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Changing the navigator's course: How the increasing rationalization of healthcare influences access for undocumented immigrants under the Affordable Care Act



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ABSTRACT

A number of researchers have shown that brokers (e.g., navigators and street-level bureaucrats) bridge access to healthcare services and information for immigrant patients through rich personal relationships and a mission of ethical care. An open question remains concerning how the increasing rationalization of healthcare over the past few decades influences brokerage for undocumented immigrant patients. Drawing from fieldwork and interviews conducted in California, as the Affordable Care Act (ACA) was implemented, I develop the concept of the “double-embedded-liaison.” While other studies treat brokers as acting either as gatekeepers or patient representatives, this study explains how brokers simultaneously operate on multiple planes when new roles are added. I argue that with more formalization and scrutiny at health centers, the impact of brokerage is destabilized and, subsequently, diminished. Two consequences of the double-embedded-liaison brokerage form are: (1) some brokers become disillusioned and exit—resulting in the loss of valuable resources at the health centers, and (2) immigrants move away from the health centers that historically served them. In looking at brokers’ simultaneous performance as gatekeepers and representatives, this research extends brokerage typologies and street-level bureaucracy arguments that largely treat brokerage in a mono-planar rather than in a bi-planar mode. Furthermore, in examining the risks and opportunities brokerage brings to addressing health disparities, the study provides insights into the effects of replacing the ACA or repealing it all together in the Post-Obama era.

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1. Introduction

Historically, the most viable pathway for access to and use of healthcare services for immigrants (particularly the undocumented), a group that represents at least 27 percent of the uninsured (Zuckerman et al., 2011), has been through brokers in safety net organizations. Brokers help immigrant patients navigate structural barriers such as a lack of health insurance, social support, or English proficiency. Additionally, brokers bridge gaps in access and information via their membership in immigrant networks (Viladrich, 2005). Love et al. (1997), in a survey study of 197 health care providers in the Bay Area counties, show that brokers “generally work with the underserved and are indigenous to the community in which they work—ethnically, linguistically, socio-economically, and experientially.” In general, brokers enable access

through rich personal relationships based on membership in social groups and a strong mission of ethical care (Okie, 2007; Shi et al., 2009).

However, the increasing formalization of the medical system and a movement towards accountability and efficiency threatens the system of personal relationships and the ethic of care that has characterized healthcare brokerage for immigrant patients. Several scholars examining the influence of Medicaid reforms of the 1990s argue that medicine has become more rationalized and brokers face increasing pressures for system efficiency and accountability (Boehm, 2005; Horton, 2006; Horton et al., 2001; Lamphere, 2005; López, 2005; Weiner et al., 2004). One identified mechanism explaining the negative effect of new policies geared towards privatization, cost-cutting and rationalization is that access is hampered when care becomes scripted and providers are forced to take shortcuts in order to meet efficiency goals (Lamphere, 2005).

The lessons from Medicaid managed care services from the 1990s raise questions about other mechanisms at play when new

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policies limit healthcare access for vulnerable populations. For example, the 2010 Patient Protection and Affordable Care Act (hereafter the ACA) has transformed the organizational context in which brokers operate. Previously, immigrants gained access to healthcare services at Federally Qualified Health Care Centers (FQHCs) and public and teaching hospitals (Menjívar, 2002; Portes et al., 2012). These clinics hire bilingual community members, thus enabling trust with patients and providing linguistic and culturally oriented care. Furthermore, the clinics have been central to immigrant access, as their funding through third-party reimbursements (mainly from Medicaid), Federal grants and loan guarantees provided them with enough flexibility to serve undocumented immigrants, a population generally excluded from Federally funded programs (Cordero-Guzmán and Quiroz-Becerra, 2007).

However, although undocumented immigrants are prohibited from receiving the benefits of the ACA, it nevertheless has an effect on access for this vulnerable population since changes brought about by the ACA also apply to FQHC patients that are uninsured, including the undocumented. The ACA allocates 11 billion dollars to the growth of FQHCs and more than 200 million dollars for outreach and navigation in the first phase of implementation, dramatically expanding funding for these clinics (Mickey, 2012). In addition, the ACA created the Patient Navigation Program to facilitate outreach and patient enrollment in healthcare coverage. While these initiatives are expected to improve healthcare access, they might have the unintended consequence of limiting a navigator's discretion and autonomy in service provision. This is the case because the Federal government has set rules and standards for Navigator and non-Navigator assistant personnel –including certification, non-discrimination, and conflict of interest– and pegged FQHCs funding for outreach and navigator assistance to the adherence to these rules (see CMS-9949-P). Furthermore, the ACA provisions require electronic medical records, which are more traceable, potentially undermining the trust immigrant patients have in brokers. Maintaining trust in brokers is particularly important to undocumented patients, who generally avoid formal transactions with public service organizations due to a constant fear of being apprehended and deported (Berk and Schur, 2001; Castañeda, 2009) and who fear being perceived as a “public charge” to the nation (Arijit Nandi et al., 2008).

