Policy Perspectives on Public Health For Mexican Migrants in California

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Summary: This analysis focuses on public policies that affect primary HIV prevention and access to HIV care for Mexican migrants residing in California. Policy or structural level interventions, as opposed to behavioral or psychologic interventions, help to shape the environment in which people live. We use a conceptual model for policy analysis in public health to understand better the challenges faced by Mexican migrants. We assess potential policy level interventions that may serve as barriers to or facilitators of primary HIV prevention and care for Mexican migrants. Among potential barriers, we discuss restrictions on public health services based on legal immigration status, limits placed on affirmative action in education, and laws limiting travel and immigration. Under potential facilitators, we discuss community and migrant health centers, language access laws, and the use of community-based groups to provide prevention and treatment outreach. We also report on the limited research evaluating the implications of these public policies and ways to organize for more responsive public policies.

Key Words: Mexican migrants, policy, HIV prevention

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California and Mexico are more than just geographic neighbors. In fact, before being annexed to the United States, California was a part of Mexico. Thus, the state and country share a history and a culture and continue to have strong ties in the arenas of the economy, trade, development, population, public health, and welfare. California is now the fifth largest economy in the world, and Mexico is its primary trading partner.[1]

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California's population was estimated to be 34.5 million in 2001.[2] Since 1970, it has been the most populous of the United States, with the number of residents tripling to 30 million between 1950 and 1990.[2] A significant portion of the explosive growth has been the flow of Mexican immigrants, now totaling 3.8 million, into the state.[3] California is home to the nation's largest population of Spanish speakers. Overall, Latinos make up 32% of Californians, and their share of the state's populace is growing by approximately 1% every 2 to 3 years.[2]

During the 1990s, 11 million people immigrated to the United States, with 9 million of them coming from Mexico.[4] Two thirds of all Mexican–Americans and Mexican nationals in the United States live in California, and the state continues to absorb more temporary workers (28%) than any other.[4] Mexican immigrants in California are conspicuously mobile and often travel back and forth across the international border for reasons of work and family. Indeed, the border crossing at San Ysidro, CA, is the busiest in the world.[5]

For complicated historical, structural, economic, and political reasons, the largest number of undocumented immigrants to the United States comes from Mexico—54% or approximately 2.7 million people.[6] Moreover, a high percentage of Mexicans (78%) living in the United States are not US citizens, which is a much higher figure than the average for all other immigrant groups (45%).[4] California absorbs into its workforce and economy the highest concentration of undocumented Mexicans of any state. It is understandable then that not only are issues surrounding immigration unusually forceful in California but that illegal immigration from Mexico plays a particularly prominent role in discussions of public policy.

As part of the efforts of the California–Mexico Health Initiative, we have attempted to assess structural factors or public policies at the national and state levels that serve as barriers to or facilitators of primary HIV prevention and access to HIV care for Mexican migrants. We define migrants as individuals born in Mexico and residing in the United States permanently or temporarily. We have not attempted to analyze policies in Mexico. We also identify gaps in public policy research that, if filled, would help us to under-

stand better how migration- and health-related public policy may reduce the impact of AIDS and HIV in California and Mexico.

HIV AND AIDS AMONG MEXICAN MIGRANTS

California accounts for 15% of the cumulative AIDS cases reported in the United States,[7] with Latinos comprising 20% of those statewide cases.[8] Although Mexico's population is 3 times as large as California's, it has only one third as many reported AIDS cases.[9] The higher prevalence of HIV in California means that Mexican migrants are more likely to be exposed to HIV in California than in Mexico.

