

Access to health service by Brazilian emigrants in the United States¹

O acesso aos serviços de saúde por emigrantes brasileiros nos Estados Unidos

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Resumo

A análise do atual contexto político e econômico existente nos EUA, que envolve o acesso e utilização de serviços de saúde pelos imigrantes, diz respeito aos mais de 20 milhões de indivíduos estrangeiros que residem naquele país e não possuem seguro de saúde. Essa população corresponde a 43,8% de 46 milhões de pessoas que não possuem cobertura de provedores privados de saúde nos EUA, sendo 10,5 milhões residentes sem a documentação exigida para viver no País. Para explorar as necessidades, o acesso e a utilização dos serviços de saúde americanos pelos emigrantes de Governador Valadares, MG, Brasil, o presente estudo entrevistou uma amostra de 14 emigrantes valadarenses selecionada por meio da técnica bola de neve. Foram elaboradas questões relacionadas à documentação, local de residência, profissões exercidas, necessidade, acesso e utilização de serviços de saúde. As informações recolhidas junto aos emigrantes residentes nos Estados de Massachusetts e Connecticut permitem afirmar a viabilidade do acesso e da utilização dos serviços de saúde subsidiados pelos governos federal e estaduais e de organizações não governamentais.

Palavras-chave: Sistemas de Saúde; Acesso aos Serviços de Saúde; *Tax Equity and Fiscal Responsibility Act*; *Medicaid*; *Medicare*.

Abstract

Analysis of the current political and economical context in the U.S.A., which involves access to and utilization of health services by immigrants, concerns more than 20 million foreign individuals who live in the country and do not have health insurance. This population corresponds to 43.8% of the 46 million people that do not have private health coverage in the U.S.A.; of these, 10.5 million do not have the legal documentation required to live in the country. In order to explore the needs, access and utilization of American health services by emigrants from Governador Valadares (located in the state of Minas Gerais, Brazil), fourteen emigrants from this city were selected by means of the snowball technique and were interviewed for this study. Questions concerning interviewees' documentation, place of residence, jobs, needs, access to and use of health services were created. Information collected from emigrants residing in the states of Massachusetts and Connecticut allows us to assert the viability of access and utilization of health services subsidized by the federal and state governments and nongovernmental organizations.

Keywords: Health Systems; Health Service Accessibility; Tax Equity and Fiscal Responsibility Act; Medicaid; Medicare.

Introduction

According to Andersen (1995) and Donabedian (1973), access is an important characteristic which explains the utilization of offered health services. This in turn is also related to the health needs expressed by the morbidity, gravity and urgency of illness in the population and by the characteristics of the individuals who use the health services.

For Travassos and Martins (2004), utilization cannot be explained by the potential determinants of access, just as its impact on the health and satisfaction of users cannot be explained solely by the determinants of using the services. Utilization of services depends on predisposing factors, health needs and contextual factors; effective and efficient use depends on the individual factors and the internal factors of the health services which affect the quality of the services provided.

The issue becomes even more complex when the citizenship of an individual or an immigrant community restricts and/or impedes access to and utilization of health services. It is the case in countries like the United States, where debates centering around the utilization of US health services take on a large political, social and economic dimension; at least 20 million aliens live in the country and do not have health insurance. In the United States, health care provided by private insurance is not compatible with these individuals' financial resources; their average income corresponds to 25% of US citizens' average income (Mohanty et al., 2005).

This population accounts for 43.8% of the 46 million people in the US without private health coverage; there are 10.5 million (23%) who live in the country without the documentation required to live there legally (Hoefler et al., 2008; Du Bard and Massing, 2007).

In the USA, public financing for health care for people without private health insurance mainly occurs through the Medicaid and Medicare programs, and the costs are divided between the federal and state governments. Medicaid is the farthest-reaching public health insurance program for residents who have low and medium income levels; Medicare provides benefits to low-income people over age 65, those with special needs or who are in the final

stages of kidney disease. Unlike Medicaid, Medicare provides basic coverage; that is, it does not cover all medical expenses and long-term care.

