FACTS Reports

Field Actions Science Reports

Special Issue 2 (2010)
Migration and Health

Helen B. Marrow

Access Not Denied? The Role American Localities Can Play

Electronic reference
Helen B. Marrow, « Access Not Denied? The Role American Localities Can Play », *Field Actions Science Reports* [Online], Special Issue 2 | 2010, Online since 01 October 2010, Connection on 12 October 2012. URL : http://factsreports.revues.org/483

Publisher: Institut Veolia Environnement
http://factsreports.revues.org
http://www.revues.org

Document available online on: http://factsreports.revues.org/483
This document is a facsimile of the print edition.

Field Actions Science Report
www.factsreports.org

FACTS Reports

Access Not Denied? The Role American Localities Can Play

H. B. Marrow

Department of Sociology, Tufts University

Abstract. San Francisco represents a unique case in the United States in that it has enacted a set of inclusive policies at the local level to increase unauthorized immigrants' access to and utilization of health care. Based on interviews conducted with 36 primary care providers working in the city's public safety net in 2009, I examine how this inclusive local policy environment both reinforces and constrains their aspirational views of unauthorized immigrants as morally "deserving" patients, and how it operates to help provide care to unauthorized immigrants. On one hand, this environment reinforces safety-net providers' aspirational views by creating a more legal-status-blind environment that encourages unauthorized immigrants to come in for care, and by facilitating their abilities to offer key services to and advocate for unauthorized immigrant patients. At the same time, this environment constrains their aspirational views by operating through an institutional structure whose bureaucratic rules effectively deter some unauthorized immigrants from accessing care, and by explicitly delimiting unauthorized immigrants' access to care to the realm of select primary medical services. These results highlight the great potential of, but also the limitations and internal dilemmas constituting, local "right to care" strategies that seek to ameliorate unauthorized immigrants' health vulnerability in what is still a hostile U.S. federal context.

Keywords. Immigration, Incorporation, Unauthorized, Deservingness, Health Care, Safety Net.

1 Introduction

The federal and state health care policy context toward the estimated 11.9 million unauthorized immigrants living in the United States today (Passel and Cohn 2009) 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 very few exceptions, unauthorized immigrants face an array of direct eligibility restrictions against public insurance (Fox 2009; Fremstad and Cox 2004; Quill *et al*. 1999; Schwartz and Artiga 2007). Although all qualify for select public health and nutrition measures—including immunizations, WIC, and testing and treatment for communicable diseases (Fremstad and Cox 2004)—they can only qualify for a limited form of Emergency Medicaid (which covers labor 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 nonemergency care in a handful of states that use their own state funds to offer it (Fremstad and Cox 2004; Goldman, Smith, and Sood 2005; 2006).

In addition, there are indirect eligibility restrictions. The new Health and Immigration Study (HIS) shows that many unauthorized immigrants 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 criteria that *are* required for admission into these institutions (Portes, Fernández-Kelly, and Light n.d.; Portes, Light, and Fernández-Kelly 2009; see also Heyman, Núñez, and Talavera 2009).

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 (see Berk *et al*. 2000; Goldman, Smith, and Sood 2005; 2006; Marshall *et al*. 2005; Nandi *et al*. 2008; Ortega *et al*. 2007). Moreover, the Health Care and Education Reconciliation Act of 2010 does not help the situation at all. Under it, 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 completely with their own money (Jackson and Nolen 2010). 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).

Therefore, 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

Correspondence to: Helen B. Marrow
(helen.marrow@tufts.edu)

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, or for some other reason—they will have to look to other creative alternatives.

2 Creative Alternatives

One viable alternative is the national network of federally qualified health centers (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 has increased federal funding to FQHCs, and this will certainly help to reduce significant disparities in access to and utilization of care for some unauthorized immigrants. However, it will not reduce them all, since FQHCs are only located where social entrepreneurs have advocated for them (Portes, Fernández-Kelly, and Light n.d.; Portes, Light, and Fernández-Kelly 2009), do not offer most specialty services (focusing instead on primary and preventive care), and continue to be governed by the more restrictive federal and state eligibility rules regarding proof of low income and local residency that the Health and Immigration Study shows effectively bar or deter some unauthorized immigrants from seeking care.

