labor market segmentation," or the coexistence of noncommunicating labor markets – one for the general public and one for the disenfranchised who have been unsuccessful at assimilating into the main economic stream – ethnic enclave theory emphasizes the distinction between ethnic economies and the general market. Rather than competing within the general market economy, ethnic enclave economies develop within their own sort of informal economic sector so that the

businesses within them come to have their own relative monopolies on the goods and services provided. "Ethnic enclave economies obtained these advantages thanks to superior recapture of coethnic spending. This recapture was caused ultimately by vertical and horizontal integration along ethnic lines" (Light and Gold, 2000, p.12). These vertical and horizontal linkages are now seen as being derived from social capital. Mr. Singh's defined his ethnic enclave to me as a group of Pakistani and Indian business professionals who traded services within their respective fields.

"For instance, if I have heart trouble, I go to see my friend from India who is a cardiologist," Sunil explained.

"Does that mean your friend the cardiologist eats for free in your restaurant?" I asked.

"Why of course!" Sunil smiled.

Within Sunil's ethnic enclave, a nonmonetary system of trade persisted within what many sociologists see to be an informal sector of our economy. I would argue that one of the main reasons for the proliferation of such enclaves among immigrant groups in major urban areas of the United States is because of their exclusion from the formal economic sector. In particular, we see this to be what has happened in the economic realm of health care. With health care costs too exorbitant for immigrants who are barred from gaining access to affordable care, long-standing residents and members of ethnic communities have developed their own means of coping with this exclusion.

How should we view Sunil and others' strategies of survival within a Foucauldian framework of biopower? What does it mean to survive when the state has deemed you too insignificant to keep alive? Sunil's story seems to want to lend to anthropologists an example of agency at work. Within a larger structure of biopolitical control, individuals intended for

exclusion like Sunil have found ways to navigate their way through the structure and to even prosper. Yet we must not lose sight over stories like those of Mr. Trang. Agency can be dynamic and shifty. Both Mr. Trang and Mr. Singh are arguably surviving within a society that has designed measures to isolate them from the benefits of mainstream society, and yet it is easy to tell that Mr. Singh has managed to carve out a lifestyle that is much more comfortable in the U.S. Differing levels of agency can be seen at work here. Arguably time spent in the U.S., one's ability to speak English, and one's understanding of how our health care system works contribute to an individual's ability to choose how to interact with our nation's health care system. Mr. Singh understands how the system works and how to survive within and outside of it. Mr. Trang is still learning the fundamentals of what is required to stay healthy for him and his family.

Examining the recent Health Care Reform from a Perspective of Deservingness

In the year before the ACA was passed, many policy makers and Americans seemed to think that the time had come for a general acceptance of the right to health in the United States. In a perspective article in the New England Journal of Medicine, Senator and chairman of the Senate Finance Committee Max Baucus (2009) wrote framed his argument in favor of health care reform based on the belief that everyone should have access to the medical treatment they need, and not just what they can afford. Baucus was one of the key players in the success of passing the ACA in the Senate and has been cited as playing the critical role of gaining bipartisan support for the legislation (E. Emanuel, UPenn lecture, February 15, 2012). Speaking on behalf of all congressmen and women, Baucus wrote, "We share a commitment to giving patients the peace of mind to know that *no person* in the United States of America will go broke just because he or she gets sick" (emphasis added) (2009, p. 2). It is important to note the

implied universality of such a statement. Senator Baucus chose to include all people, and not just American citizens, or those minorities who have been underrepresented in the past. His language takes on a nondiscriminatory tone that many social scientists have argued is the necessary language for framing such a discussion as a human rights issue (Yamin, 2005).

Senator Baucus goes on to conclude his editorial with a comment that seems to imply that a right to health is congruent with American ideals, as well: "Americans are counting on us to end the status quo and bring our health care system in line with the principles and character of this great nation" (2009, pp. 2-3). What readers are left to figure out is what sort of "principles and character" are conducive to the creation of a law that demands universal health care? After examining the Senator's language, it does not seem like a stretch to argue that the formation of the ACA was built on a framework that claims a universal deservingness of access to health care. Clearly this type of discourse would be more amicable for providing a political environment in which all immigrants could be included in health care reform.

