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Deserving to a point: Unauthorized immigrants in San Francisco's universal access healthcare model

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ABSTRACT

In the "decidedly hostile" federal context toward unauthorized immigrants in American healthcare (Newton & Adams, 2009, p. 422), a few subnational governments have implemented strategies seeking to expand their access to and utilization of care. In this article, I draw on interviews conducted with 36 primary care providers working in San Francisco's public safety net between May and September 2009 to examine how such inclusive local policies work. On one hand, San Francisco's inclusive local policy climate both encourages and reinforces public safety-net providers' views of unauthorized immigrants as patients morally deserving of equal care, and helps them to translate their inclusive views into actual behaviors by providing them with increased financial resources. On the other hand, both hidden and formal barriers to care remain in place, which limits public safety-net providers' abilities to extend equal care to unauthorized immigrants even within this purportedly inclusive local policy context. I discuss the implications of the San Francisco case for policymakers, providers, and immigrants elsewhere.

Scholars have noted a recent trend toward greater subnational involvement in immigration and immigrant integration policymaking. Not only have many national governments devolved responsibility for immigration control down onto internal governmental and nongovernmental institutions (Lahav, 1998; Van der Leun, 2006), but a variety of subnational institutions and actors have also expressed "grassroots" interest in managing immigrant integration and service provision and engaging in immigration control and policing (Alexander, 2007; Filc & Davidovitch, 2007; Varsanyi, 2010; Wells, 2004, p. 1308). This trend is especially salient in the United States, where state and local governments have enthusiastically entered the immigration policymaking fray since 2005. Some have enacted restrictive policies of their own, either to increase cooperation with restrictive federal policies or to challenge what they perceive as a federal loss of control. Others have enacted inclusive policies, either to achieve goals not directly related to immigrant integration or to soften the impact of restrictive federal policies (Hopkins, 2010; Mitnik & Halpern-Finnerty, 2010; Newton & Adams, 2009; Walker & Leitner, 2011).

Significantly, in one analysis of the intersection between national and state policymaking on immigration across various U.S. policy domains, Newton and Adams (2009, p. 422) categorize healthcare as a federal arena "decidedly hostile" toward unauthorized immigrants. This raises key practical and theoretical questions regarding the role that subnational strategies play in integrating unauthorized immigrants into the American healthcare system: How exactly do existing inclusive local policies toward unauthorized immigrants in healthcare work? What promises do they carry for improving unauthorized immigrants' access to care in the face of a still hostile federal healthcare policy? Vice versa, what limitations do they face in their endeavors, and why? In this article, I draw on original qualitative research conducted in the city of San Francisco to answer these questions. I connect distinct literatures in immigrant incorporation, street-level bureaucracy, and "health-related deservingness" (Willen, 2012) to examine how one uniquely inclusive American local policy climate affects the attitudes and behaviors of public safety-net healthcare providers toward unauthorized immigrants, and thus potentially by extension, unauthorized immigrants' access to and utilization of healthcare.

On one hand, I document two cultural and structural mechanisms through which this uniquely inclusive local policy climate "works". First, it encourages and reinforces public safety-net providers' views of unauthorized immigrants as patients morally deserving of equal care; indeed, it actively sanctions any disentitling views of them as morally undeserving. Second, it helps

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public safety-net providers to translate their inclusive views into actual behaviors by providing them with increased financial resources. On the other hand, I also document two structural mechanisms through which this uniquely inclusive local policy climate "fails". First, because it is modeled on and partially embedded within the more restrictive structure of federal and state Medicaid policy, hidden bureaucratic barriers to care remain in place. Second, because it does not fully counter the weight of restrictive federal and state policy toward unauthorized immigrants in the first place, formal barriers to care remain. Ultimately both mechanisms limit public safety-net providers' abilities to extend equal care to unauthorized immigrants even within this purportedly inclusive local policy context, which carries important implications for other locales with aspirationally inclusive healthcare policies.

The San Francisco case in national context

Lack of legal status severely depresses unauthorized immigrants' access to and utilization of care. In the United States, with only a few exceptions (see Fremstad & Cox, 2004; Goldman, Smith, & Sood, 2005; Goldman, Smith & Sood, 2006), restrictive government policies have rendered unauthorized immigrants ineligible for most federally-funded public health insurance or programs – such as Medicare, regular Medicaid, and SCHIP – since the early 1970s (Fox, 2009). These direct federal eligibility restrictions on public insurance, combined with the fact that unauthorized immigrants are concentrated in a range of low-wage and often informal jobs unlikely to provide private insurance, help explain why unauthorized immigrants exhibit some of the highest rates of uninsurance and chronic uninsurance, highest rates of lacking a usual source of care, least frequent rates of visiting a physician, lowest rates of per capita health spending, and highest out-of-pocket costs for care among comparable populations in national, state, and local studies (Berk, Schur, Chavez, & Frankel, 2000; Goldman et al., 2005; 2006; Marshall, Urrutia-Rojas, Mas, & Coggin, 2005; Nandi, Galea, Lopez, Nandi, Strongarone, & Ompad, 2008; Ortega, Fang, Perez, Rizzo, Carter-Pokras, Wallace, et al., 2007). Moreover, bureaucratic eligibility requirements erected by federal and state policies have the *de facto*, even if not *de jure*, effect of excluding the neediest of immigrants – many of whom are unauthorized – from being able to access care, even at federally-funded safety-net institutions that do not, in theory, restrict care based on legal status. This is because many are employed in informal jobs, move constantly between jobs, live in overcrowded housing, and are unable to produce income tax forms or utility bills that can serve as proof of local residency and low income (Heyman, Núñez, & Talavera, 2009; Portes, Fernández-Kelly, & Light, in press; Portes, Light, & Fernández-Kelly, 2009).

