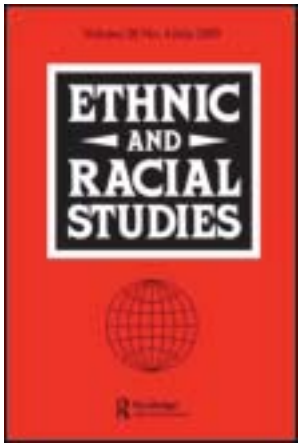

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The power of local autonomy: expanding health care to unauthorized immigrants in San Francisco

Helen B. Marrow

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Abstract

I analyse the mechanisms through which an inclusive local policy environment in the integrated city-county of San Francisco operates to improve unauthorized immigrants' access to and utilization of health care. Within – but not outside – the bounds of this inclusive local context, committed providers reported being able to provide attention to unauthorized immigrants without worrying about the direct costs of doing so; to buffer, marshal resources, and advocate for individual unauthorized patients; and to exert substantial autonomy in deciding how to approach lack of legal status in their patient–provider interactions. These results highlight the potential and limitation of sub-national policies seeking to ameliorate unauthorized immigrants' health vulnerability in a hostile US federal context.

Keywords: Immigration; incorporation; unauthorized; health care; safety net; autonomy.

Introduction

The federal and state health care policy context toward the estimated 11.1 million unauthorized immigrants living in the USA today has been described as so decidedly hostile that it leaves little leeway for government officials, health care providers, and immigrant advocates to make the situation more inclusive, even when they want to (Newton and Adams 2009). With few exceptions, restrictive government policies have rendered unauthorized immigrants ineligible for most federally funded public health insurance – such as Medicare, regular Medicaid, and State Children's Health Insurance Program (SCHIP) – since the

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early 1970s (Schwartz and Artiga 2007; Fox 2009). All unauthorized immigrants qualify for select public health and nutrition measures – including immunizations, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and testing and treatment for communicable diseases – but they can only qualify for a limited form of Emergency Medicaid (which covers labour and delivery and other designated emergencies) if they fall into certain categories like low-income children or pregnant women, and they can only qualify for non-emergency care in a handful of states that use their own state funds to offer it.

In addition, unauthorized immigrants face a range of indirect eligibility restrictions. Many are effectively barred or deterred from seeking care even in federally funded institutions that do not in theory restrict care based on legal status. This is because they are employed in informal jobs, move constantly between jobs, and live in overcrowded housing, so they often have difficulty producing income tax forms or utility bills that can serve as proof of local residency and low income – two bureaucratic criteria that *are* required for admission into such institutions (Portes, Light, and Fernández-Kelly 2009; Portes, Fernández-Kelly, and Light 2011).

Together with other barriers like fear, direct and indirect eligibility restrictions lead to some of the most severe disparities in access to and utilization of care among comparable populations in national, state, and local studies (Goldman, Smith and Sood 2005; Ortega et al. 2007). Moreover, under the Health Care and Education Reconciliation Act of 2010, unauthorized immigrants will not be eligible to receive federal subsidies to purchase their own private insurance, nor will they be allowed to purchase health insurance through new state-based health insurance exchanges, even if they pay with their own money. In fact, unauthorized immigrants are projected to become a full one-third of the remaining 23 million uninsured Americans by 2019 (Pear and Herszenhorn 2010).

If government officials, health care providers, immigrant advocates, and other actors want to reduce disparities by legal status – whether to help prevent the spread of infectious diseases, reduce the cost of preventable emergency care, or help institutions comply with ethical stances that support the provision of care to all humans, all residents of their communities, or all workers – they must look to other creative alternatives. One viable alternative is the national network of federally qualified health centres (FQHCs), which offer a variety of primary, mental, and dental services to unauthorized immigrants across the country and which, like public hospitals, do not in theory restrict care based on legal status. The Health Care and Education Reconciliation Act of 2010 did increase federal funding to FQHCs, and this will

certainly help to reduce some, but not most, disparities in access to and utilization of care for unauthorized immigrants.

Other creative alternatives are bi-national, although these too may be problematic since unauthorized immigrants face increasing restrictions on moving back and forth across international borders.

A third set of creative alternatives consists of inclusive sub-national policies that may be enacted at the state and local levels in receiving communities – especially since new patterns of geographic dispersion have brought unauthorized immigrants into an unprecedented array of states and localities, all of which are now struggling to determine how best to respond to their presence. In this article, I ask: what are the *mechanisms* through which inclusive local policy environments can operate to improve unauthorized immigrants' access to and utilization of health care, specifically via the actions of providers and staff working in public health care safety nets that they govern?