In 1996, legislation entitled the *Personal Responsibility and Work Opportunity Reconciliation Act* - PRWORA (Washington DC, 1996) changed public policies for immigrants in order to reduce federal spending on social welfare and health services.

After PRWORA, legal immigrants (with some exceptions) were declared ineligible for non-emergency Medicaid services during their first five years in the country. To qualify for full Medicaid coverage, non-citizens can no longer receive public benefits during the first five years of their work visa. Before and after PRWORA, benefits for non-qualified foreigners continue to be restricted to emergencies (Castel et al., 2003).

This situation causes immigrants and US citizens to use the health services in different manners. The majority of health care provided to undocumented immigrants occurs through emergency services, while other care is obtained from clinics and community health centers (Du Bard and Massing, 2007).

According to Footracer (2009), the less-frequent utilization of health services by immigrants to treat chronic diseases is due to various factors. The first consideration is that, compared with the native population, immigrants are relatively younger, resulting in a population with lower levels of illness. In general, legal and undocumented immigrants present lower rates of diseases such as cancer, heart disease, arthritis, depression, hypertension, and asthma than US citizens.

The second consideration is that the process of migration itself, especially in the case of people who enter the country without documentation, can result in positive selection for health, as the less healthy are unable to make difficult journeys to immigrate. A third possibility is that many immigrants, especially the undocumented, avoid seeking medical care for fear of being noticed by the authorities.

In this way, they are compelled to wait until their clinical presentation is more severe and then they can access emergency hospital services through the *Emergency Medical Treatment and Active Labor Act* (EMTALA) of 1985, which assures emergency medical treatment to any person who enters a hospi-

tal. In other words, regardless of their ability to bear hospital expenses, all patients should be examined and receive the treatment needed for recovery, or be transferred to another hospital service as soon as they become stable.

Emergency Medicaid cannot demand proof of citizenship or residence and, consequently, can be used by any person in the United States, including visitors, foreign students and undocumented immigrants.

For this reason, studies raise the hypothesis that cases of documented and undocumented immigrants without health insurance, when hospitalized - as they do not have coverage for any type of medical care after discharge such as walk-in services or transfers to home care which often are the standard of care for chronic or incapacitating conditions - lead hospitals to maintain patients who are ineligible for Medicaid in acute care facilities for more time than is necessary (Castel et al., 2003).

This results in hundreds of millions of dollars in hospital costs, and occurs because the care for uninsured immigrants affected by PRWORA, who are only eligible for emergency Medicaid, is translated into uncompensated costs generated by free service and/or failure to pay.

Uncompensated costs are the total value of health services provided to patients who are unable to or do not want to pay for such services. In the US, the majority of uncompensated costs stems from hospital care for low income and unemployed patients. The lack of financial coverage for assistance provided affects the health economy and the level of Medicaid financing in each US state. In general, the higher the amount of uncompensated costs, the lower the amount of Medicaid funds which are granted, which increases each state's costs of health care (Hsieh et al., 2010).

In reality, studies which investigate PRWORA's impact on Medicaid suggest that the law has had a negative financial impact on hospitals, especially those which serve large immigrant populations (Borjas, 2001; Zimmermann and Fix, 1998).

Beyond the discussions surrounding spending on health for the immigrant population, it is important to consider that they live, work and study in the US and, nevertheless, the laws and bureaucratic

barriers which reduce their utilization of preventative health services such as immunizations and programs combating infectious disease contribute to bad public health policy, since by denying primary care to immigrants, these laws increase the cost of health care for everyone (Okie, 2007).

In this context, the search for health care, especially for the 12 million illegal immigrants in the USA, frequently leads to startling encounters with a fragmented, confusing and hostile system. The majority of employers do not offer health care and immigrants cannot pay the premiums for insurance and/or medical care, and furthermore, they face language and cultural barriers (Okie, 2007).

Based on the information obtained through research projects on the topic *Immigration and Health in the USA* (Footracer, 2009; Hooper et al., 2008; Du Bard and Massing, 2007; Okie, 2007; Ku, 2009; Goldman et al., 2006; Mohanty et al., 2005), the association between the lack of health insurance and the undocumented resident's condition, low levels of education, higher poverty rates, lower disease mortality rates and employment which is less likely to provide health coverage leads to less access to health services and restricted utilization of these services by immigrants to the USA.