Along this human rights framework for health care reform comes the long-standing belief that the government has an obligation to protect those who are disenfranchised (Schneider, 1999), but perhaps this idea should be modified to specify *who* is worthy of protection and *why*. Do our American principles of taking care of the poor extend only to those whom we call citizens? Or, do we mean to include everybody? Viladrich (2011) points to a national narrative that used to stress the importance of Americans providing for those who come from other countries, as well. Refugees, elderly and young immigrants have had a history of being absorbed into the American welfare system and given the same rights as citizens. The United States as a symbol of shelter for immigrants in war-torn, diseased, or unsafe countries was at one time an agreed upon reality. Yet since September 11, 2001, Americans have begun to turn their backs to the

outside world as anti-terrorism and anti-immigration discourses begin to propagate in our national media and politics (Kullgren, 2003; Viladrich, 2011; Ku & Pervez, 2010). As a result, the divide between Americans and legislators who support the inclusion of immigrants in matters of public policy, like health care reform, and those who continue to oppose their addition has widened.

The fight to include all immigrants under a universal health care plan has been adopted by public interest groups and lobbyists. These supporters of immigrants' inclusion in health care reform are in favor of a universal right to health in the United States, and yet Viladrich argues that pushing forward the agenda of a minority may be counterproductive to achieving a universal aim (2011). She writes, "proposals towards progressive inclusion, which are based on additive notions of rights, are in clear contradiction with the principle of health as universal human rights" (Viladrich, 2011, p. 6). In other words, Viladrich makes the point that the general principle behind fighting for universal health coverage is that it includes *everyone*, and yet, the way in which politics is structured in the U.S. is in order for each group to fight for its inclusion of American privileges and rights. Perhaps this structure is at the heart of why even the ACA has failed at calling for true universal health care coverage – all American factions are too busy worrying about themselves.

Health Care Post-Affordable Care Act: Do We see a Universal Right to Health in Our Future?

In the previous pages, we have discussed how the framing of immigration has been negatively reflected in health policy over the decades. Anti-immigration sentiment has also continued to rise, and has been shown to have an effect on the exclusion of immigrant groups in recent legislation like PRWORA and the Deficit Reduction Act. Since 9/11, Americans' fear of

the outside has been heightened, only furthering the divide between those who support and are against the inclusion of immigrants within the mainstreams of our society. Unfortunately, this has fostered an environment through which the Affordable Care Act has followed in the legacy of legislation before it to explicitly exclude much of the immigrant population from gaining access to affordable health care. Particularly the measures which are in place to prohibit undocumented immigrants from entering health insurance exchanges as individuals not only works to exclude them, but actively works to make finding affordable health insurance more difficult for immigrants than it is now on the private market. With this in mind, perhaps the ACA is moving in the wrong direction when it comes to the inclusion of immigrants in health care.

So how do we determine where the future of the Affordable Care Act will lead us? Are we following in the footsteps of past failed attempts at universal reform, or does the ACA have the potential to pave a new route in American social policy towards more inclusive legislation down the road? One of the ways in which the ACA broke with convention was in its accomplishment at achieving bipartisan support of health care reform. President Obama's careful selection of appointed positions within the executive branch were critical to fostering a political environment in which legislation could be passed (Iglehart, 2009; E. Emanuel, UPenn Lecture, February 15, 2012). The appointments of Rahm Emanuel, "a powerful congressman from Illinois" (Iglehart, 2009, p. 206), and Senate Majority Leader Daschle as secretary of Health and Human Services, for example, were early indications of the president's dedication to maintaining close ties with Congress in order to make collaboration more feasible.

Indeed, the president and Congress were successful at drafting legislation that attempted to achieve the goal of universal health care in the United States. In both the Senate and the

House, the bill passed by slim majorities, which makes one wonder, what would, or could, have been the deal breakers? Galarneu (2011) argues that maybe the inclusion of all immigrants in health care reform was still too much for policy makers to handle because it is such a divisive issue among the American public. Quoting Senator Baucus, Galarneu writes, " 'We're not going to cover undocumented workers, because that's too politically explosive.' When pressed on this, he reiterated, 'That's very politically charged. And I don't want to take on something that's going to sidetrack us'" (2011, p. 423). It seems the Senator was willing to fight for affordable health coverage for all, *but* within reason.

I discussed earlier how public discourse concerning immigration and health care reform can be reflected in policy decisions (Zietlow, 2011; Ku & Pervez, 2010; Viladrich, 2011). If the inclusion of immigrants as recipients of affordable health care is a polemical issue among Americans, chances are it is going to find difficulty in gaining support as legislation. Kullgren (2003) reminds us that there are still many popular misconceptions about immigration in the United States. Framings of narratives of immigrants as welfare stealers and economic burdens for Americans have continued to be popular despite much evidence to the contrary (Kullgren, 2003; Viladrich, 2011; Berk & Schur, 2001; Stimpson et al., 2010). Until these attitudes about immigration change, we cannot reasonably expect the government to make efforts to protect them.

