COMMENTARY

"Getting Creative": From Workarounds to Sustainable Solutions for Immigrant Health Care

Nancy Berlinger

In France, it is called *la conscience rusée* — the "cunning conscience." Or *tricherie* — "cheating" — when one feels pressured to do work the wrong way. In Singapore, it is explained like this: "by right you would do this, so by left …" In the United States, the word "workarounds" covers a range of behaviors improvised to manage conflicts between rules and reality in health care and other complex systems. A workarounds taxonomy includes four overlapping categories familiar to practitioners and reflected in studies of work in complex systems.[1] *Getting the job done* workarounds aim for efficiency, and often to control the creep of "managerialism" into practice.[2] They may reflect judgments about rules whose value is unclear.[3] Language alluding to workarounds reveals moral intuitions: knowing a "shortcut" suggests confidence, "cutting corners" suggests unease. *Avoidance* workarounds aim to manage problems through relocation ("turfing") or limiting involvement. *Getting creative* workarounds aim to solve problems, to "make it work." Advocating for patients can be experienced as creativity, and *bending the rules* workarounds arise in the advocacy context.[4] Rules-bending may overlap with selective description to meet an eligibility threshold ("tailoring the chart"); the workaround arises when the truth is stretched, or potentially disqualifying information omitted. Informal resource allocation benefitting selected patients creates procedural justice problems due to lack of transparency, and introduces unfairness toward patients with equivalent or greater needs and claims who cannot access secret stashes of supplies.[5]

In their empirical study, Fabi and Taylor use workarounds as an analytical framework to understand how practitioners make and act on normative judgments concerning care for uninsured pregnant women excluded from federally funded benefits such as Medicaid because they are not "qualified non-citizens." These practitioners are aware of competing obligations. Professional guidance is clear: medical care throughout pregnancy is standard of care to ensure a pregnant person's health, monitor the development of a pregnancy, and manage risk factors for perinatal mortality and morbidity.[6] Medicaid coverage reflects these standards, covering reproductive, prenatal, and postpartum services, prescriptions, and supplies.[7] Medicaid covered 45 percent of births in 2010 (before Medicaid expansion in some states under the Affordable Care Act).[8] Medicaid and the Children's Health Insurance Program (CHIP) are the major insurers of children in the U.S.[9] Medicaid operates as 50 distinct state-level programs, and Fabi and Taylor explain state-level mechanisms that work around federal restrictions. A state-funded mechanism that the authors' informants evidently did not directly discuss is Presumptive Eligibility (PE) for Medicaid. As the authors note, 30 states permit uninsured pregnant women to be enrolled automatically in Medicaid to provide coverage while a Medicaid application is being processed. In some states, the PE application will stipulate that immigrants who lack "qualified" status are ineligible for PE, given that they will not qualify for Medicaid; in other states, the PE application does not ask about immigration status.

What should a provider do when caring for an uninsured patient who needs continuous access to health

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care due to pregnancy when this patient is income-eligible for Medicaid but her status as a "qualified non-citizen" is unclear? Fabi and Taylor's data suggest that their informants wrestle with this question personally and when making judgements about practices they observe. A California informant values the intellectual challenge of workarounds — "you get to use some creativity" — even as she finds the need to resort to workarounds frustrating. This informant mentions the temptation for creativity to cross into law-breaking, hastening to add, "[w]e don't do that." Habits of secrecy concerning workarounds make it hard for providers to describe their own "creative" workarounds and explain how these differ from inappropriate behaviors such as fraud, and Fabi and Taylor's informants do not offer many details. When a state does not ask about immigration status concerning eligibility for a state-funded resource, some providers may perceive this administrative silence as sufficient to justify using this mechanism; other providers may feel uneasy. One of Fabi and Taylor's informants expresses uneasiness about directing an undocumented immigrant to the emergency department. It is legal to do so under the Emergency Medical Treatment and Active Labor Act (EMTALA), and ED referral may be the only way for an uninsured patient to see a specialist or secure services not available in a primary care clinic. But this informant knows that turfing a pregnant person to the ED for routine prenatal care with the goal of cost-shifting is *tricherie*, "cheating" the patient by fragmenting her care.

Health policy scholarship has demonstrated that undocumented immigrants are a low-risk pool who put more into the system than they take out.[10] Health care ethicists are sometimes reluctant to point this out: Shouldn't the moral case for coverage and care be sufficient? Do we have to make the cost case, too? Yes, we do. We have to point out that using emergency services to manage routine care is costly in three ways — price, value, and burden — and we have to show how a coherent and humane system can work and be sustained.[11] Despite a dismaying national political environment concerning immigration-related policy and messages, there are opportunities for constructive action by state Medicaid programs, municipal public health systems, and private non-profit health systems. System leaders should acknowledge the need to structurally support frontline practitioners coping with coverage gaps and other policy-induced problems. They should promote safe opportunities for frontline practitioners to discuss challenges in providing appropriate care to immigrants including workarounds used to manage coverage gaps. And leaders should use the leverage they've got to advance organizational, municipal, and state-level policy solutions on behalf of immigrants and those who serve them.

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Note

The author has no conflicts to disclose.

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