Statistics separating Mexicans from the larger Latino population in California are generally not available. However, those born in Mexico make up such a large proportion of California Latinos that figures for the larger group are illustrative of the conditions faced specifically by Mexican migrants. Recent epidemiologic data suggest that people of Mexican origin have considerable risk of becoming infected with HIV, especially men who engage in sex with other men[9,10] and migrant workers who have sex with commercial sex workers. HIV infection among migrant workers poses risks for Mexican women, especially those who remain in Mexico and are sexual partners of men who migrate between California and Mexico. Migration is now affecting the spread of HIV to rural areas.[11]

We cannot address the HIV epidemic without also addressing the difficulties that Mexican migrants face in accessing health care services in California, a difficult issue in California. In 1999 to 2000, 19% of all nonelderly Californians were estimated to be without health insurance. The problem is especially acute among Latinos. Approximately 34% of California's Latino residents have no health insurance, making them the group most likely to be uninsured and the least likely to have job-based medical benefits. A lack of health care access is not limited to the unemployed, however. Even in California, of families with at least 1 full-time worker, 18% have no insurance.[12]

STRUCTURAL INTERVENTIONS AND PUBLIC HEALTH

Governments at all levels adopt policies designed to promote public health. Examples are common in alcohol and smoking prevention (eg, prohibiting drunk driving, prohibiting cigarette and liquor sales to minors) and in injury control (eg, speed limits, seat belt laws). Although HIV prevention and access to care traditionally have been dominated by individual level approaches, increasing attention is being paid to structural factors—barriers that create vulnerable populations and facilitators that support safe behaviors and access to care.[13]

To understand better the public health challenges faced by Mexican migrants in California, we use a conceptual model (Table 1) adapted from a framework for policy analysis in public health.[14] Our purpose is not to place every intervention into a single category but rather to provide a heuristic model by which we can evaluate systematically the impact of a given policy. This model recognizes that interventions can be targeted at 3 different levels: individual, organizational, and environmental.

Individual

Individual level interventions focus on changing behavior 1 person at a time. A common example involves social marketing campaigns. Public service announcements promote the benefits of desired behaviors (or the costs of the undesired behaviors), with the hope that each individual will choose to adopt health-promoting activities.

Organizational

In contrast, organizational level interventions promote behavior change by altering the practices of businesses, community groups, governmental agencies, or other institutions. For example, a strategy used to increase seat belt use was to have automobile makers install reminder alarms.

Environmental

Finally, environmental level interventions attempt to alter the physical or social environment in a way that is condu-

TABLE 1. HIV-Related Public Health Policies

	Individual	Organizational	Environmental
Availability	Criminal penalties for intentional HIV transmission Needle exchange	Anonymous HIV testing sites Bathhouse regulations	Screening the blood supply
Acceptability	Antiprostitution stigmatization campaigns "HIV Stops With Me" campaign	Antistigma public service announcements	Condom social marketing
Accessibility	Condom distribution program for migrant farm workers Culturally appropriate case management	Expansion of HIV voluntary counseling and testing and care in community and migrant health centers	Legal immigration documentation requirements

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cive to better public health. These approaches require no action by individuals themselves. A well-known example is the decision to fluoridate the water system as a means of reducing dental cavities.

The model also divides interventions according to 3 major sources of problems to be addressed: availability, acceptability, and accessibility.[14]

Availability

Availability interventions attempt to influence public health by increasing the likelihood of adopting health-promoting behaviors (eg, providing free condoms, increasing the number of anonymous HIV test sites) and decreasing the likelihood of health-damaging practices (eg, banning cigarette vending machines). HIV/AIDS-related examples include California's adoption of criminal laws for intentionally transmitting HIV and decisions by local governments to regulate bathhouses as a means to discourage unprotected sex. Another example is a recent change in state regulations to allow HIV counselors to perform rapid HIV antibody tests.

Acceptability

Acceptability interventions are designed to alter social norms and typically have been based on 2 different approaches. The first makes use of shame. Interventions are designed so that those who engage in undesired public behaviors are exposed to community censure. An example would be publishing the names or photographs of individuals who employ sex workers.[15] A second and more positive approach emphasizes social responsibility and the benefits of adopting a particular individual behavior, such as the recent campaign "HIV Stops With Me" sponsored by the San Francisco Department of Public Health.[16] Through media and Internet-based messages, the goal of the program is to foster a social norm of personal responsibility that encourages HIV-infected individuals to prevent transmission to those not infected.

Accessibility

Accessibility interventions respond to concerns about disparities in health care outcomes, particularly among racial and ethnic minority groups—disparities that are created by unequal access to health services. Thus, accessibility interventions targeting Latinos in general, and Mexican migrants in particular, are of particular concern as part of the California-Mexico Health Initiative. An example of an accessibility intervention is the introduction of culturally appropriate case management for individuals with HIV disease. Other interventions currently before the state legislature would establish a university-based center to eliminate health disparities and provide continuing medical education credit for cultural and linguistic competency.

