

# Hospital Infrastructure

## Section 7

**H**undreds of infants born to Hispanic immigrants who moved to the New Orleans area after Hurricane Katrina to work on reconstruction have placed additional strains on the region's health infrastructure, the *New York Times* reports. According to the *Times*, much of the state-financed Charity Hospital system, which provided care to most of the uninsured and low-income residents in the area, remains closed.

The two local health units that are administered by the Louisiana Department of Health and Hospitals from January through mid-November admitted more than 1,200 pregnant women, the majority of whom were Hispanic. "Before [Hurricane Katrina], only 2 percent were Hispanic; now 96 percent are Hispanic," Beth Perriloux, head nurse at the state health and hospitals clinic in Metairie, La., said.... Many Hispanic women do not have private health insurance and cannot afford to pay for prenatal care or delivery services, and non-emergency Medicaid is not available to undocumented immigrants or legal immigrants who have been in the country for fewer than five years...."<sup>1</sup>

New Orleans suffered a unique natural disaster. The stress placed on its hospital system is increasingly common, however. Hospitals throughout the country have been inundated by uninsured immigrant. The financial strain has affected the quality of medical services, forced hospitals to close clinics and emergency rooms, and put infrastructure expansion plans on hold.

### Immigration v. Hospitals

Immigrants are disproportionately employed

in low-wage jobs, small firms, and service or trade jobs that are less likely to offer health benefits. More than 46 percent of foreign-born noncitizens were uninsured in 2006—three times the uninsurance rate of native-born persons (15 percent). Most of the growth of the uninsured population is due to immigration: Over the 1994 to 2006 period, immigrants accounted for 55 percent of the increase.<sup>2</sup>

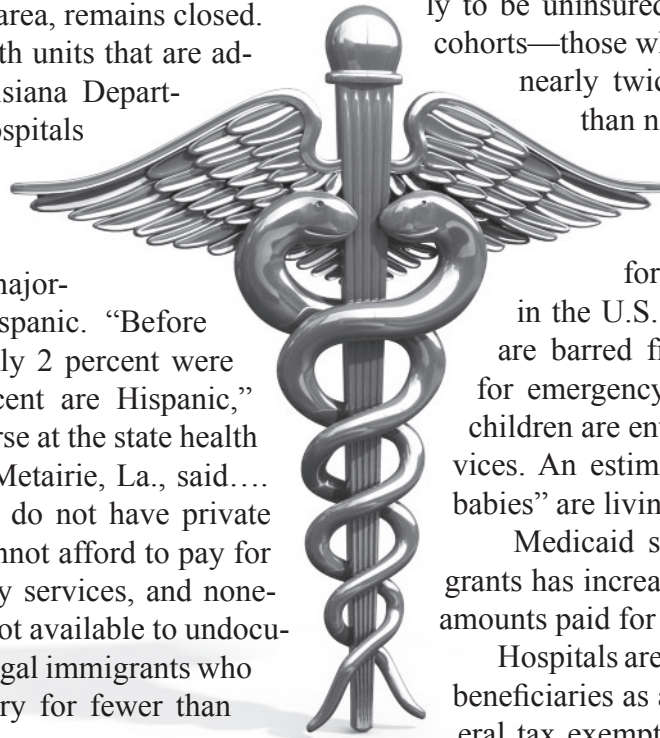
Although recent immigrants are the most likely to be uninsured, even the oldest immigrant cohorts—those who arrived prior to 1970—are nearly twice as likely to be uninsured than natives.

Legal immigrants are eligible for Medicaid, the federal insurance program for the indigent, after five years in the U.S. Although illegal immigrants are barred from medical benefits except for emergency room care, their U.S.-born children are entitled to the full gamut of services. An estimated 3 million such "anchor babies" are living in the U.S.

Medicaid spending on behalf of immigrants has increased far more rapidly than the amounts paid for native-born recipients.

Hospitals are required to care for Medicaid beneficiaries as a condition for receiving federal tax exemptions. This is a financial burden for hospitals, however, because Medicaid reimbursements do not cover the full cost of services. Medicaid underpaid hospitals by \$11.3 billion in 2006, up from \$2.6 billion in 2000. This translates a payment of 86 cents for every dollar spent by hospitals caring for Medicaid patients in 2006.<sup>3</sup>

Uncompensated health care costs have created a two-tier hospital system. Treatment at "safety net" hospitals—that is, those catering primarily to immigrants and other Medicaid patients—lags behind that offered at facilities that do not treat large num-



bers of such patients:

Hospitals with high percentages of Medicaid patients had worse performance in 2004 and had significantly smaller improvement over time than those with low percentages of Medicaid patients. Hospitals with low percentages of Medicaid patients improved composite acute myocardial infarction performance by 3.8 percentage points vs. 2.3 percentage points for those with high percentages.... Larger performance gains at hospitals with low percentages of Medicaid patients were also seen for heart failure (difference of 1.4 percentage points,  $P = 0.04$ ) and pneumonia (difference of 1.3 percentage points,  $P < .001$ ). Over time, hospitals with high percentages of Medicaid patients had a lower probability of achieving high-performance status.<sup>4</sup>

**Uninsurance v. Infrastructure**

This is a boom time for hospital construction. A record \$41 billion in hospitals and clinics was under construction in the fourth quarter of 2007. Despite the credit crunch and recession fears, medical infrastructure construction growth is expected to continue in the low double digits through 2009.<sup>5</sup>

There are several reasons for the building boom: obsolete facilities, new technology that improves the efficiency and quality of hospital care, and seismic code changes that require replacing buildings in California. Overarching everything is the aging of the baby-boom generation.

Abut three-fifths of hospitals of surveyed by the American Hospital Association (AHA) in October 2007 either had projects under construction or planned to initiate construction of new projects within three years.

Unfortunately, many hospitals cannot afford to replace inferior facilities. They are deterred by the double whammies of rising uninsured case loads and declining federal reimbursement rates for Medicaid patients, which provide 60 percent of

the income received by some safety-net hospitals:

“As you continue to fight reimbursement issues at a facility and you’re trying to upgrade, it becomes difficult,” says Donna Craft, executive director of support services, NorthEast Medical Center in Concord, N.C. “It is getting much harder to elevate the aesthetic standards and the bottom line.”<sup>6</sup>

Making matters worse is that the cost of hospital construction is highest in immigrant gateway cities such as New York, Los Angeles, San Francisco, and Chicago.

**The Emergency Department**

Emergency departments are the most common item found on the infrastructure “wish lists” of U.S. hospitals. Architect and engineering expert Joseph

**Hospitals by the Numbers**

- 5,747 hospitals in the United States (2006)
- \$607.4 billion total expenses of all U.S. hospitals (2006)
- 35.4 million inpatient admissions in 2006
- 118.4 million emergency room visits (2006)
- 5.6 days average length of inpatient stay (2006)
- 2.0 days reduction in average inpatient stay, 1981-2006
- 12 million+ uninsured immigrants in the U.S. (2006)
- 92 percent immigrant share of uninsured population growth, 1998-2003

**Hospital Infrastructure Spending (a)**  
 2005 estimated: \$41.0 \$billion (\$135 per capita)

**2050 Spending Projections (b)**  
 \$60.7 billion: at current population trends  
 \$52.6 billion: at 50-percent reduction in immigration  
 \$41.0 billion: at zero population growth

**Notes:**  
 a. Value of hospitals and clinics under construction in the fourth quarter of 2007.  
 b. Assumes per-capita construction spending remains at 2007 levels.

**Sources:** American Hospital Association, Health Facilities Management, Employee Benefit Research Institute, Pew Research Center.

Sprague, director of health facilities for the Dallas-based architectural firm HKS Inc., says that almost every project his firm does has some sort of emergency department (ED) component: “The ED has become the front door of the hospital...People go to use the emergency room and they end up using the hospital.”<sup>7</sup>

But EDs are an endangered species. The number of EDs fell from 5,108 in 1991 to 4,587 in 2006—a 10-percent decline. Over the same period ED visits increased by a whopping 33.8 percent.

A Centers for Disease Control (CDC) study found that half of EDs experienced overcrowding in 2003 and 2004. An ED is deemed to be “crowded” if ambulances had to be diverted to other hospitals; if average waiting time for urgent cases was 60 minutes or more; or if at least 3 percent of patients left before being treated.<sup>8</sup>

People die from these delays. Autopsies of accident victims who died after reaching EDs in San Diego hospitals suggested that 22 percent of the deaths were preventable.<sup>9</sup>

Illegal immigration is a major factor behind the ED emergency. On the demand side, illegal aliens utilize hospital EDs at more than twice the rate of the overall U.S. population: 29 percent versus 11 percent.<sup>10</sup> On the supply side, uncompensated illegal alien care is the cause of many ED closures.

Not surprisingly, California EDs are among the hardest hit. Fox News reports that “Sixty percent of [LA County’s] uninsured patients are not U.S. citizens. More than half are here illegally. About 2 million undocumented aliens in Los Angeles County alone are crowding emergency rooms because they can’t afford to see a doctor.”<sup>11</sup>

In the last decade, 60 California emergency rooms closed.

One federal law in particular has made things worse. The Emergency Medical Treatment and Labor Act (EMTALA), enacted in 1986, requires that every emergency department in the country treat uninsured patients for free. Naturally, this includes immigrants and illegal aliens.