The discussion around the inclusion of all immigrants in the Affordable Care Act's universal health coverage may be convincing that the legal and legislative avenues may not be the best methods by which we can ensure the health rights of *all* individuals who live in the U.S. If this is so, then it is important to examine what other options are at the public's disposal in order to protect the health of immigrants. Although this could certainly be the scope for an entire

other paper on the topic of immigrant health care, it is worth mentioning the role of community health centers as possibly of the best route for ensuring all members of a local region are giving the same medical rights and opportunities. Despite the enacting of PRWORA and the ACA, many health centers have continued to provide coverage for undocumented and newly arrived immigrants, who would otherwise be ineligible for Medicaid or other forms of health insurance. Yet some studies have shown that such health programs may be unsustainable without local government or federal financial aid (Hirota et al., 2006).

Federal aid may be relatively impossible for the purpose of providing ineligible immigrants with health coverage, but it is not unreasonable to expect that some states might choose to keep health care options for immigrants open (Stimpson et al, 2010). For example, many states in New England and the northeast have already enacted legislation that permits the opening of health care centers that provide medical care to immigrants (Stimpson et al, 2010). We can only hope that more states may follow their lead down the road.

Conclusion

In her concluding remarks of a recent article on health deservingness among undocumented immigrant groups in Tel Aviv, Sarah Willen (2012) writes:

> Sociologist Josh Guetzkow (2010) has recently argued that scholarship on welfare needs to move beyond "deservingness" and "undeservingness," primarily because these categories hold only limited value in explaining how law and policy emerge. While this may be true for scholarship on welfare, the health domain demands a different research agenda at present, particularly if we aim to leverage the strengths of an anthropological approach. Before we can move beyond these categories to analyze their impact on law and policy, we first need a clearer empirical sense of how health-related deservingness and undeservingness are constructed and employed by divergent stakeholders. Only then can we move beyond such constructions both to "study up" and to better understand their reverberating impact – ideological, practical, and

> embodied – in the lives of unauthorized im/migrants and other vulnerable groups (p. 819).

This paper has aimed at poking through the surface of providing a multi-faceted outlook at the intersection of immigration and health care reform in the United States. From the above examination of the stories of two very different immigrant individuals – in combination with relevant social theories on framing, othering, structural violence, and biopower – I hope to have shown not only who the unenfranchised will continue to be as health care reform pushes forward, but also how this group has come to navigate a system that is designed to impede their progress and success.

It should also be clear that critical to facilitating immigrants' inclusion in health reform in the future will be a change in the framing of how the general American public understands the effects of immigration on society. As long as the framing continues to be centered on defining immigrants as illegal, undocumented, non-citizens, and aliens, policy will reflect these perceptions with exclusionary legislation. How we propagate the truth about the potential benefits of immigration to our economy and to our health system is a challenge. The social science fields of anthropology, sociology, public health, political science, and history should be open to collaboration on raising the public's awareness to the positive effects of immigration from as many approaches as possible; otherwise, the realm of academia is too limited to have broad reaching effects on the public's minds and policy change. For now, the place to bring about change may not be the legal arena, but more informally through grass roots organizations and public awareness campaigns. In the end, we can only hope that eventually American ideology will come full circle back to the early days of when the United States recognized every American's habitation as the outcome of immigration and every newcomer was sooner or later assimilated fully into American society as a protected citizen.

References

Agamben, G. (1995). *Homo sacer: Sovereign power and bare life.* Guilio Einaudi editore.

Baucus, M. (2009). Doctors, Patients, and the Need for Health Care Reform. *The New England Journal of Medicine,* 361, pp. 1817-1819.

Berk, M., Schur, C. (2001). The effect of fear on access to care among undocumented Latino immigrants. *Journal of Immigrant Health*, 3(3), pp. 151-156.

Dolgin, J. and Dieterich, K. (2010). When others get too close: Immigrants, class, and the health care debate. *Cornell Journal of Law and Public Policy,* 19(6), pp. 283-334.

Fassin, D. (2001). The biopolitics of otherness: undocumented foreigners and racial discrimination in French public debate. *Anthropology Today*, 17(1), pp. 3-7.

Forbes.com. (2007) *Immigration's Impact.* Retrieved February 20, 2012. http://www.forbes.com/2007/01/02/immigration-minimum-wage-ent-hr-cx_kw_0102whartonimmigration.html?boxes=custom.