STRUCTURAL BARRIERS

One approach to policy analysis is to examine specific policies in light of established goals—in this case, the public health goals of primary HIV prevention and access to HIV-related health care.[17] The determination of whether any given policy or structural intervention is a "barrier" or "facilitator" is a judgment that should be based on evidence. Unfortunately, appropriate research studies are often lacking.

We next identify a number of policies that impede effective HIV prevention and access to health care among Mexican migrants in California. To the extent that research is available, we have tried to summarize what is known.

Proposition 187

In 1994, 59% of California voters approved Proposition 187. Although ultimately struck down by the federal courts, it prohibited state and local governments from providing a broad range of services, including nonemergency health care services such as HIV primary care to anyone who could not affirmatively verify legal residence in the United States. Furthermore, agencies that determined a person was in the country illegally were obligated to report their finding to state and federal agencies, including the Immigration and Naturalization Service.

Proponents argued that the initiative would "end the illegal alien invasion" and "save our state".[18] They further argued that welfare, education, and medical benefits are the "magnets" that draw illegal immigrants to California and that the federal government had failed in its duty to control the nation's borders. Opponents countered that enforcing existing laws against illegal immigration was a more appropriate and effective response to the problem and argued that the denial of education, welfare, and health benefits would have serious consequences for the state in the future, with the costs of the initiative's verification requirements far exceeding any savings.

As a structural barrier, Proposition 187 operated at several levels. Its most direct effect, restricting the people to whom government offices could offer service, was meant for an organization level but was never enforced because of the successful legal challenges. The debate surrounding Proposition 187 may have created indirect environmental access barriers, however. Mexican immigrants were made to feel unwelcome and to fear possible reprisals if they sought health services. As such, Proposition 187 might have had deterrent effects even though the courts invalidated it.

Studies on this matter have produced mixed results. Researchers in San Francisco reported a 26% decrease in Latino clients' initiation of treatment at sites operated by the Division of Mental Health and Substance Abuse Services,[19] and a study at the largest county hospital in Los Angeles found a decrease in the use of ophthalmology services.[20] A statewide analysis of primary care clinics serving low-income populations found no significant decline in monthly visits, however, even though clinic directors perceived a deterrent effect.[21] It is not clear why the results of the studies diverged. Some have speculated

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that the declines observed in selected services in San Francisco and Los Angeles may have been localized occurrences.[21]

Although Proposition 187 may or may not have had a deterrent effect on the use of health care services, it did have definitive political repercussions. The initiative served to mobilize the Latino community throughout California to become more politically active and assert its interests more aggressively. Thus, the longer term consequences of the initiative may have been more positive than negative for Mexican nationals in California.

Proposition 209

In 1996, 54% of California voters approved another initiative, Proposition 209.[22] This measure, which has been upheld by the courts, prohibits government institutions, including schools and colleges, from giving preferential treatment to any individual or group in hiring, education, and contracting. It effectively terminated existing "affirmative action" programs that had benefited Latinos and other groups.

Proponents argued that discrimination on the basis of race is wrong and that the government should end such practices.[23] Their position was based on the premise that programs designed to ameliorate the effects of past bias ultimately prove to be discriminatory in practice and, consequently, generate resentment when the "less qualified are preferred." Opponents countered that the initiative would eliminate many programs necessary to promote equal opportunity to disadvantaged groups and would bar outreach and recruitment efforts necessary to bring important services, such as health care, to targeted groups.