Site selection and methods

To identify such mechanisms, I conducted a case study of thirty-six safety net health care providers and staff who work in a large, residency-training, outpatient clinic – hereafter called Hospital Outpatient Clinic (HOC). HOC is associated with the public safety net hospital of the integrated city and county of San Francisco, which exhibits a uniquely inclusive local policy environment toward unauthorized immigrants but which continues to be embedded in the more restrictive federal and state context described above. Examining providers and staff in a public safety net clinic such as HOC is valuable because it is they who constitute the front-line or street-level bureaucratic arms of local governments, and who have some discretion to interpret, enact, and enforce government policies during the execution of their work, even while remaining heavily influenced by rules and bureaucratic processes (Lipsky 1980).[1] HOC provides comprehensive primary care and select specialty services – most FQHCs do not provide the latter – and is one of the city's Healthy San Francisco (HSF) medical homes. Like its parent hospital, HOC serves a diverse patient population that is predominantly low income, uninsured, and racially, ethnically, or linguistically in the minority.

Between May and September 2009, I sought out a variety of providers and staff in HOC through a combination of purposive and snowball sampling. Purposively, I wanted to include a range of types (from physicians to non-physician staff) who come into contact with unauthorized immigrants in different statuses and roles. Respondents included five physicians; seven resident physicians-in-training; and twenty-four non-physician providers and staff members, including eight registered nurses, three nurse practitioners, seven medical evaluation

assistants, four clerical staff, one social worker, and one health worker. I also conducted interviews with an additional eighteen safety net providers and staff (including two hospital Medi-Cal eligibility staff) working in other hospital clinics and departments, a nearby Latino-oriented FQHC, and a nearby Latino day labourer-oriented free clinic in order to uncover their perspectives on how unauthorized immigrants view and interact with providers and staff at HOC and its parent hospital.

Interviews lasted between forty-five and ninety minutes and over two-thirds (thirty-eight of the fifty-four respondents) were conducted in isolation, although due to their workday time constraints the remainder (sixteen) were interviewed in small sets of focus groups. I tape-recorded, transcribed, cleaned, coded, and analysed all interviews using ATLAS.ti, a qualitative analysis software program. To ensure anonymity, I have changed all names and identifying characteristics of individual respondents.

Creating an inclusive policy climate

Local government officials in San Francisco have worked hard to create an inclusive and less stigmatizing environment for unauthorized immigrants than exists at the federal level or in most other localities, one that is consistent with the city's vanguard reputation for being on the leading edge of progressive social and political change. They have allocated relatively generous funds to the city's public safety net, 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 centre. 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 non-profit 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 measures that separate lack of legal status from the provision and receipt of public services and benefits. First, they have strengthened their commitment to an official sanctuary policy. Originally passed as a symbolic resolution in 1985 to declare the city a refuge for, and to prohibit discrimination against, Salvadoran and Guatemalan refugees, San Francisco's sanctuary policy has evolved into an active ordinance in the city's Administrative Code. Recently, the ordinance has been subjected to a federal grand jury investigation (ongoing) to determine whether or not it violates federal immigration law but, through it, San Francisco has joined over fifty 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).

Second, local government officials recently approved a municipal ID ordinance (effective 15 January 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 makes them 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) and de Graauw (2009) 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 health care plans to all local resident children aged up to eighteen who do not qualify for other forms of federal or state public insurance (including regular Medi-Cal and Healthy Families – California's regular Medicaid and SCHIP programmes) regardless of legal status. Similarly, HSF provides 'universal access' to primary medical care to all local resident adults aged eighteen to sixty five who have incomes under 500 per cent 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. However, 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 health care institutions (to date, almost exclusively public safety net ones) or otherwise funded by HSF monies, and a range of specialty and select primary care services are not covered, including dental, vision, organ transplants, and long-term care.

Thus, although San Francisco is not immune to the conservative pressures that have increased class and racial inequality and put severe

pressure on the public social safety net nationwide; even though its two main policy efforts to divorce lack of legal status from the provision and receipt of local public services and benefits have come under strong attack; and even though its HSF universal access model remains 'categorically unequal' (Light 2011), the city exemplifies a much more inclusive and less stigmatizing environment than does either the state of California or the nation as a whole. HOC respondents, especially those who have worked in other states and localities, including some in the surrounding Bay area, noted such 'exceptionalism' frequently and emphatically.

