



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.

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Scholars have noted a recent trend toward greater subnational involvement in immigration and immigrant integration policy-making. 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 disenfranchising 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 health-care 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 Graauw (2009, p. 4) term a conception of local “inhabitation” or “residence” (e.g., *jus domicilii*) 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, Diringler, & 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.

Street level bureaucracy in action: site selection and methods

Thus, San Francisco offers a unique and theoretically informative site in which to examine the question of how inclusive local policies toward unauthorized immigrants in American healthcare work. Data come from semi-structured interviews with 36 safety-net providers and staff working in a large, residency-training, outpatient clinic associated with San Francisco's public safety-net hospital – hereafter called *Hospital Outpatient Clinic (HOC)*. Like its parent hospital, HOC serves a diverse patient population, most of whom are low income, uninsured, and racial/ethnic or linguistic minority. HOC provides comprehensive primary care services and select specialty services, and it serves as one of the city's Healthy San Francisco (HSF) medical homes.

Examining providers and staff in a public safety-net clinic such as HOC is valuable because it is such people who are considered to be the main 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, p. 3; Maynard-Moody & Musheno, 2003). New research from political sociology confirms that a range of street-level bureaucrats, including public teachers, medical and social welfare services providers, law enforcement officers, and even librarians and zoning officers, play important roles in everyday processes of immigrant incorporation and exclusion (Jones-Correa, 2008; Lewis and Ramakrishnan, 2007; Marrow, 2009; Van der Leun, 2006). Incorporation appears strongest where financial resources are greatest, since resource scarcity tends to produce what Lopez (2005, p. 26) calls “*de facto* disenfranchisement” by many types of street-level bureaucrats (also Horton, 2004; 2006; Lamphere, 2005; Lipsky, 1984).

Additionally, Marrow (2009) argues that incorporation appears most visible in institutions where inclusive government policies intersect with strong, service-oriented professional missions among bureaucrats; vice versa, it appears least visible in institutions where restrictive government policies intersect with strong, regulatory-oriented professional missions among bureaucrats (also Bloemraad, 2006; Jones-Correa, 2008). Of course, as large and complex organizations, all street-level bureaucracies exhibit both service- and regulatory-oriented functions, but they nonetheless occupy different positions along this continuum. For example, Horton (2006) and Van der Leun (2006) distinguish the more powerful and service-oriented roles of clinicians in healthcare institutions from the less powerful and more regulatory-oriented roles of workers in social welfare services agencies. And within healthcare institutions, other scholars distinguish the more service-oriented roles of “insulated caregivers” (Walter & Schillinger, 2004, p. 304) and lower-level “front-line clerical personnel” (Weiner, Laporte, Abrams, Moswin, & Warnecke, 2004, p. 306), who have sustained face-to-face interactions with clients, from the more regulatory-oriented roles of higher-level administrators and utilization managers, whose primary responsibility is to maintain their organizations' fiscal survival (Portes et al., 2009).

Between May and September 2009, I sought out a variety of types of providers and staff in HOC through a combination of purposive and snowball sampling. Purposively, I wanted to include a range of providers (from professional physicians to mid-level professional nurses to non-physician staff) who come into contact with and provide care to unauthorized immigrants in different statuses and roles. Respondents ultimately included five physicians; seven resident physicians-in-training; and 24 non-physician providers and staff members, including eight registered nurses (RNs), three nurse practitioners (NPs), seven Medical Evaluation Assistants (MEAs), four clerical staff, one social worker, and one

health worker. I also conducted interviews with an additional $N = 18$ safety-net providers and staff (including two hospital Medical eligibility staff) working in other hospital clinics and departments, a nearby Latino-oriented federally qualified health center (FQHC), and a nearby Latino day laborer-oriented free clinic in order to uncover their perspectives on how the city's unauthorized immigrants view and interact with providers and staff at HOC and its parent hospital, versus other institutions and departments. Most interviews lasted between 45 and 90 min and over two thirds of the 54 total respondents ($N = 38$) were conducted in isolation, although due to their workday time constraints the remainder ($N = 16$) were interviewed in small sets of focus groups.

Ethical approval for the study was obtained from the Committee for the Protection of Human Subjects at the University of California at Berkeley, using a Memorandum of Understanding with the Committee on Human Research at the University of California at San Francisco. I tape-recorded, transcribed, cleaned, coded, and analyzed all interviews using Atlas.ti, a qualitative analysis software program. To ensure anonymity, I have changed all names and identifying characteristics of individual respondents.