The health care barriers manifested in this act again operate at multiple levels. Most directly, at an organizational level, the initiative prohibits universities from considering race and ethnicity in admissions decisions. A negative impact on the training of Latino health care providers has already been observed. A report by the Center for California Health Workforce Studies found deleterious effects at all stages of the medical school application process.[24] From 1995 to 1998, there was a 25% reduction in the number of underrepresented minorities applying to medical schools in California, with Mexican-Americans accounting for most of the decline. Similarly, the number of minorities admitted to medical school in 1998 had declined by 30% from the all-time high in 1993 to 1994. Finally, the number of minorities enrolling in 1998 had dropped by 32% from a peak in 1993. Although decreases were not observed in admissions to California residency programs, the authors of the report noted that the long duration of medical education could result in a significant lag between the implementation of Proposition 209 and its impact on advanced training. The observed declines in the number of Latinos seeking and obtaining medical education are important because they eventually may lead to a reduction in Latino physicians in the state, an environmental level change that can affect the availability and quality of health care to Mexican–Americans.

Yet another initiative, Proposition 227, was approved by 61% of California voters in 1998.[25] It ended bilingual education in favor of English-only public school instruction.[26] Although having less direct impact on public health, critics point out that in the context of the other ballot initiatives, this measure contributed to a perception that the Latino community was being blamed for a variety of the state's problems in education, health care, the cost of government, and social cohesion.

Welfare Reform

As part of the Personal Responsibility and Work Opportunity Reconciliation Act signed into law in 1996, noncitizens were divided in 2 categories: qualified and nonqualified aliens.[27] The latter category includes undocumented immigrants and individuals admitted legally for temporary purposes. These individuals are barred from most direct federal assistance. In contrast, qualified aliens (legal permanent residents, refugees, and individuals granted asylum) are potentially eligible for federal government assistance. A variety of restrictions limit the number of qualified aliens actually able to obtain assistance, however. For example, many legal permanent residents have to demonstrate that they have worked for 10 years or that they have a connection with the military (eg, active-duty service) to receive food stamps, Supplemental Security Income (SSI), Temporary Assistance to Needy Families (TANF), and Medicaid.

Welfare reform poses clear barriers at an organizational level by making important federal assistance legally unavailable to immigrants failing to meet eligibility requirements. Although some states, including California, have softened the impact by providing aid through their own funds, the symbolic importance of the reforms remains. The restrictions are an overt endorsement of a long-standing ideology that opposes admitting immigrants likely to become a "public charge".[27] Welfare reform sends a clear message intended to discourage poor people from immigrating to the country.

HIV Immigration Ban

In 1995, Congress enacted a statute placing HIV infection on the list of communicable diseases that bar entry into the country by immigrants or foreign nationals traveling to the United States. HIV had been on the list by administrative order, and President Clinton had proposed removing it. The arguments in favor of the law were the protection of US citizens' health and a reduction in the burden of HIV care on federal and state budgets. Opponents argued that HIV was not a casually contagious disease and thus did not require exclusion in terms of travel. The exclusionary precedent was discriminatory, they said, and was decried internationally by scientists and advocates as harmful stigmatization and a hindrance to prevention. The travel ban has resulted in the International AIDS Society

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disqualifying the United States as a host to the biannual International Conference on AIDS. There is no evidence that this policy has achieved its cost-saving objectives. The policy, however, serves as an organizational barrier, because the Immigration and Naturalization Service is required to screen all applicants for their HIV status as part of the legalization process.

The ban on immigration has had an effect on Mexican nationals living with HIV in California. In most cases, these effects operate on the environmental and organizational levels. For example, when Mexican nationals apply for legalization, they are required to undergo HIV testing. If they test positive, they are permanently excluded from entry into the United States, are ineligible for services in this country, and are subject to deportation. Thus, for those who have reason to believe they could be infected with HIV, the immigration policy can be a major deterrent to testing and a barrier to prevention and early intervention.

STRUCTURAL FACILITATORS

Public policy makers also have undertaken interventions that enhance HIV prevention among Mexican migrants in California. Below, we identify a number of policies that facilitate effective HIV prevention and access to health care among this population.

Community Health Centers

The establishment of community and migrant health centers, recently reauthorized under Section 330 of the Health Centers Consolidation Act of 1996, is an example of a policy facilitator. These entities are intended to provide underserved rural and urban populations with access to family-oriented primary and preventive health care services. They emphasize community outreach and culturally appropriate care. As part of the War on Poverty, migrant health centers were created in 1962 and community health centers in 1965. Currently, there are 121 migrant health centers at more than 400 clinics nationwide (in California specifically, there are 17 migrant health centers and 107 clinics). Half of all patients served nationally are Latino. The community health center program has administered grants to more than 700 organizations that support more than 3000 clinics.