As this article proposes to characterize access to and utilization of health services by Brazilian immigrants from Governador Valadares, Minas Gerais (MG) in the USA, it is important to clarify that some of the citizens of this city founded the first internationally migratory social network for Brazilians.

The Valadarian diaspora has existed for more than two decades and was not stimulated by any incentive program from the US government, but the process has grown in such a way that brought the city national attention. Actually, the diaspora occurred due to the search for work and is similar to the majority of modern-day international flows of labor, with the USA as the preferred destination for this population (Fusco, 2005).

According to Soares (1995), the Brazilian economic recession in the 1980s and stagnation in the local economy at that same time partly explain the phenomenon which led to 15% of the city's population immigrating to other parts of the world. Scudeler (1999) estimates that 18% of the city's house-

holds had at least one international emigrant family member in 1997. This corresponds to 6.7% of the municipality's total population of 210,000 people.

Sales (1999), in analyzing the flow of migration from Governador Valadares between 1985 and 1989, determined that 86% of the emigrants from this area went to the USA, and almost half of this group went to the state of Massachusetts.

With regards to how they landed on American soil, Siqueira (2006) showed that 52% of the individuals in his sample of 141 people from the Governador Valadares region in the main immigrant strongholds in the USA entered the country on a tourist visa, 32% entered by crossing the border with Mexico and 12% with a false passport, which explains the fact that the majority of his sample (58,7%) was undocumented.

In general, the studies show that the largest motivation for emigration comes from the financial factor, which is to acquire goods and improve lives through work which pays in dollars. This option can be interpreted as "a leap" to a standard of consumption which is inaccessible by the salary prospects offered in these people's city of origin; it is not important that this economic ascent comes through occupations which are of low professional qualification in the USA (Fusco, 2000; Martes, 1999).

In fact, in their first stay, individuals in the sample selected by Scudeler (Sales, 1999) obtained 75% of their work opportunities in the tertiary sector - contraction of services and sale of merchandise - more specifically in food service, hotels and domestic positions, which together represent at least three fourths of the total of the functions exercised in the tertiary sector and 56% in relation to all occupations. The civil construction sector employs approximately 12% of the migrants; transformation around 10%, and agriculture employs only 2%. Proprietors represent only 1% of the sample and act mainly in the tertiary sector.

However, part of this population is submitted to two or three intense daily work sessions, which was evident in the data from Siqueira (2006), who related that 41% of the subjects interviewed worked between 11 and 19 hours per day, and 33% of this sample stated that they worked in at least two places. This combination of physical and mental exertion

can lead to work-related illness and workplace accidents provoked by the usage of toxic substances without the necessary biosecurity cautions in cleaning activities, and the absence of protective equipment in civil construction, besides the mental stress (Siqueira and Lourenço, 2006).

Soares (1995) and Fusco (2000) determined that more than 80% of individuals from Governador Valadares chose the USA as the destination for their first trip abroad. This proportion of migrants with experience in the USA rose to 88.7% with the consideration of individuals who, having initially chosen another country for their first trip, later opted for the USA. These Brazilians' destinations, in their first trip to the USA are: Massachusetts = 51.2%; Florida = 15%; New Jersey = 14.5%; New York = 11.3%; other states = 8%. The migrants from Valadares, therefore, form communities in four American states, but the concentration of 51% in Massachusetts shows this as the main destination for these Brazilians.

Another important issue about the profiles of the immigrants is the length of their stay in the USA. The largest concentrations are seen among those who stay from two to three years (18%) and eight to nine years (18.6%). Approximately 75% of returnees spent up to six years in the USA and 65% of those who left stayed seven or more years in that country (Fusco, 2000).

The information present in the various studies referenced here with respect to emigrants from Governador Valadares allows for the affirmation of the existence of heterogeneity in this population, which is made up of diverse individual profiles. In general terms, it is understood that over the 25 years of its existence, the international flow of immigrants from this region moved from what was once predominantly a masculine, middle-upper class activity to another reality which included women and individuals from lower layers of the area's middle class.