Local bureaucratic autonomy: self-selecting into the safety net and providing primary care

HOC providers feel that they have actively self-selected themselves into the San Francisco safety net environment. Over the course of their medical training, all selected: (1) primary care, which is lower paying and less prestigious than specialty care; (2) the American social safety net, which is devoted to serving under-served populations; and (3) living and working in San Francisco, which is one of the most politically liberal cities in the country. Taken together, self-selection shapes their positive attitudes toward unauthorized immigrants, whom many considered to be equally deserving of care either because they are human beings (human rights perspective), members of a disadvantaged and under-served population (social justice perspective), members of the local community (public health and community perspective), positive contributors to the American economy (deserving worker perspective), or simply 'sick' and in need of care (humanitarian perspective). While some variation did exist among respondents in the degrees to which – and various rationales for why – they supported providing care to unauthorized immigrants, all exhibited an inclusive attitude, and several reported that public safety net hospital's institutional culture imposes sanctions on providers and staff who openly disagree.

San Francisco's inclusive policy climate helps HOC providers put their attitudes into practice in several ways. First, it allows them to provide care to unauthorized immigrants without having to worry about direct costs. As physician Charlotte explained, San Francisco's public-salaried payment structure insulates them from having to 'eat' the direct costs of treating uninsured patients, making them less reluctant to treat them than many providers working in private practice. Likewise, San Francisco's generous funding of public health care insulates these public safety net providers from the 'frustration' of unfunded mandates to treat unauthorized immigrants who are uninsured, which HOC providers view as a more pressing issue in

other localities with more restrictive policy environments. As Charlotte stated:

> We all take a pay cut to work in a safety net institution... We do it because it frees us from some of the structural problems of private practice. And there is... a whole [San Francisco] city understanding for investing in this infrastructure. [It is] a place where you don't have [that] level of frustration... like "Okay, so we have to deal with the unfunded patients and do not get any resources from the local government to do so."

Indeed, local HSF investment – which, as clerical worker Shana reported 'kicks in the money' for many services that federal and state policies do not fund for poor people and unauthorized immigrants – allows HOC providers, in nurse practitioner Sarah's words, to offer 'access to better than 90 per cent' of primary care services without thinking or asking about patients' legal statuses. According to Sarah:

> There's just once in a while something you can't do. And I feel lucky that I don't really care [about legal status]. It doesn't, you know, for the most part it doesn't really affect what we can do for people.

HOC providers knew that their ability to disregard patients' legal statuses would disappear if local sanctuary or insurance policy were to become more restrictive, since, according to physician Joseph, it would:

> become much more germane to know if someone's unauthorized because you want to know what benefits you can try to get people access to. If that's [a] criterion for excluding people from benefits then, you know, we would probably start asking [patients about their legal statuses].

Physician Mary agreed that providers:

> often don't know [legal status] because we are very lucky in San Francisco in having no [legal or financial constraints placed on us] for anything we can provide on-site [at the public safety net hospital] to anyone who lacks health insurance.

She went even further than Charlotte or Sarah to explain how additional local investment even allows providers to link patients to care at other area institutions through a system of city contracts if the public safety net hospital does not provide a particular service on site: 'If we don't have a whole department that provides it here, the city

actually has a contract where they pay for it, usually at [another nearby academic medical centre], to buy the care for patients there.' As Mary showed, San Francisco's inclusive local policy, which includes a generous allocation of local funding to the city's safety net, allows HOC providers to more effectively marshal resources for individual uninsured patients.

This inclusive context also allows providers to more effectively muster resources and advocate for such patients in other ways. For instance, the city's sanctuary policy reaffirms many providers' beliefs that unauthorized immigrants are often scared to seek health care services because of the restrictive federal policy toward unauthorized immigrants. Sanctuary policy supports them in their efforts to engage in what Horton (2006) and Lamphere (2005) call 'buffering' strategies as they try to smooth and compensate for such fear (Konczal and Varga 2011). At an institutional level, buffering strategies include attempts by hospital administrators to create trust in the local immigrant community (by advertising a 'safe' hospital context, in which data on lack of legal status will not be unlawfully collected or transmitted to authorities) and the creation of a standard, neutrally coloured hospital 'gold card' (which outpatient clinic providers and staff can use to view patients' medical record numbers instead of requesting their citizenship and legal status information directly).