In California, this network of providers has been especially important to the Mexican migrant population. It is estimated that more than 90% of farm workers in rural California are Mexican-born and that roughly 70% of this population has no access to any kind of health insurance whatsoever. Migrant and seasonal farm workers have some of the most severe health problems of any population in the United States as a result of the confluence of poverty; poor diet; bad housing; and exposure to pesticides, infectious diseases, and weather extremes.[28] Moreover, health care services for all residents are scarce (and becoming more so) throughout rural California, even for those with insurance. In urban areas, lack of insurance, low incomes, and other factors combine to make Mexican migrants particularly dependent on neighborhood health centers. As of 2002, Latinos comprised 34.8% of the patients at such clinics.[29] In addition, Mexican migrants frequently travel back and forth across the border, which can mean disruption in access to HIV medications, interrupted care, and choosing between being with family or being in care. Community health centers emphasize educating and counseling their clients about these difficult personal and practical issues.

Training Latino Health Professionals

Latino patients are more likely than white patients to report problems in communicating with their physician and to think that they have been treated with disrespect during a health care visit.[30] Diversity in the health care professions can help to rectify these problems. Some HIV clinics with predominantly Latino populations have built rapport and improved care by matching patients with providers from similar cultures.[31] Research has shown that Latino physicians are more likely to serve in areas with high percentages of Latino residents.[32] In addition, Latino patients report receiving more and better quality care if their physician is someone of the same ethnic group.[33] Thus, programs that seek to improve minority participation in health professions are interventions that serve to increase the acceptability and accessibility of important health services.[34] For example, the Health Resources and Services Administration (HRSA) is authorized to provide a number of programs to promote minority training opportunities. The future of these programs is threatened by potential cuts to nondefense domestic programs, however, and will ultimately be determined in annual federal budget deliberations.

AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) is another example of a structural facilitator. Established in 1987, the program provides HIV-related drugs at no cost to uninsured and underinsured individuals with limited incomes. The program disproportionately assists Latinos in California. In 1998, Latinos constituted 23% of people living with AIDS but 32% of participants enrolled in the ADAP.[35] The program effectively changes the health care environment for HIV-infected low-income people around the country by removing the financial barriers to treatment. California has adopted a number of policies in terms of income eligibility, number of drugs covered, and number of participating pharmacies so as to increase access and reduce racial/ethnic disparities in the California ADAP compared with other states.[36]

Education and Outreach

Treatment, education, and outreach programs are excellent examples of accessibility interventions designed to increase Latino participation in health care. Many undocu-

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mented individuals are not aware that they may qualify for services, including the ADAP. Language, cultural beliefs, and lack of family support may all be barriers to seeking or getting access to care in the migrant and recent immigrant communities. A strategy for overcoming these barriers is to fund directly community-based organizations working with migrant and Latino populations to correct misinformation and to link clients to culturally appropriate care. This approach has been used extensively in New York and to a lesser extent in California.[36] Unfortunately, evaluation data on these programs have not been collected.

Language Access

Language access policies in California stand in sharp contrast to English-only initiatives. In 1973, the California legislature enacted the Dymally-Alatorre Bilingual Services Act, which requires all state agencies to provide language translation services if at least 5% of their clients speak a language other than English. In 1999, the State Bureau of Audits determined that departments were largely not in compliance with the act; legislation has been introduced calling for greater enforcement. Recently, the Mexican–American Legal Defense and Educational Fund (MALDEF) made passage of this enforcement legislation a top legislative priority, along with increased funding for agencies to assist with language access and to enforce the act. Advocacy has focused on requiring state agencies to develop long-term implementation plans to bring agencies into compliance with this law. These policies facilitate accessibility to health care and social services for Latino migrants.