Foucault, M. (1978). The Right of Death and Power Over Life. In N. Scheper-Hughes and P. Bourgois (Eds.) *Violence in War and Peace: An anthology,* (pp. 79-82). Malden, Massachusetts: Blackwell Publishing.

Galarneau, C. (2011). Still missing: Undocumented immigrants in health care reform. *Journal of Health Care for the Poor and Underserved,* 22, pp. 422-428.

Gardner, D.B. (2004). Immigration and health care reform: Shared struggles. *Nursing Economics,* 25(4), pp. 235-237.

Goffman, E. (1986). *Framing analysis: An essay on the organization of experience.* Boston: Northeastern University.

Guetzkow, J. (2010). Beyond deservingness: congressional discourse on poverty, 1964-1996. *Annals of the American Academy of Political and Social Science*, 629(1), pp. 173-197.

Hirota, S., Garcia, J., Silber, R. and Lamirault, I. (2006). Inclusion of immigrant families in U.S. health coverage expansion. *Journal of Health Care for the Poor and Underserved,* 17(1), pp. 81-94.

Hirsch, J. S. (2003). Anthropologists, migrants, and health research: confronting cultural appropriateness in anthropology and contemporary immigration. In N. Foner (Ed.), *American arrivals: Anthropology engages the new immigration* (pp. 229-257). Santa Fe: School of American Research Press.

Iglehart, J. (2009). Visions for Change in U.S. Health Care – The players and the possibilities. *The New England Journal of Medicine,* 360(3), pp. 205-207.

Ku, L. and Pervez, F. (2010). Documenting Citizenship in Medicaid: The struggle between ideology and evidence. *Journal of Health Politics.* 35(1), pp. 5-28.

Kullgren, J. (2003). Restrictions on undocumented immigrants; access to health services: The public health implications of welfare reform. *American Journal of Public Health*, 93(10), pp. 1630-1633.

Lakoff, G. and Ferguson, S. (2006). *The framing of immigration.* The Rockridge Institute. Available at http://www.rockridgeinstitute.org/research/rockridge/immigration/ [Accessed 04.10.12].

Light, I. and Gold, J. 2000. *Ethnic Economies*. San Diego: Academic Press.

Public Law 104—193. (1996). *Personal responsibility and work opportunity act of 1996.* Washington DC: US Government Printing Office. Available at http://www.gpo.gov/fdsys/pkg/PLAW-104publ193/content-detail.html [Accessed 02.23.12].

Public Law 109—171. (2005). *Deficit Reduction Act of 2005.* Washington DC: US Government Printing Office. Available at http://www.gpo.gov/fdsys/pkg/PLAW-109publ171/content-detail.html [Accessed 02.26.12].

Sanchez, G., Sanchez-Youngman, S., Murphy, A., Goodin, A.S., Santos, R. and Valdez, R.B. (2011). Explaining public support (or lack thereof) for extending health coverage to undocumented immigrants. *Journal of Health Care for the Poor and Underserved,* 22, pp. 683-699.

Schneider, J.A. (1999). And how are we supposed to pay for health care? Views of the poor and the near poor on welfare reform. *American Anthropologist*, 101(4), pp. 761-782.

Stimpson, J., Wilson, F. and Eschbach, K. (2010). Trends in health care spending for immigrants in the United States. *Health Affairs,* 29(3), pp. 544-550.

Viladrich, A. (2011). Beyond welfare reform: Reframing undocumented immigrants' entitlement to health care in the United States, a critical review. *Social Science & Medicine*, 30, pp. 1-8.

Willen, S. S. (2011). Do "illegal" migrants have a "right to health"? Engaging ethical theory as social practice at a Tel Aviv open clinic. *Medical Anthropology Quarterly*, 45(3), pp. 303-330.

Willen, S. (2012). How is health-related "deservingness" reckoned? Perspectives from

unauthorized im/migrants in Tel Aviv. *Social Science & Medicine,* 74, pp. 812-821.

Yamin, A. (2005). The right to health under international law and its relevance to the United States. *American Journal of Public Health*, 95, pp. 1156-1161.

Zietlow, R. (2011). Democratic Constitutionalism and the Affordable Care Act. *Ohio State Law Journal,* 72(4), pp. 1-40.

Zuckerman, S., Waidmann, T. and Lawton, A. (2011). Undocumented immigrants, left out of health reform, likely to continue to grow as share of the uninsured. *Health Affairs,* 30(10), pp. 1997-2004.