Encouraging and reinforcing providers' views of unauthorized immigrants as morally deserving patients

HOC providers felt that they have actively self-selected themselves into the San Francisco safety-net environment. Over the course of their medical training, all recounted self-selecting themselves into: (1) primary care service provision, which is lower-paying and less prestigious than specialty care service provision; (2) the American safety net, which is devoted to serving underserved populations; and (3) living and working in San Francisco, one of the most expensive and politically left-leaning cities in the country. Taken together, self-selection shapes their positive attitudes toward unauthorized immigrants, whom many considered deserving of equal care based on complex combinations of dominant health ethics frameworks (such as humanitarianism, human rights, social justice, and public health) combined with other frameworks related to the perceived worthiness of work and local residency, or the perceived economic utility of disease prevention over treatment (for one overview of these logics, see Filc & Davidovitch, 2007). Providers' mobilization of such inclusive frameworks is noteworthy given the relative lack of attention paid thus far to conceptions of unauthorized immigrants' “health-related deservingness” (Willen, 2012), as compared to a more voluminous literature examining their deservingness in the realm of social welfare benefits.

To illustrate, medical evaluation assistant Victoria described HOC providers' views of unauthorized immigrants as deserving by invoking the arguments that all individuals have a right to medical care (human rights) and that providers must adhere to a professional norm to give care to all people who are sick, regardless of its potential costs (humanitarianism):

Victoria: I think that [providers here] feel that everybody has a right to be seen. I mean, otherwise they probably wouldn't be working here. If you're sick, you have a right to health. I mean, know it's a burden on the system but it's a complicated thing. How are you going to turn someone away who is sick? Legal, undocumented, I think that healthcare should be for everybody.

Somewhat differently, social worker Dawn characterized unauthorized immigrants as deserving by invoking a mix of three arguments: first, that providing them primary care saves money in the long run, by keeping medical problems from escalating to the point that patients have to seek care in higher-cost emergency rooms (utilitarian preventionism); second, that all members of

disadvantaged and underserved populations should at least be able to get care in a “safety-net” (social justice); and, third, that unauthorized immigrants are positive contributors, not fiscal burdens, to the American economy (worthiness of work):

Dawn: It makes financial sense to provide our patients with primary care so we can prevent them from ending up in the emergency room. It worries me when people take that attitude that if someone comes and applies for public benefits that we should be reporting them to immigration because they're “obviously draining the system”. I think that we should have a safety net for everyone, and the undocumented immigrants that I've had the experience of working with have been very hard working and came here to work and be productive and have just had unfortunate circumstances that they can't do so.

Still differently, registered nurse Harriet characterized unauthorized immigrants as deserving by combining the argument that providing them care improves the entire community's health, by lowering its members' risks for contracting communicable diseases (public health), with the argument that doing so reduces long-term healthcare costs (utilitarian preventionism):

Harriet: I think that everybody should get care. If you're not going to treat someone for TB because they're undocumented, or if you're not going to give them birth control or treat their diabetes because “it doesn't affect” you, [you should know] it all affects you. If you can't take care of your community then you can't take care of yourself.

And resident Eduardo thought that one of the reasons there might be a “lack of debate” among HOC providers about the issue of treating unauthorized immigrants is due to the fact that physicians and residents there are trained to work according to an ideal professional norm of giving care to all people who are sick, “suspending any judgment” about who they are (humanitarianism). In Eduardo's words, physicians and residents are taught to abide by a moral imperative to find practical solutions to “always do what is medically best for the patient.” While he has seen them failing to live up to this ideal in regard to several other characteristics (e.g., race, poverty, and limited English language ability) that are well documented in the literature on how images of patient disreputability (Roth, 2001) lead providers to make judgments about patients and provide unequal care, lack of legal status has so far not been among them:

Eduardo: From a resident's perspective, especially here [San Francisco], it's very liberal. So the thinking is like “You don't do that. Everyone's entitled to the same level of care irrespective of citizenship status.” I can tell you that since I've been here I've never heard of a discriminatory or reproachable sort of attitude towards anyone we suspected was illegal – never. I've heard some nasty things from some of my fellow residents towards a patient for other reasons, but never for that. Because ultimately underlining all this is that our focus is that we have to do what's best for the patient. Just because they're an illegal immigrant doesn't make them any less than anyone else.