At the individual level, buffering strategies include attempts by hospital Medi-Cal eligibility workers to reassure applicants that they only ask about citizenship and legal status insofar as it is required to determine plans and payers (e.g. federal or state public insurance programmes or the two local initiatives, SFHK and HSF), never for disqualification purposes. As medical evaluation assistant Marta attested, front-desk clerks and medical evaluation assistants reported accepting alternative documents (e.g. medical record numbers) instead of social security numbers when checking in patients for appointments; sometimes they also 'run after' patients whom they notice are visibly fearful and so 'turn around and leave', in order to reassure them that 'it is safe here'.

In the more insulated back rooms of the clinic, physicians, residents, registered nurses, and nurse practitioners also reported going to great lengths to advise and advertise to patients that San Francisco is a 'safe' context where it is okay to utilize services and programmes. Likewise, they reported encouraging patients to collaborate with 'safe' social workers (who understand eligibility rules and can help both providers and patients 'work around' confusing legal status restrictions to access more resources) and drawing on their professional networks to request compassionate assistance from external non-safety net providers when they are unable to provide certain services internally. As nurse practitioner Lynne described:

> I really do encourage people. ''It's okay. You're not going to get arrested. You're not going to get deported just because you're seeking health care. You can use your real name.'' Or, ''If you're really scared, go to the refugee clinic.'' Or I'll try to send them to the social worker to get some referrals to a Spanish-speaking advocacy agency where they can get reassurance if that's what they need.

Throughout the clinic, providers and staff all reported engaging in buffering strategies to reduce unauthorized immigrants' fear, including not asking patients about their legal statuses directly, heavily downplaying such requests when they do (e.g. prefacing requests with 'It doesn't matter to me…'), never documenting patients' lack of legal status directly in patients' records, and utilizing patients' social networks (both inside and outside the clinic) to encourage greater utilization of resources.

Perhaps most importantly, San Francisco's inclusive policy grants these providers substantial autonomy to decide if, how, and why they will approach lack of legal status in their patient–provider interactions in order to offer unauthorized patients with the most effective medical care. Some providers choose to actively 'ignore' or 'look beyond' patients' legal statuses, to comply not only with the city's sanctuary policy but also with their dominant professional norm to 'suspend judgument' and 'not disenfranchise' patients. As physician Charlotte explained, 'We try to treat people the same no matter what… do our damnedest not to think about [legal status].' In fact, registered nurse Jane emphatically described a strategy of never asking patients about legal status 'not because are trying to avoid the issue, but rather because we are trying to get around it to help people and give them equal care. It just interferes with medical care to bring [legal status] up.' For this group of providers, San Francisco's inclusive context not only strengthens the dominant professional norm of 'don't ask, don't know, don't care' regarding legal status but also legitimates their cognitive beliefs that ideally lack of legal status should not matter to health care delivery. Resident Eduardo even interpreted this as an additional directive to 'follow the same algorithm no matter what' and treat all patients equally.

Other providers choose different approaches to offer culturally competent and compensatory care. San Francisco's inclusive local policy environment assists them by creating a secure environment in which they can, according to physicians Mary and Elena, more easily seek out patients' 'social histories of migration' to help 'contextualize their medical conditions'. Most providers in this group continued to refrain from asking patients directly about their legal statuses, fearing that doing so would give them a false impression of stigmatization or service restriction. Instead, they tried to elicit the information from

patients indirectly, often making inference to it through 'related' characteristics such as their recent arrival, day labourer or caregiver occupational status, lack of English language skills, separation from family members abroad, and/or inability to travel internationally. Context-oriented providers saw such characteristics associated with conditions of illegality, as causing patients stress and trauma, and as compromising patients' health and ability to follow care recommendations.

While San Francisco's inclusive policy climate does not solve the internal provider debate as to whether to 'ignore' or 'acknowledge' lack of legal status, it does set both approaches within a more protective and enfranchising context.

Where autonomy ends: referring to specialty and ancillary care

The restrictive federal and state context in which San Francisco's inclusive local policy is embedded does not necessarily change HOC providers' desires to provide care for unauthorized immigrants. They are, after all, part of the heavily self-selected social safety net. Nonetheless, restrictive federal and state policy does limit the range of resources that HOC providers can offer to unauthorized patients, force providers to directly engage patients' legal statuses when they might not otherwise do so, and depress providers' strategies for buffering and advocating for individual unauthorized patients.