EMTALA defines medical “emergency” as any complaint brought to the ED, from hangovers to hangnails, from gunshot wounds to AIDS. The hottest ED diagnosis, according to medical lawyer

Madeleine Cosman, is “permanent disability” – a vaguely defined condition that covers mental, social, and personality disorders.<sup>12</sup>

Drug addiction and alcoholism are among the fastest growing of such “disabilities.” A disability diagnosis automatically qualifies illegal aliens for Supplemental Security Income, a federally funded cash transfer payment.



The University of North Carolina builds a new cancer hospital in Chapel Hill in February 2007.

Fines of up to \$50,000 are imposed on hospitals refusing to treat ED patients—even when the attending physician examines and declares the patient’s illness or injury to be a non-emergency. Lawyers and special interest groups are granted more authority than doctors in these matters.

EMTALA was supposed to make EDs more accessible to the uninsured. Talk about unintended consequences!

**Not only did this unfunded mandate contribute to the closure of numerous emergency departments and trauma centers, it also created a perverse incentive for hospitals to tolerate emergency department crowding and divert ambulances while continuing to accept elective admissions. Rather than improving access to emergency care, EMTALA diminished it.<sup>13</sup>**

### Hospitals Strike Back

Illegal aliens enter the U.S. medical system via the EDs. Their ED stays are usually short, albeit



costly in the aggregate. Sometimes things go horribly awry, however.

Case in point: Luis Alberto Jimenez. Mr. Jimenez, working as a gardener in Stuart, Florida, suffered devastating injuries in a car crash with a drunken Floridian. Martin Memorial Hospital saved his life, but the crash’s impact on his brain left Jimenez incapacitated. After failing to find a rehabilitation center willing to accept an uninsured patient, the hospital kept him as a ward for years at a cost of \$1.5 million.

Medicaid does not cover long-term care for illegals. Neither does the state of Florida. Martin Memorial originally had no recourse except to keep Mr. Jimenez as a long-term care patient. He became essentially a boarder at the hospital, wheeling around the hallways and hanging out with the nurses. Over time, Mr. Jimenez became depressed, exhibiting anti-social habits such as spitting, yelling out, kicking, and defecating on the floor.

What happened next set the stage for a continuing legal battle: Martin Memorial leased an air ambulance for \$30,000 and flew Mr. Jimenez back to his home country of Guatemala. U.S. immigration authorities were not consulted and played no role in his transfer.

Prior to the transfer, the hospital contacted Guatemalan authorities. Eventually a letter from the Guatemalan health minister arrived, assuring Martin Memorial that his country was prepared to care for Mr. Jimenez.

Martin Memorial is not alone. Medical deportations are happening with varying frequency and varying degrees of patient consent throughout the country. No government agency tracks them, but a recent *New York Times* article provides snapshots of the phenomenon: 96 medical deportations at St. Joseph hospital in Phoenix, Arizona; 6 to 8 patients repatriated from Broward County Medical Center

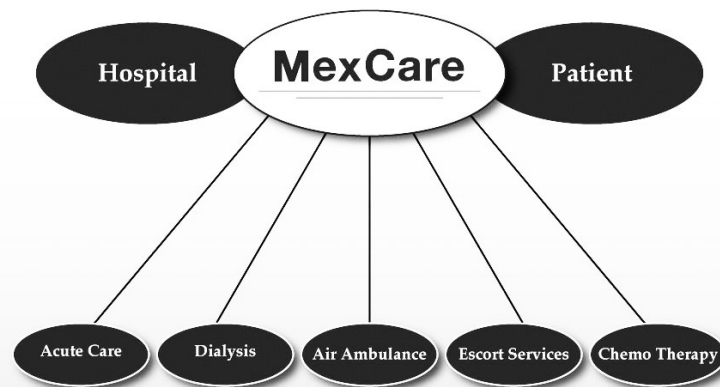
in Ft. Lauderdale, Florida; 10 flown to Honduras from Chicago hospitals since early 2007; some 87 cases involving Mexican illegals deported by San Diego area hospitals.<sup>14</sup>

There is enough medical deportation traffic to sustain at least one transportation company. Mex-Care, founded six years ago to service this niche, is headquartered in California but connects hospitals throughout the U.S. with a network of 28 hospitals and treatment centers in Latin America.

Hospital administrators view these as costly, burdensome transfers that force them to shoulder responsibility for failures of the U.S. immigration system. Medical deportations are a last resort—designed to free up beds for ill U.S. citizens. In the long run, these

transfers prevent an even worse scenario: financial insolvency and closure of a community’s hospital.

Martin Memorial is being groomed as a test case by the pro-immigration lobby. Perhaps the hospital should sue the U.S. Department of Homeland Security. ■



**Endnotes**

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