When respondents did identify concerns over unauthorized immigration, they unilaterally characterized them as fiscal (i.e., concerns about how best to provide adequate medical care to all community residents in situations of limited financial resources) rather than moral (i.e., concerns about whether unauthorized immigrants are inherently deserving of equal treatment). Even in a very liberal political context like San Francisco, for instance, HOC respondents reported hearing their patients, friends and family members, and sometimes even colleagues (most often lower-level

staff and hospital eligibility in-take workers, but sometimes also residents and physicians) express views of unauthorized immigrants as “less deserving” of publicly-provided medical services than other “legal” and “citizen” community members, especially in tightening fiscal climates. Resident Eduardo even described this internal conflict among his fellow residents, some of whom he suspected “are sort of irked by that decision [to provide care to unauthorized immigrants]” because they have internalized the larger American public's concern about its fiscal costs and burdens, yet nonetheless “agree that it's the right thing to do ethically, morally” as healthcare providers, from both human rights and humanitarian perspectives.

Similarly, Shana, Victoria, and Jia described the tension between these ethical versus fiscal perspectives among some HOC colleagues. Clerical worker Shana noted that a “large portion” of her citywide health worker union, many of them African Americans, have “an attitude that undocumented immigrants shouldn't be here”, even though “everyone tends to agree that kids should get help”. She described their rationale as one that privileges legal citizenship in a time of declining resources: “We've only got so many resources, so Americans should get priority. That's the attitude. And it's gotten worse since the economy's gotten worse.” Similarly, medical evaluation assistant Victoria, who earlier expressed the belief that “everyone who is sick has a right to health”, also admitted that she is not 100 percent supportive of unauthorized immigrants having equal access to publicly-provided medical services – a view she admitted was passed down to her from her parents, who as legal Mexican immigrants, wonder “why are we working for years and footing the bill” for unauthorized immigrants to also receive services? “You know,” Victoria mused, “We can only pay so much for people coming here.” But at the same time, Victoria joined clerical worker Jia, who admitted that she “understands both sides of the debate”, in balking at the idea of denying care to unauthorized immigrants. In Jia's words, even though Americans (especially those she knows outside the medical community) resent “having to pay taxes and provide for [unauthorized immigrants] when we Americans or San Franciscans are doing without”, unauthorized immigrants also need care, and if they cannot get it in the safety net, “Where else would they go?”

Thus, some HOC respondents reported encountering fiscal resentment toward unauthorized immigrants among their colleagues even though, as registered nurse Catarina explained, as a safety-net clinic HOC espouses a more inclusive “philosophy” toward unauthorized immigrants than do most American healthcare institutions. Likewise, they reported encountering it among their patients, especially low-income African Americans and legal or citizen Hispanics who invoke a discourse of citizenship to portray unauthorized immigrants as less deserving of publicly-provided medical services than they. In response, most respondents reconfirmed their professional commitments to providing equal care to unauthorized immigrants regardless of its potential costs. Nurse practitioner Julia emphasized that “we all need healthcare” and that “healthcare doesn't know papers or not papers” in response to disentitling sentiments expressed by some of her family members, who are descendants of legal immigrants from eastern Europe who blame “illegals getting services for our problems with the budget”. Likewise, nurse practitioner Sarah emphasized that unauthorized immigrants are productive contributors to American society (“Our society would not function without [unauthorized] people working for nothing and paying taxes and not getting any services”) in response to resentments expressed by some of her patients and friends outside the hospital context, as did health worker Mariana in response to disentitling sentiments from some of her less inclusively-oriented colleagues:

Mariana: I have had issues with them in the clinic, and I've had to verbally explain to them that illegal immigrants cannot get Medi-Cal, except if it's an emergency. I've told them that illegal people buy things here and pay taxes every place they go. How if they use a wrong social security number, all the taxes that they pay with it are taken away from them and they're never gonna get benefits of retirement, disability, none.

Various respondents also strengthened their commitment to expanding preventive and primary care services to unauthorized immigrants, in order to reduce the more expensive costs of emergency services.