A growing number of analysts underscore the ACA's focus on efficiency, cost-cutting, and new programming (Coughlin et al., 2012; Islam et al., 2015; Phillips and Fitzsimons, 2015). Together with research on managed care reforms, these analyses suggest that the role of brokers in access may become increasingly formalized and supervised (Phillips and Fitzsimons, 2015), thus compromising the traditionally enabling role of brokers as they face increasing pressures for system efficiency and accountability. However, an open question remains concerning how the potential formalization of medical services associated with these new reforms influences brokerage in healthcare access for immigrants.

I examine how organizational change associated with the ACA alters the brokerage role of navigators at community clinics and access to healthcare for immigrant patients. I bridge the literature on social networks and street-level bureaucracy to enhance current explanations of healthcare access for undocumented immigrants. Furthermore, I show that the increasing formalization occurring at some safety net organizations (i.e., FQHCs) has transformed the role of brokers and has had the unintended consequence of increasing barriers for immigrants as brokers began simultaneously acting as representatives of the patients and gatekeepers of their employing organizations. As a result, many health workers were frustrated by not being able to meet their commitments, and some

undocumented patients faced the harsh reality of being denied access to healthcare by a member of their own community and subsequently walked away from healthcare services at the clinics.

The study contributes to the brokerage literature and the study of mediation in organizations by highlighting how the political context can disrupt the stability of brokered relationships. Prior studies describe brokerage as an unstable process. The standard argument is that, as the gains to the broker mount, the other parties in the transaction lose trust in the impartiality of the broker (Stovel and Shaw, 2012). In this study, however, brokerage instability results from changes in the brokers' organization related to formalization, forming an inherently unstable brokerage type not captured in other analyses of brokerage in healthcare access. Furthermore, in examining brokerage as a form of “bridging” social capital, this study provides a more nuanced examination of social capital, making the concept more relevant to the analysis of healthcare access.

2. Brokerage and street-level bureaucracy in access for immigrant patients

This study fits within a large body of research on social networks showing that brokerage is a fundamental process by which immigrants gain access to resources and information in American society (Portes, 1995). In this vein, brokerage is the process in which “intermediary actors facilitate transactions between other actors lacking access to or trust in one another” (Marsden, 1982, p. 202). The “actors” fit into groups of affiliation that determine the type of brokerage deployed in the transaction and the effectiveness of the intermediary in enabling the flow of resources (Gould and Fernandez, 1989, p.91). To the extent that these transactions bridge structural holes or facilitate the flow of information and resources, brokerage can be construed as a form of social capital (Burt, 2004) —the processes and actions by which social relations and social action facilitate goal seeking behaviors (Kawachi and Berkman, 2001). Extending brokerage ideas to healthcare access, I argue that the exclusion of undocumented immigrants from affordable health care access creates a “structural hole” in the healthcare system.

Sociologists identify different brokerage types and their influence on access (Gould and Fernandez, 1989; Stovel and Shaw, 2012). In the healthcare context, Gould and Fernandez (1989) indicate that brokers perform the role of Coordinator, Itinerant, Gatekeeper, Representative and Liaison, as depicted in Fig. 1 in the Appendix. These roles are distinguished by the brokers' degree of embeddedness in the groups being brokered. The baseline assumption in the typology is that membership in groups is mutually exclusive, even though the broker is connected to two groups in a transaction (Gould and Fernandez, 1989). Under this form of brokerage—for analytical purposes, “mono-planar brokerage”—the different groups establish their relationship to the broker based on the same fundamental characteristic (e.g., home community, workplace, etc.). The broker must declare an exclusive group affiliation which determines whether a broker is a gatekeeper (member of the receiving group), an agent (member of the sending group), or a liaison (member of neither group). Brokers who advocate for their group members are referred to as “representatives” working to connect community members with societal institutions. In cases of mono-planar brokerage, the broker may have to deal with trust issues from an outside group, but the broker's loyalty is clear.

The treatment of brokers in the literature generally centers on cultural brokers serving in the role of representatives. Research on

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