The objective of the present study is to explore the health needs, access to and utilization of health services for emigrants from Governador Valadares in the USA; identify the American health services most utilized by this group of emigrants; and describe the emigrants' perceptions with respect to the professionals and services they used in the USA.

Methods

This research project, which is of a qualitative and exploratory nature, investigated experiences of the emigrants and their families in American health services. Fourteen interviews were conducted with respondents selected through snowball sampling to relate the perception of the emigrants in the sample regarding the professionals and health services they utilized in the USA. Snowball sampling does not provide trustworthy statistical samples, which impedes the construction of quantitative inferences with respect to the level of frequency of phenomena in the population (Cornelius, 1982). The main reason why this method was chosen to identify the individuals in this study is due to the clandestine conditions in which a large part of the international flow of migrants from this Governador Valadares lives: as the size of the population is unknown, it is very difficult to compose a representative sample.

The target population was placed into two groups, each with seven people to be interviewed: the first was made up of seasonal emigrants, in other words, those who reside abroad and regularly visit Valadares, who we here call - *visitors* (CHART 1), and the second group who returned after a period of immigration - *returnees* (CHART 2).

A script was prepared for the interviews in order to gather information about the characteristics of the people interviewed such as gender, current age and age at first immigration, year of return and periodicity of visits to their home city, and current level of education and education level at the time of their first emigration.

The interviews were organized in a way that highlighted the immigrants' perceptions of the health professionals as well as access, utilization and costs related to the topic in the USA. To do this, questions related to the following aspects were prepared: (a) documentation upon entry to the country, (b) place of residence, (c) professions practiced, (d) documentation upon return, (e) usage of health services, (f) need for hospitalizations, (g) usage of diagnostic exams and surgeries, (h) preexistence of chronic diseases, (i) occurrence of work-related illnesses, (j) coverage of health insurance, (l) nature

of services utilized, (m) estimate of money spent on health services and (n) perception of quality of the US professionals and services.

Results and discussion

Analysis of the access to and utilization of the health services in the USA by emigrants from Governador Valadares should include consideration of the characteristics of health needs, the year of arrival in the country, status with regards to documentation and the place chosen to reside. The ideal combination of these factors allows these individuals to access US health insurance benefits. On the other hand, lack of these conditions represents a giant barrier to accessing health programs aimed at low income/immigrant populations in the USA.

It is important to understand that each US state has its own way of dealing with health and welfare

issues and that PRWORA requires that immigrants wait five years after obtaining permanent legal residence (a Green Card) to take advantage of federal benefits. Some states and municipalities such as Illinois, New York, the District of Columbia and certain cities in California utilize their own funds to expand health insurance coverage, even for undocumented immigrants, children, and pregnant women with low incomes. Nevertheless, other states, such as Arizona, Colorado, Georgia, and Virginia, have approved laws which make it even more difficult for non-citizens to access health services (Okie, 2007).

In states such as California and Texas which border Mexico, the impact of this legislation has generated distinct problems and solutions. California, the most populous US state and the one with the highest level of wealth, opted to create alternatives which allowed its 9,145,340 inhabitants which were born abroad - 26.8% of the total population - access

Chart 1 - Profile of Interviewed Visitors

Visitors	Year of Departure	Years of emigration	Current age	Age at first emigration	State
Visitor 1	1973	36	62	26	Hawaii, New York, Massachusetts
Visitor 2	1984	25	50	25	Massachusetts
Visitor 3	1988	21	43	22	Massachusetts
Visitor 4	1993	16	32	16	Massachusetts
Visitor 5	2000	9	35	26	New Jersey, Connecticut
Visitor 6	2007	2	54	52	Connecticut
Visitor 7	Born in the USA	Son of Visitor 2	16	American citizen	Massachusetts

Source: Prepared by the authors based on information from interviews with visiting emigrants.