Thus, 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 distinguished their more inclusive views not only from those of the general American public but also from more conservative healthcare providers and many of their own legal immigrant and citizen patients. Furthermore, in a surprising twist to the disorienting practices commonly documented in the literature on street-level bureaucracy, several also reported that public safety-net hospital's inclusive institutional culture – shaped in part by the city's inclusive local policy context – imposes sanctions on providers and staff who openly disagree, thereby disciplining them to avoid using social judgments about immigrant patients in order to ration care. In clerical worker Shana's opinion, its institutional emphasis on “treating everyone, of all groups” tempers providers' expressions of fiscal resentment toward unauthorized immigrants by emphasizing the concept of unauthorized immigrants as “insiders, and part of my community” instead of as “those people” and by giving people of different ethnic backgrounds the opportunity to work together. In resident Eduardo's words, voicing a view of unauthorized immigrants as “undeserving” within the San Francisco safety-net is taboo; thanks to a strong and inclusive institutional culture, while “you hear those things at the margins, the general reaction would be for people to say, ‘We don't say that kind of thing here.’ I think you would be reprimanded for it and seen as someone negative.”

Facilitating providers' abilities to extend care to unauthorized immigrants in primary care

San Francisco's inclusive local policy climate helps HOC providers put these supportive attitudes into practice in several ways. Notably, it reinforces providers' symbolic understandings of unauthorized immigrants as deserving local community residents, something that physician Mary speculated might explain why the debate over eligibility throughout the hospital “plays out less” than expected for this group whose reputability is often challenged elsewhere. In her view, hospital in-take eligibility staff are most concerned about the fiscal costs of providing care to people (especially the homeless) who are not legitimate “local community residents” of San Francisco. By this logic, San Francisco's sanctuary and municipal ordinances, combined with its two citywide health programs, dampen some of the discounting of unauthorized immigrants that would otherwise arise out of concern over their potential fiscal impact, by including them within the city's symbolic conception of “local community” via proof of local inhabitation or residence (de Graauw, 2009; Ridgley, 2008).

In addition, respondents reported that the city's sanctuary ordinance legitimates providers' views of patients possessing the “right” to access care and to receive treatment regardless of legal status. Health worker Mariana explains that “while San Francisco does have prejudice and I've overheard that they want to start this whole thing about not serving people that are not legal, San Francisco voted on being a sanctuary city and so we do not ask people if

they're legal or illegal.” In this sense, the sanctuary ordinance reinforces a legal-status-blind environment within the city's safety net, which respondents argued reduces some of the fears that unauthorized immigrants exhibit about accessing care here compared to other places they have worked. According to physician Elena, it creates “a very high level of trust with the [unauthorized] community” precisely because “we do not collect data on [lack of] legal status”. Likewise, according to resident Devin, the municipal ID ordinance reinforces this level of trust by creating “the sense that people have access to public services and they are safe there. Safe from law enforcement, safe from ICE or whatever.” Although Devin admitted that local sanctuary policy and municipal ID card policies “alone” cannot provide a full sense of safety, he thought they are a “good start”, and he also recounted seeing New Haven's municipal ID ordinance “doing some wonders” when he attended Yale Medical School there.

Going further, in several respondents' views, the sanctuary ordinance also helps providers to comply with their dominant professional norm to “suspend judgment” and “not disenfranchise” patients according to personal characteristics, by encouraging them to actively “ignore” or “look beyond” patients' legal statuses in their patient-provider interactions. As physician Charlotte explained, “We try to treat people the same no matter what ...do our damndest not to think about [legal status].” In fact, registered nurse Jane emphatically described a strategy of never asking patients about legal status “not because [we] 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 these providers, San Francisco's inclusive local policy context not only strengthens the dominant professional norm of “don't ask, don't know, don't care” regarding legal status (Light, *in press*; also Portes et al., *in press*; Portes et al., 2009) but also legitimates their cognitive beliefs that ideally lack of legal status should not matter to healthcare delivery (Marrow, *in press*).