DISCUSSION

The structural barriers and facilitators outlined in this article demonstrate a growing tension in the politics of California and the nation as a whole. There is increasing debate about the role of race and ethnicity in official government policy. One ideologic position argues that the government must never consider a person's race or ethnicity in its allocation of services, because to do so is to encourage unequal treatment. It is through this perspective that initiatives banning affirmative action and requiring English-only instruction are passed. A related core belief argues that public policies are needed to discourage illegal immigration and to prevent noncitizens from becoming public charges.

An opposing core belief is that the government must continue to consider race and ethnicity in the distribution of its services. Only through targeted programming is society able to rectify fundamental inequalities brought on by the historical mistreatment of racial and ethnic minority groups as well as by extant prejudices. In addition, government consideration of race and ethnicity is considered essential to respond effectively to racial and ethnic disparities in health outcomes. A related core belief is that protecting public health requires a strategy of expanding access and acceptability through engagement of racial and ethnic minority communities. It is through this philosophic lens that legislators enact programs to increase the number of underrepresented minorities in the health professions or to fund such programs as community health centers in minority neighborhoods.

Our analysis suggests that in California, policies identified as "barriers" have often been established by voter initiative, whereas those identified as "facilitators" have generally been acts of the legislature. The two avenues are distinctively different and suggest important lessons for future action. The initiative process is dominated by well-funded individuals and interest groups able to identify "hot button" public concerns and design proposals with widespread political and emotional appeal. Initiatives succeed because expensive media campaigns are able to appeal to large blocks of voters in the most populous and media-driven state. Acts of the legislature, however, are more likely to succeed if coalitions of interest groups are able to convince 1 or more legislators that a policy offers a worthwhile solution to an ongoing problem. Fact-based problem solving has a better chance of succeeding in a legislative setting than in a statewide political campaign; over the years, the California legislature has demonstrated a willingness to tackle public policy issues that affect the state's migrant population.

Principles of the advocacy coalition framework of policy analysis[37] are applicable and instructive here. The advocacy coalition that has come together to work for increased access for Mexican migrants, including increased language access and increased access to Latino providers and community outreach, includes direct advocacy organizations, legislators and relevant executive branch agencies, journalists or other media covering these issues for targeted communities, and mostly university-based researchers who provide much of the evidence documenting need. It is important to recognize that there also is an advocacy coalition representing the interests of those who wish to restrict immigration and share a core belief about limiting the size and scope of government. This coalition includes advocacy groups favoring lower taxes and restricted immigration, like-minded legislators and media targeting those receptive to these messages, and "think tanks" that generate facts and figures in support of the coalition policy objectives.

One principle of the advocacy coalition framework states that widely held core beliefs on major controversies such as illegal immigration tend to be stable over periods of at least a decade or so as reflected in California ballot initiatives.[37] Thus, the initiative process is likely to remain a playing field in which advocates for the interests of migrants are most likely to be on the defensive.

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A second principle states that even when it is not possible to change widely held core beliefs of the general public, it is still possible to move key policy brokers, such as legislators, with evidence suggesting solutions to practical problems.[37] With fewer actors to convince and a greater likelihood that evidence can sway policy makers already familiar with issues such as lack of language access, the state legislature is an environment in which improvements in policies related to migration are more likely to be adopted. In California, moreover, the growing strength of the Latino vote has resulted in more representatives who are receptive to public policies that facilitate benefits for migrant groups.

A third principle states that a skilled exploitation of opportunities by advocacy coalitions is required[37] to accomplish the goals of the coalition. California has a substantial network of individuals and interest groups—employers, unions, legal aid service providers, and human rights groups, for example—capable of creating such advocacy coalitions. This principle stresses the importance of external mobilization for any legislative policy success.

Beyond the advocacy coalition framework, it also is important to consider "window of opportunity" issues.[38,39] From time to time, political, social, and economic circumstances come together to allow consideration of particular issues for a limited period. Often, budget imperatives are an important element of such windows of opportunity.

Advancement of the California–Mexico Initiative must take a long-term perspective. It may take 10 or more years to implement various policy options for accomplishing these public health goals. Almost all these options require resources, which means that advocacy must be considered in the context of larger budget debates. The success of this initiative requires taking advantage of strategic opportunities and the effective use of an advocacy coalition. Hopefully, a better understanding of this policy framework and the environment in which policies are developed can be useful in moving the agenda forward.

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