Chart 2 - Profile of Interviewed Returnees

Returnees	Year of departure	Years of emigration	Current age	Age at first emigration	State
Returnee 1	1986	16	65	42	Massachusetts
Returnee 2	1986	14	44	21	Florida, Connecticut
Returnee 3	1989	19	60	40	Massachusetts, Florida
Returnee 4	1996	12	39	26	Massachusetts
Returnee 5	1997	10	41	29	New Jersey
Returnee 6	2000	6	29	20	Massachusetts, New York
Returnee 7	2000	9	50	41	Connecticut

Source: Prepared by the authors based on information from interviews with returned emigrants.

to the state's health services (Nationmaster, 2009). This alternative, added to the fact that more than two million of these residents are undocumented, was the reason for the bankruptcy of several California hospitals, according to some researchers (Borjas, 2001; Zimmermann and Fix, 1998).

The same has not happened in Texas, which has 3,148,620 inhabitants born abroad, approximately 30% of whom are illegal residents (Nationmaster, 2009). These individuals' lack of access to Texan services leads them to seek health care in Mexican cities near the border with the USA, which not only severely compromises public health conditions in Texas, but also promotes dramatic episodes between illegal immigrants and US Customs & Border Protection when they return to the USA (Heyman et al., 2009).

However, there are other realities, and this became evident in the narratives from emigrants from Governador Valadares interviewed who concentrated in the state of Massachusetts and other regions of New England. The multicultural and humanistic characteristics of the state, which was built on the presence of populations from different cultures such as Irish, Italians, English and French, seem to have favored welcoming communities of immigrants such as the Portuguese, with whom the Brazilians aligned themselves starting in the mid-1980s.

But the number of illegal immigrants in Massachusetts may be the best explanation for the ease of accessing health services in this state. The population of undocumented immigrants in Massachusetts is 87,000 (1%), a substantially lower total than that of other states such as California and Texas, which respectively hold 2,209,000 (7%) and 1,041,000 (5%) illegal immigrants. There is no doubt that offering health services to a population of undocumented immigrants such as that of California or Texas is much more costly and complex than for the population in Massachusetts (Nationmaster, 2009).

Regardless of the motives, it is certain that the more that national legislation restricts access to medical care for a large part of the population, the more public policies in Massachusetts favored coverage of health needs for the entire resident population, exemplified by the *Massachusetts Health Reform Act* of 2006. The reach of this cover-

age includes everything from urgent care to walk-in clinics and its capacity to trickle down to each individual in migratory social networks seems to be the component which facilitates access:

[...] I fell in the street and hurt my knee; it got very swollen [...] I only went to the hospital after three weeks [...] They took several X-rays, asked many questions... (Visitor 6, 54 years of age).

[...] I broke my leg twice during this period [...]; I fell in a workplace accident [...]. The first time I fell off a 4-meter ladder [...]; I fell into a lake [...]; the second time I landed on the floor, and I broke my leg [...]. My boss was really good, thank God! He took me to a hospital, and they took good care of me [...] (Returnee 6, 29 years of age).

[...] When I did tests, if there were any changes, they called me and I went back in [...]. I even did physical therapy there because of a herniated disk (Returnee 1 and Receiver 6, 65 years of age).

[...] Every year we have to get a checkup, whether you have anything or not [...]. Going to the doctor every year, he discovered that I had a problem with my liver and needed a more intensive treatment with a specialist in Boston (Visitor 2, 50 years of age).

[...] The assistance there is good, I never paid for a consult and all the things that followed: X-rays, MRIs [...]. I never paid for anything; medication (because I have high blood pressure). I had a check up every year [...], including a vision test [...]. I'm talking about the state of Massachusetts - because there things go by state - where I lived at the time, because I know there are some states where everything is paid for [...]. Even my daughter-in-law Rafaela, she's from Florida [...] and she knew that if she stayed there, she would have to pay a lot for childbirth. She went to Boston when she was five months along. She came to live with me, she went to do the prenatal appointment and didn't pay a cent, and she got first-class treatment at the hospital for the birth. Everything, a person has a right to (Returnee 3, 60 years of age).

The various federal programs were restructured and added to other state and non-governmental programs in order to promote universal health access for the entire resident population of the state.

In general, these programs prioritize assistance to children and individuals over 65. However, the testimony from the emigrants from various age brackets proves the viability of access to health services for emigrants from Valadares in Massachusetts.