Another set of creative alternatives, of which several interesting ones are emerging today, are binational. However, these may be problematic for unauthorized immigrants as they develop, since this population faces increasing restrictions on moving back and forth across international borders. They may also be problematic to the extent that they are organized only through Mexican-based initiatives (what about non-Mexican unauthorized immigrants?) or executed only in areas of high demographic concentration (what about unauthorized immigrants who live elsewhere?).

This leaves us with an option for inclusive subnational policies to 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, which are now struggling to determine how best to respond to their presence.

3 San Francisco: A Unique Case for Subnational Strategies

To this effect, I conducted a case study of a unique set of subnational strategies in San Francisco, where local government officials have worked to create a more inclusive and less stigmatizing environment toward unauthorized immigrants. Not only have local government officials historically allocated generous funds to the city's public safety-net infrastructure, but they have also enacted two measures that divorce lack of legal status from the provision and receipt of local public services and benefits. The first is a Sanctuary Ordinance, which prohibits the city's public employees from either requesting or collecting any information on legal status that is not required by federal or state law, and from cooperating with federal immigration officials regarding any persons not under investigation or convicted of felonies (Tramonte 2009). The second measure is a new Municipal ID Ordinance, which makes it easier for unauthorized immigrants (as well as other city residents) to access the local services and benefits to which they are entitled. Both measures acknowledge unauthorized immigrants' de facto right to live in and be part of San Francisco's civic community on the basis of what geographer Jennifer Ridgley (2008) and political scientist Els de Graauw (2009) term local "inhabitance" or "residence" (*jus domicili*), as opposed to birthright, ancestry, or legal citizenship.

Moreover, local government officials have enacted and committed substantial local public funds to two notable health programs—San Francisco Healthy Kids (SFHK) and Healthy San Francisco (HSF)—that increase access to health care for all low-income resident children and adults, respectively, regardless of legal status, who do not qualify for other forms of federal or state public insurance coverage (Bitler and Shi 2006; Dow, Dube, and Colla 2009; Frates, Diringer, and Hogan 2003; Katz 2008). Importantly, services covered in the HSF model are not equivalent to insurance coverage. They are limited mostly to select primary care services (plus a few specialty services) that are provided by participating institutions (that to date are almost exclusively in the public safety net) or otherwise funded by HSF monies.[1]

In my project, I ask: How does this inclusive local policy environment both reinforce and constrain safety-net providers' aspirational views of unauthorized immigrants as morally "deserving" patients, and what are the mechanisms through which it operates to help provide care to unauthorized immigrants?

4 Site Selection and Methods

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)—that also serves as one of the city's HSF medical homes.

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. Respondents ultimately included five physicians, seven resident physicians-in-training, and 24 nonphysician providers and staff members, including eight registered nurses (RNs), three nurse practitioners (NPs), seven Medical Evaluation Assistants (MEAs), four

[1] Also noteworthy is that HSF was never about cost savings. In 2010, the city's General Fund committed $90 million to the program to make up the difference after $36 million was raised in revenue from patients and employers (SF DPH and SF OLSE 2010), which comes out to approximately $111 per capita by my own calculations. But government officials note that the city was already paying substantial amounts to care for the uninsured, including unauthorized immigrants, prior to HSF. So the program does not necessarily represent an infusion of new money into the safety-net system. Rather, it was conceived as a way to integrate, further destigmatize, and make more efficient the prior robust safety net that the city already had in place, while simultaneously expanding the focus on preventive/primary care in a system of medical homes.

clerical staff, one social worker, and one health worker. For contextualization, I also conducted interviews with 18 safety-net providers and staff in other hospital clinics and departments (including two hospital Medi-Cal eligibility staff); a nearby Latino-oriented FQHC; and a nearby Latino day laborer-oriented free clinic, though I limit my analysis here primarily to interviews conducted in HOC.

Most interviews lasted between 45 and 90 minutes and were conducted in isolation, although some were conducted as small focus groups. 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.

5 Findings

5.1 Constructing Deservingness: Self-Selecting into the Safety Net

HOC providers felt that they have actively self-selected themselves into, first, primary care service provision, which pays less and is less prestigious than specialty care service provision; second, into the American safety net, which is devoted to serving underserved populations; and third, into 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 care based on complex combinations of dominant "health ethics" frameworks such as humanitarianism, human rights, social justice, and public health (see Coyle 2003; Dwyer 2004, 2009; Grove and Zwi 2006; Kuczewsku 2000; Kullgren 2003; Ruiz-Casares *et al*. 2010; Romero-Ortuño 2004; Scott 2004; Tickten 2006; Ziv and Lo 1995) as well as other frameworks that I call the "deserving worker," "local community resident," and "preventive fiscal" perspectives.