This important set of limits on providers' bureaucratic autonomy is most clearly visible at two critical junctures – the first between primary medical care and specialty medical care, and the second between primary medical care and ancillary social support care. Government officials have enacted and committed substantial local public funds to two programs (SFHK and HSF) that in theory expand access to care to all low-income children and adults who are San Francisco city residents. Nevertheless, as a universal access model, HSF remains categorically unequal (Light, 2011) with respect to other forms of public health insurance – even Medi-Cal and Healthy Families – in that it only includes primary care provided by participating health care institutions or otherwise funded by HSF monies. HSF does not cover certain specialty care services (including dental and vision) or other ancillary services (including public housing, General Assistance (GA), Supplemental Security Income, food stamps, disability, or hospice). Unauthorized immigrants' access to these services lies outside the domain of local San Francisco policy and continues to be delimited by more restrictive federal and state polices (WIC is a notable exception).

Consequently, HOC providers' ways of dealing with patients' lack of legal status change dramatically as they cross the line separating locally covered primary medical care services from other specialty care

and ancillary services. They are suddenly forced into thinking and asking about lack of legal status. According to health worker Mariana, clerical workers and medical evaluation assistants learn about patients' legal statuses not only when they 'need to know [what insurance is] going to cover some specific test we are setting up, or if patients need a pre-authorization to do that' (specialty services), but also when they 'need to send patients to the social worker to see if there are any [social support] resources available.' Similarly, physician Elena does not usually have to ask about legal status and is 'able to provide standard of care for the majority of my patients who are chronically ill' without knowledge of it since 'the city and county of San Francisco commits amazing, amazing resources to provide an enormous amount of things.' However, for the small group of patients who do become 'severely ill, or have the wrong thing', it matters because they 'just can't get [specialty] care' and 'it becomes really hard, depending on what the service is.' It is rare that Elena has 'to come flat out and ask a patient, 'Are you documented?'. Nevertheless, in a 'clinically exigent situation when patients need a specialty service that requires they are U.S. citizens or legal immigrants', she is forced to ask.

As a result, providers like Elena see clear patterns of 'blocked access' emerging for unauthorized patients regarding select high-tech specialty procedures such as organ transplants, open MRIs, nuclear medicine tests, coronary bypass or bariatric surgeries, endoscopies, cystoscopies, screening colonoscopies, intervention cardiology procedures, and PET or DEXA scans, because such services are either not offered on site at the public safety net hospital or not covered by HSF or other local, state, or federal monies. Coming up against these barriers, HOC providers reported going into advocacy mode, trying desperately to 'twist some arms' and find ways to link their unauthorized patients to care. In a few cases their efforts have been successful, but as resident doctor Laura explained of the time when an external allergist agreed to see one of her unauthorized patients who had recurrent anaphylaxis, such success is 'voluntary' and 'discretionary' rather than systemic, and it declines as the cost of the specialty procedure rises. In most situations, providers reported that their 'hands are tied' and that their efforts to buffer and advocate for their unauthorized patients fall short, as happened to physician Mary:

> [My patient] is someone who by... every criterion would get a liver transplant. She's socially stable, she's married, she's adherent to absolutely everything that you ask her to do, there's like nothing wrong. And I asked the liver specialist here to see her [but] as soon as they found out she didn't have papers it was like very clear [that she would not be treated]... That's just a devastating conversation to have [with a patient].

Likewise, physician Elena argued that lack of legal status quickly becomes 'determinant of the care one receives' at the point of transition into high-tech specialty care:

> If I advocate hard enough for an African-American patient who needs a particular service outside the ones we provide [at the public safety-net hospital], usually I can get it. There's usually all sorts of hoops to jump through but I can get it.

However, with unauthorized patients her advocacy strategies prove ineffective: 'I just can't.' As registered nurse Harriet confirmed, in the context of high-tech specialty care, 'When you're unauthorized,' providers have even less [ability to] 'work around.' At this point providers described the frustration of watching unauthorized patients unable to access needed services, or only able to access insufficient stopgap or (in resident Kate's words) 'band-aid' emergency services that do not constitute a 'long-term solution'. Several even began debating the pros and cons of advising patients to return to their home countries to try to obtain specialty medical care services there.

The restrictive federal and state policy context also depresses these public safety net providers' strategies for buffering and advocating for individual unauthorized patients in the realm of ancillary services, where rules governing access are strict and strongly enforced. As physician Mary said, even in remarkable cases, where the city does fund certain specialty medical care services for unauthorized immigrants, HOC providers' 'hands get tied' when accessing critical support services like unemployment, disability, or public housing that would allow patients to support themselves and their families as they heal:

> When I sent a patient to the social workers, I asked them, ''Is there any miracle we can pull off here [hooking him up to unemployment or disability benefits]?'' And they basically said ''No.'' And at this point, you know, the city's about to pay $100,000 to get an ICD [implantable cardioverter-defibrillator] implanted in him [for cardiac arrythmia]. So it's hard. We work to send him to the food bank and stuff, but he's basically losing his housing and it's just a mess. He wound up having to send his children, who are American-born and are U.S. citizens, and his wife back to his home country, because he can't afford to keep them fed or anything. He's someone who, because he can get this procedure, should be able to recover, be a productive member of our society, and be able to raise two kids who will be, too. But there's nothing we can do right now.