[...] I didn't have health insurance, there it was a government program [...]. Before I paid out of pocket for appointments. Then a friend got me into this clinic [...]. There was a doctor who saw me [...] and I didn't pay anything. It was good. I even had gall-bladder surgery and the treatment there was excellent, without paying anything... Even the medication was free! [...] I also did physical therapy because of a herniated disk [...] (Returnee 1, 65 years of age).

[...] When I went in 2000, I had already done treatment for rheumatoid arthritis here in Valadares [...]. Then I looked for a doctor there [...]. The Medical Hero Clinic is a free clinic [...]. I did treatment there from 2000 to 2006 [...]. They are great [...], there was always an interpreter [...] and I always saw the same doctor every two months. I did new tests in the hospital [...]. The tests were at the hospital. When I had the prescription, with everything ready, I even had a discount on the medications [...]. There are pharmacies there [...]. I paid a set price of US\$4.00 for any medication (Returnee 7, 50 years of age).

The information gathered from emigrants from Valadares in June, July and August of 2009 indicates the viability of access to and utilization of health services subsidized by the federal, state and local governments in the states of Massachusetts and Connecticut, which along with four other US states, make up the region known as New England, where the largest communities of immigrants from Governador Valadares are concentrated in the United States.

[...] My daughter had an accident in 2003: she fell down the stairs [...] Her ankle [...] was operated on, they put in pins [...]; later they took out the pins. It cost around US\$40.000.00 [...]. I talked to the State of Connecticut in Danbury [...] and I got her entire treatment paid for [...]. In 2004, another problem [...]: my son fell off a wall [...] on a night out with the Brazilians [...]. He cut all the tendons in his right foot and in the middle of the night we got a call from the hospital telling us he was in Danbury Hospital

[...] He was in the hospital for 30 days... It was great treatment, really good, and I also didn't pay for anything [...]. It was US\$ 80.000.00 (Returnee 7, 50 years of age).

[...] In Danbury, I needed a public hospital when I hurt my knee [...]. I was very well received. They take good care of you. But later, the bill comes [...]. It's ridiculous [...]: US\$ 900.00 [...]. But then my husband talked to a financier who helps (in these situations). (She) said that we couldn't pay it, that (my husband) was out of work [...]. The hospital didn't send a letter any more; they sent one with the charge and then (after) they haven't sent another for more than a year (Visitor 6, 54 years of age).

[...] In Massachusetts, there is a clinic where you only need to prove that your salary is lower, that you are the co-payer for the consult (to get the discount) [...]. I always took antidepressants [...]. One consult with a psychiatrist, I think would cost around US\$ 300.00 to US\$ 400.00. In this clinic, you pay US\$ 12.50 [...]. I was never looked after so well as I was in this clinic [...]. They have interpreters for Russian, Chinese, Portuguese, Japanese, Spanish.... And all you need to do to register for the Free Care clinic is to say that you're unemployed [...]. My employer gave me a declaration of how much I earned and I could use the clinic's services paying what they charged me, services for dentistry, gynecology, psychology, whatever you could think of. A detail: the clinic sends you to the big Massachusetts hospitals within the same payment system (Visitor 1, 62 years of age).

[...] I have a health plan because I have insurance, it's from my husband's job [...]. We pay a small monthly payment: US\$ 50.00 for each [...], [adding together] me and my husband [...]. When he got this plan, his salary wasn't enough for the whole family. Then the government adds to it, because my treatment is really expensive [...]. It's been more or less four years since I've been doing this treatment. [...] My son doesn't pay anything, he's a dependent [...]. It's paid for by the government, dentist, everything, everything... And I don't spend a thing for him [...]. After 18 years, we make a private plan [...], he can enter into our plan [...]. I even have the best specialist in Boston - and look, [for] my plan I pay little, only

US\$ 50.00 [...]. And nothing in comparison [to what it's worth], because today private health insurance in the US is US\$ 800.00 per family. Extremely expensive (Visitor 2, 50 years of age).