Finally, inclusive local policy allows respondents to provide care to unauthorized immigrants without thinking or worrying about the direct financial costs of doing so. As physician Charlotte explained, San Francisco's public-salaried payment structure insulates them, as public providers, from having to “eat” the direct costs of treating uninsured patients, making them less reluctant than many providers working in private practice would be to treating unauthorized patients. Likewise, Charlotte argued, San Francisco's generous funding to its public healthcare infrastructure insulates them from the “frustration” of unfunded mandates to treat unauthorized immigrants who are uninsured, even compared to public safety-net providers working elsewhere. Indeed, local HSF investment – which, as clerical worker Shana reported, “kicks in the money” for many services that federal and state policies do not currently fund for unauthorized immigrants and other low income, uninsured immigrants and natives – allows HOC providers, in nurse practitioner Sarah's words, to offer “access to better than 90 percent” of primary care services without thinking or asking about patients' 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.” Yet Mary 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 something on-site. As Mary demonstrated, San Francisco's inclusive local policy environment, which includes generous allocation of local funding to the city's safety-net infrastructure, allows HOC providers to more effectively marshal

resources for individual uninsured patients, including unauthorized ones, that facilitate their access to and utilization of care (Marrow, *in press*).

Gatekeeping unauthorized immigrants' Entry into primary Care

Nevertheless, tangible legal status barriers to care in San Francisco remain. A first reason is that San Francisco's inclusive local policies are modeled on and partially embedded within the more restrictive structure of federal and state Medicaid policy, which effectively deters some unauthorized immigrants from accessing care in HOC. As mentioned, HOC respondents frequently described San Francisco as one of the most "open" healthcare systems in the country; time and again, they stated that the city's inclusive local policy context helps them to "do much better" at reaching the unauthorized immigrant population than can providers working in public safety-net systems elsewhere, where deterrents to seeking care are stronger. Still, several respondents openly admitted to "not knowing" how many unauthorized immigrants in the city fear trying to access their care. They agreed with physicians Joseph and Elena that an "inherent selection bias" structures their experiences with the city's unauthorized immigrants, such that the patients they do see in their clinic are likely to be the "least fearful", "most savvy", and "most persistent" – that is, patients who have successfully navigated not only the hospital's initial eligibility registration process (which screens and determines which plans will cover them – one of federal or state public insurance programs or one of the two local initiatives, SFHK and HSF), but also the clinic's overburdened phone lines (which physician Charlotte admitted are rarely answered) and long waiting lines in order to get appointments in HOC.

To illustrate, several respondents – especially those who have more extensive contact with unauthorized immigrants outside the clinic, either by living in the local Latino community or by engaging in independent volunteer health or civic outreach activities with them – recounted seeing complex "documentation steps" effectively exclude some unauthorized immigrants from being able to access care in the public safety net. In medical evaluation assistant Jorge's words, the public safety-net hospital only reaches "a pinch" of the unauthorized population despite the city's inclusive local policy climate, because Medi-Cal requires proof of legal immigration status or U.S. citizenship as well as proof of low income, while Healthy San Francisco requires proof of local San Francisco residency, low income, and also denial from Medi-Cal (a bureaucratic requirement verified by Esteban, a hospital Medi-Cal eligibility supervisor). Indeed, Healthy San Francisco, despite its efforts to be more inclusive of low-income city residents than either federal Medicaid or state Medi-Cal policy, relies on many of the latter's disempowering rituals, scripts, and symbols, including similarly-structured eligibility protocols and application processes and similarly-rationalized definitions of low income and local residency.

Very likely this is because Medicaid has been normatively sanctioned as a legitimate and efficient way of determining need for health-related economic assistance in American society, such that HSF has had to organize itself in concert in order to gain legitimacy of its own, and to fulfill its public financial reporting requirements (on the coercive pressures toward institutional isomorphism, see DiMaggio and Powell, 1983). Regardless, the embeddedness exposes a central dilemma, as several HOC nurses highlighted. On one hand, HSF is ostensibly "universal" for all low-income residents of the city, demonstrating the equalizing potential of bureaucratic programs to level legal status differences in access to care. Yet on the other hand, it shares with its more

restrictive federal and state program counterparts a tendency toward bureaucratic disempowerment and a failure to accommodate the special needs of highly stigmatized client groups such as unauthorized immigrants. Such groups struggle to produce the items required as proof of local residency and low income (e.g., income tax forms, bank accounts, utility bills, rental agreements, etc.) or even alternate documents allowed by the more expansive local San Francisco policy (e.g., affidavits of support from landlords to prove local residency, signed statements from employers to prove low income, etc.).