Responding to this restrictive federal policy context toward unauthorized immigrants, local government officials in San Francisco have worked hard to create a more inclusive and less stigmatizing environment, one consistent with the city's vanguard reputation for being on the leading edge of progressive social and political change (de Graauw, 2009). Historically, San Francisco has allocated generous funds to the city's public safety-net infrastructure, which stands at the country's leading edge of promoting culturally and linguistically competent care and is anchored by a community-oriented acute care public teaching hospital affiliated with a well-respected academic medical center. Reflective of its strong system integration, this public teaching hospital gets referrals for specialty care from its own internal outpatient clinics, a system of closed satellite public outpatient clinics, and another system of affiliated nonprofit federally qualified health centers (FQHCs). Providers and staff working within the infrastructure are paid on public salaries with local Department of Public Health funds.

Local government officials in San Francisco have also enacted several measures that divorce lack of legal status from the provision and receipt of local public services and benefits. First, they have strengthened their commitment to an official "limited cooperation", or "sanctuary", policy. Originally passed as a symbolic resolution in 1985 to declare the city a refuge for, and to prohibit city officials from discriminating against, Salvadoran and Guatemalan refugees on the basis of immigration status, San Francisco's sanctuary policy has evolved into its current status as an active ordinance entrenched in the city's Administrative Code (Ridgley, 2008; Wells, 2004). Although recently the ordinance has been subjected to a federal grand jury investigation (ongoing) to determine whether or not it violates federal immigration law, through it San Francisco has joined over 60 other American localities to actively prohibit (a) the asking or collection of any information on legal status other than that required by state/federal statute, court decision, or regulation, or by federal, state, or local public assistance criteria; and (b) the cooperation of public service providers with federal immigration officials regarding any persons *not under investigation or convicted of felonies* (Tramonte, 2009; my emphasis; also Mitnik & Halpern-Finnerty, 2010).

Second, local government officials recently approved a Municipal ID Ordinance (effective January 15, 2009), making San Francisco the second city in the country after New Haven, Connecticut, to offer a municipal identification card to all city residents regardless of legal status. The ordinance's originators were primarily interested in the benefits it would bring to the city's approximately 40,000 unauthorized immigrants, yet they were also careful to design and frame the ordinance inclusively to better withstand public criticism and avoid stigmatizing the card's future holders (de Graauw, 2009). Thus, although the ID card does not grant any new services or benefits to unauthorized immigrants, it does make those to which they are entitled easier to access. Both the sanctuary and municipal ID ordinances acknowledge unauthorized immigrants' *de facto* legitimacy to be part of San Francisco's civic community, based on what Ridgley (2008, p. 56) and de Grauuw (2009, p. 4) term a conception of local "inhabitance" or "residence" (e.g., *jus domicili*) rather than birthright, ancestry, or legalistic citizenship.

Third, local government officials enacted and committed substantial local public funds to San Francisco Healthy Kids (SFHK) (effective 2002) and Healthy San Francisco (HSF) (effective April 2007). SFHK provides subsidized healthcare plans to all local resident children ages 0–18 who do not qualify for other forms of federal or state public insurance coverage (including regular Medi-Cal and Healthy Families – California's regular Medicaid and SCHIP programs, respectively) regardless of legal status (Bitler & Shi, 2006; Frates, Diringer, & Hogan, 2003). Similarly, HSF provides "universal access" to primary medical care to all local resident adults ages 18–65 who have incomes under 500 percent of the federal poverty line but do not qualify for other forms of federal or state public insurance coverage regardless of legal status. Participation is free if residents' incomes fall below the federal poverty line; otherwise it is based on designated quarterly participation and point of service-fees (Dow, Dube, & Colla 2009; Katz 2008; Mitnik & Halpern-Finnerty, 2010). Importantly, services covered in the HSF universal access model are not equivalent to insurance coverage. They are limited to those primary care services provided by participating healthcare institutions (to date, almost exclusively public safety-net ones) or otherwise funded by HSF monies. A range of specialty and select primary care services are not covered, including dental, vision, organ transplants, and long-term care.