Access to health services for the emigrants from Valadares who reside in Massachusetts and possess documentation to work in the USA occurs through the *MassHealth* and *Commonwealth Care* programs. This access subsidized by the state, local and municipal governments is tied to the income levels of the emigrants there. The undocumented interviewees use the state health services through the *Health Safety Net (Free Care)*. The *Health Safety Net* functions as a “last-chance” resource for low-income residents to obtain access to health services after these individuals run out of possibilities of inclusion in other public programs.

[...] There is Free Care for those who have no insurance at all. It's like the National Health System here, except the treatment is excellent [...]. Today it's more complicated because of the situation in the country, but, if the person is pregnant, she needs to have the baby and she doesn't have anything, they do the birth and she gets it for free. It's Free Care (Visitor 2, 50 years of age).

[...] Every year they call. You have a mammography on such-and-such day, pap smear another day, everything at the clinic [...] (Returnee 7, 50 years of age).

It is curious to note the contrast between the difficulties in accessing US health services shown by various researchers and the perceptions of the interviewees who related frequent use of the health services (hospital and clinic) in New England (Ku, 2009). This possibility of access seems to be the explanation for the fact that all the respondents considered the quality of professionals and services in the USA to be “excellent”.

However, in general, a sense of “astonishment” was perceived with regards to qualitative comparisons between health services in industrialized and prosperous cities in the suburbs of the capital of the state of Massachusetts and those available in Governador Valadares, a medium-sized city in a needy region of eastern Minas Gerais. The majority of emigrants seem to disregard the difference between

the two realities, perhaps because the large part of the migrants from Minas Gerais have a world view which is polarized between their native city and the USA, for example Boston. This is evident in the statement of Returnee 4.

[...] I already needed health care there [...]; it was the public health service. Except for this [...]: it's like Unimed [private insurance] here [...]. It's much better than the National Health Service. The government pays. It's as if it were public there, except there's no comparison, it's as if you “were paying here” (Returnee 4, 39 years of age).

Returning the discussion to the issues related to the emigrants' access to American health services, the surprise that her recent return to Brazil after 19 years in the US provoked in Returnee 3 stood out.

[...] This matter of health, they say it got much worse [...]. But I don't know what to say, because while I was there [...], they called me to see if I had a way to get to my exam or if they needed to come and get me [...]. If you don't have a way to get there, they come to get you [...]; I can't complain about anything (Returnee 3, 60).

Growing costs and the lack of compensation for health services have caused the issue of providing care to immigrants without insurance to become the main debate in internal American policy, particularly in the border areas and in the states whose immigrant populations have grown rapidly in recent years (Ku, 2009).

Legislation embodied by PRWORA has not reduced the costs of healthcare; on the contrary, they have penalized US hospital services which serve the most vulnerable segments of the population, as immigrants represent 43.8% of the 46 million people who do not have private health insurance coverage in the USA.

Conclusions

Interviews with the emigrants from Governador Valadares who live in the USA reveal that their health needs, when they present in an urgent manner, are due to respiratory illnesses and orthopedic trauma. Their needs for walk-in clinic care originate from pathologies of the cardiovascular, digestive and

visual systems, as well as dysfunctions in the musculoskeletal, reproductive and psychological systems.

The specialties most demanded for treatment of these conditions are: medical clinic, cardiology, ophthalmology, orthopedics, rheumatology, psychiatry, gynecology and physical therapy. Many of these needs are related to the type of work that these individuals do in the USA. There are also reports of elective surgeries to treat gastrointestinal illnesses and obstetric care for birth of the emigrants' children.

The majority of the care given to the respondents occurred in the health services in the suburbs of Boston (Massachusetts) and in Danbury (Connecticut). Access to health services by emigrants from Governador Valadares who held green cards and resided in Massachusetts was provided through the public programs *MassHealth* and *Commonwealth Care*. The undocumented interviewees used the state's health services through *Health Safety Net (Free Care)*.

None of the interviewees was old enough to be included in health assistance provided by the federal Medicare program, which restricts eligibility to individuals over 65 years of age; only one interviewee had access to health services through a private health care plan. In general, emigrants from Valadares consider the quality of American professionals and services to be "excellent".

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