In fact, restrictive policy context and the ever-looming threat of budget cuts keeps many HOC providers' constantly aware of, in Mary's words,

the 'power of the state'. It curtails their willingness to 'rock the boat too much' or to encourage unauthorized patients to apply for services they 'know they can't get', lest such actions bring about a restrictive backlash that could jeopardize what access to primary care unauthorized immigrants do have.

Conclusion

I have examined the mechanisms through which inclusive local policy environments can operate to improve unauthorized immigrants' access to and utilization of health care, specifically via the actions of street-level bureaucratic providers and staff working in public health care safety nets that they govern. HOC providers have come to their jobs both strongly selected and heavily committed to expanding access, and providing culturally competent care to vulnerable patient populations, including unauthorized immigrants. By and large they reported that the inclusive San Francisco policy context allows them to give care to unauthorized immigrants without worrying about the direct costs of doing so; to buffer, marshal resources, and advocate for individual unauthorized patients; and to exert substantial autonomy in deciding how to approach lack of legal status in their patient–provider interactions – to the point that some even go beyond the official bounds of the city's sanctuary ordinance to extend what they view as more effective medical care to unauthorized patients in ways they believe to be consistent with the ordinance's broader spirit.

Nevertheless, HOC providers also reported that their advocacy efforts and bureaucratic autonomy break down at two critical junctures during the transition from an inclusive local to a more restrictive federal and state policy climate, especially as the cost of high-tech specialty medical services rises or when federal and state regulations regarding ancillary services are strictly codified and enforced. In these realms, care becomes more 'discretionary' and 'voluntary' – successful only in a few 'miracle' cases and frustratingly unsuccessful most of the time.

These results carry important practical and theoretical implications for policymakers, health care providers, and advocates. Most importantly, they demonstrate that sub-national strategies such as San Francisco's are imperfect substitutes for including unauthorized immigrants within the bounds of federal and state health insurance and social welfare programmes. Even in San Francisco, it is 'access' rather than insurance that is the goal, since full insurance is still deemed to be unaffordable. The continued exclusion of unauthorized immigrants from national and state programmes means that even in San Francisco, local providers still face difficulties working around specialty and ancillary problems in order to care for unauthorized

immigrants. 'San Francisco is not paradise,' physician Elena reported, and 'if these problems exist here,' resident Carla said, 'you know they're everywhere else.' To fully overcome these barriers, HOC respondents noted, the American public must ultimately change its mindset about unauthorized immigrants to see them as more deserving of inclusion and financial investment.

Yet the results of my study also highlight the real potential for sub-national actors to play a positive role in enacting and implementing local strategies that can help overcome some of the barriers to access and utilization. Such strategies may be politically and financially difficult to enact elsewhere. They will likely require supportive, or at least neutral, backing from local communities and a fiscal base large enough to support redistribution. San Francisco is an extremely wealthy and politically liberal city whose public has proven willing to support and contribute taxes to progressive local policies, and whose politicians have committed what physician Elena describes as 'amazing' and 'generous' resources to its health care infrastructure.

Still, government officials in San Francisco note that even prior to the implementation of HSF, the city was already paying substantial amounts to care for the uninsured, including unauthorized immigrants, and so the programme does not necessarily represent an infusion of new money into the safety net system. Rather, it was conceived as a way to integrate, further de-stigmatize, and make more efficient the robust safety net that the city already had in place (SF DPH and SF OLSE 2010). In this regard, San Francisco can serve as an important model for other localities throughout the USA as they search for practical ways to respond to unauthorized immigration. Unless these localities are willing to let unauthorized immigrants die in the streets, they already pay for their treatment somehow – and usually in ways that are unduly expensive and less efficient than in San Francisco. If local actors are concerned about reducing disparities by legal status, the unique San Francisco case demonstrates how creating a protective civic environment and focusing on expanding and integrating access to primary care can help. This gives providers greater ability to help reduce disparities by legal status and, by extension, it allows patients greater access to and utilization of care at a systemic level.

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