Several HOC nurses even reported that HSF has made the hospital's "climate of proof of local residency" more rather than less stringent. Whereas before, in registered nurse Amy's words, eligibility in-take staff "used to be more interested in did the person have an address and was he poor, and it would take nothing more than a letter by anybody really to say that 'This person works for me a few days a week'," now with HSF "there's like three or four documents that are required" to prove local San Francisco residency. Likewise, according to registered nurse Cecilia, "It's more difficult for people to be able to prove where they're living" here now:

Cecilia: I think all of us in this room know people that are undocumented and that we've all assisted in trying to get through.

Eliza: I just encountered it a couple of weeks ago. This lady wanted to get in the system, but she didn't have residency proof because she and her family were renting a room in an apartment from somebody else, and all their bills were in that person's name. So I asked her for a letter saying, "I don't have a bill under my name because I rent a room from someone," but the landlord didn't want any involvement in it. And cell phone bills won't apply. So she said, "I don't know what to do. My husband's just getting a job right now. I'm in a bind."

Caitlin: And with the cost of living in this city being so great, that happens quite frequently because people can't afford to rent their own place.

Such documentation requirements, in these nurses' views, compound the fears that unauthorized immigrants have of attempting to obtain healthcare, constituting a *de facto* barrier to care (Portes et al., *in press*; Portes et al., 2009; Walter & Schillinger, 2004). In registered nurse Catarina's words, "Even if Healthy San Francisco and [this hospital] may not do anything with that information, if you're undocumented and you know that there's a possibility you could get deported, there is wariness to submit all this documentation or have to come up with it. So, it may not be meant as a barrier but it definitely is serving as one." Indeed, while social worker Dawn targeted her greatest frustrations at the strict eligibility requirements built into the federal Medicaid and state Medi-Cal insurance programs, she made similar (albeit more muted) criticisms of those in the local HSF program, which she reported frustrate some unauthorized immigrants to the point that many are "afraid to come and sign up" for care.

In sum, according to Sofia, a non-HOC physician who also volunteers in the nearby Latino day laborer-oriented free clinic, despite the public safety-net hospital's "pretty good reputation in the community" and the "committed" sentiment of its providers and staff, the hospital context is so "bureaucratic" and "imposing" and the city's unauthorized immigrant community is so "stratified" that most of its neediest members are not interacting with it at all. In her experience, the more "savvy" unauthorized patients "who have been here for a while, who have family members who can help them navigate the system, "who know about the healthcare programs like Medi-Cal and Healthy Families, or who know where to go for dental services or in an emergency, do come through" the

hospital system into HOC. But the “less savvy” and “needier” unauthorized families, especially single men who work as day laborers, “are an entirely different population” with no access to the public safety-net – not even to the city’s affiliated community health centers, which are also governed by bureaucratic eligibility requirements despite being “less intimidating” than the large city hospital.

Constraining providers’ abilities to extend care to unauthorized immigrants beyond primary care

Legal status barriers also remain in San Francisco due to the fact that local policy delimits unauthorized immigrants’ access to care to the realm of select primary medical services. As a universal access model, HSF remains “categorically unequal” (Light, *in press*) to other forms of public health insurance (even to Medi-Cal and Healthy Families) in that it only includes primary care services provided by participating healthcare institutions or otherwise funded by HSF monies. In contrast, HSF does not cover certain specialty care services (including dental and vision) or other ancillary “social support” services (including public housing, GA, SSI, 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 policies (WIC is a notable exception).

Consequently, as they move across two critical junctures – the first between primary and specialty medical care and the second between primary medical and ancillary care – HOC respondents reported that the range of resources they can offer to unauthorized patients gets restricted, and that their efforts to “buffer” and advocate for individual unauthorized patients get dampened (Marrow, *in press*). For example, whereas physician Elena is “able to provide standard of care for the majority of my patients who are chronically ill” since “the City and County of San Francisco commits amazing, amazing resources to provide an enormous amount of things”, for the small group of patients who do become “sicker than that level, severely enough ill, or have the wrong thing”, lack of legal status matters because they “just can’t get care” and “it becomes really hard [to get them care], depending on what the service is”.

As providers like Elena move in to the realms of specialty care and ancillary services, they see clear patterns of “blocked access” emerge 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, etc. – 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 up to care. In a few cases their efforts have been successful, but as resident Laura explained of the time when an external allergist agreed to see one her unauthorized patients who had recurrent anaphylaxis, such success is “voluntary” and “discretionary” rather than systemic, and moreover, it declines noticeably 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 in a case where she could not successfully set up a liver transplant for the “perfect” yet unauthorized patient:

Mary: [My patient] is someone who by like 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. So she’s alive and she’s doing okay but she is not eligible for a [liver] transplant, like it literally can’t be done. That’s just a devastating conversation to have [with a patient].

HOC providers’ buffering and advocacy strategies in the realm of ancillary services are also ineffective, especially where rules governing access are strict and strongly enforced. As physician Mary continued, even in remarkable cases where the city does fund certain specialty medical care services to unauthorized immigrants, HOC providers’ “hands get tied” in accessing many critical social support services like unemployment, disability, or public housing that would allow such patients to support themselves and their families as they heal:

Mary: And so 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 arrhythmia]. 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. And so I would say that our hands get tied for those kinds of things.

In these ways, in physician Elena’s words, lack of legal status becomes “determinant of the care one receives” in San Francisco beyond the realm of locally covered primary care services. Even the most committed safety-net providers have trouble translating their views of unauthorized immigrants as morally deserving patients into provision of equal care beyond this point.

Conclusion

In this article, I have examined how the uniquely inclusive San Francisco 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 in the United States. On one hand, this inclusive local policy context “works” to overcome legal status disparities in care by encouraging and reinforcing public safety-net providers’ views of unauthorized immigrants as patients morally deserving of equal care, and by helping them to translate their inclusive views into actual behaviors by providing increased financial resources. On the other hand, it “fails” to overcome legal status disparities in care by operating within the more restrictive structure of federal and state Medicaid policy, and by delimiting unauthorized immigrants’ access to care to the realm of select primary care services.

These results have practical and theoretical implications for policymakers, healthcare providers, and immigrant advocates, two of which I discuss here. First, these results highlight the real potential for subnational governments to play a positive role in enacting and implementing local right-to-care strategies as they seek to overcome some of the barriers to access and utilization created by a “decidedly hostile” federal environment (Newton & Adams, 2009, p. 422). This is especially important given that the HealthCare and Education Reconciliation Act of 2010 does not

expand access to insurance and care to unauthorized immigrants even as it does so to approximately 32 million uninsured American citizens and legal immigrants (Jackson & Nolan, 2010; Pear & Herszenhorn, 2010). Even if such strategies are politically and financially difficult to enact, they give street-level healthcare providers – especially those in the public safety net, who boast strong professional commitments to serving the underserved – greater ability to extend care to unauthorized immigrants in a systemic and not just discretionary way. In the language of immigrant incorporation (Bloemraad, 2006), local right-to-care strategies can promote unauthorized immigrants' incorporation both symbolically, by shaping inclusive local organizational cultures that encourage and reinforce their members' views of unauthorized immigrants as morally deserving clients, and instrumentally, by providing the material resources that allow providers to translate inclusive beliefs into concrete actions.

Yet these results also caution us to pay attention to underlying institutional contradictions that frustrate many street-level providers' efforts to reduce legal status disparities in healthcare even in aspirationally inclusive subnational contexts. Despite the good intentions of its local policymakers and safety-net healthcare providers, San Francisco's "experiment" to level legal status disparities in care operates within a larger federal political and moral environment that tacitly encourages the rationing of services to the poor and other groups who are deemed "undeserving". As such, both hidden and formal barriers to care inevitably remain, even in a well-intentioned locality like this one. Similar contradictions also appear in other countries where inclusive local policies conflict with restrictive national healthcare policies toward unauthorized immigrants. For instance, in Germany, an incoherent national-to-local policy environment and complex bureaucratic requirements have transformed what is already a formally-defined minimum standard of medical care for unauthorized immigrants – albeit one that is "technically guaranteed" – into "inadequate" provision and disempowering patient outcomes (Castañeda, 2009, p. 1553; Filc & Davidovich, 2007). And in Spain, unauthorized immigrants have trouble accessing the local housing and healthcare services that are technically available to them, as "residents", not only because strong bureaucratic barriers to renewing their work permits compromise their residency statuses (Calavita, 2005), but also because new deportation policies discourage them from registering at municipal town halls, which they must do in order to receive healthcare benefits (Filc & Davidovich, 2007). Thus, while local right-to-care strategies such as San Francisco's are indeed promising, in the absence of more inclusive political will and policy change at the federal level, informal and formal barriers to care will likely remain.

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