When HOC providers did identify concerns over unauthorized immigration, they unilaterally characterized them as fiscal (e.g., concerns about how best to provide adequate medical care to all community residents in situations of limited financial resources) rather than professional (e.g., concerns about whether unauthorized immigrants are inherently deserving of equal treatment). Even in a very liberal political context like San Francisco, for instance, they reported hearing their patients, friends, family members, and sometimes even colleagues express views of unauthorized immigrants as "less deserving" of publicly provided medical services than other "legal" and "citizen" community members, especially during periods of fiscal tightening. However, in response, they tended to reconfirm their professional commitment to providing equal care to unauthorized immigrants regardless of potential costs. For example, nurse practitioner Julia emphasized that "we all need health care" and that "health care doesn't know papers or not papers" in response to discounting sentiments expressed by some of her family members, who are descendants of legal immigrants from Eastern Europe and who blame "illegals getting services for our problems with the budget."

Thus, while some variation did exist among HOC providers in the degrees to which, and rationales for why, they support providing care to unauthorized immigrants, all exhibited a generally inclusive attitude, distinguishing their more inclusive views not only from those of the general American public but also from more conservative health care providers and many of their own legal immigrant and citizen patients. Furthermore, several also reported that public safety-net hospitals' inclusive institutional culture imposes sanctions on providers and staff who openly disagree. In resident Eduardo's words, expressing a view of unauthorized immigrants as "undeserving" within the San Francisco safety net is taboo: 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."

5.2 Reinforcing Deservingness: Facilitating Primary Care

San Francisco's inclusive local policy climate helps these HOC providers put their supportive attitudes into practice in several ways. First, as physician Charlotte explained, the public-salaried payment structure of and generous investment into the city's safety-net infrastructure insulates them from having to absorb the direct costs of caring for unauthorized immigrants, which in turn makes them more amenable to treating them as patients. As clerical worker Shana reported, generous local investment literally "kicks in the money" for a variety of services not covered by federal and state monies, which providers reported allows them, in nurse practitioner Sarah's words, to offer "access to better than 90 percent" of primary care services without ever having to think or ask about patients' legal status. In their opinions, this helps providers to comply with their professional norm to "suspend judgment" and "not disenfranchise" patients according to personal characteristics.

In conjunction with the city's Sanctuary Ordinance, respondents also reported that generous local investment helps providers to buffer against unauthorized patients' fears of utilizing their services, and to more effectively marshal resources and advocate for individual unauthorized patients in a variety of ways. Physician Mary not only 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 also explained how 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 certain service.

Likewise, nurse practitioner Lynne demonstrated how the city's inclusive policy environment facilitates buffering and advocacy: "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."

5.3 Constraining Deservingness: Gatekeeping Entry to Primary Care

Nevertheless, San Francisco's inclusive local policy environment does not fully reinforce HOC providers' aspirational views of unauthorized immigrants as morally "deserving" patients. One way that it constrains them is by operating through an institutional structure whose bureaucratic rules effectively deter some unauthorized immigrants from accessing care. Even though HOC respondents repeatedly 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 care are stronger, several openly admitted to "not knowing" how many unauthorized immigrants in the city still 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 them and determines whether they are covered by a federal or state public insurance program or one of the two local initiatives, SFHK and HSF) but also the clinic's overburdened phone lines and long waiting lines to get appointments in HOC.

In fact, several HOC nurses alluded to a central dilemma posed by HSF, which requires proof of local San Francisco residency, low income, and denial from Medi-Cal (a requirement verified by Esteban, a hospital Medi-Cal eligibility supervisor). 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. On the other hand, it shares with its more restrictive federal and state program counterparts a failure to accommodate the special needs of unauthorized immigrants, who face problems producing the items it requires as proof of local residency and low income (income tax forms, bank statements, utility bills, rental agreements, etc.) or even alternate documents that are allowed by the more expansive local San Francisco policy (such as affidavits of support from landlords to prove local residency, or signed statements from employers to prove income):

> *Eliza:* 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."

Such documentation requirements, in these respondents' views, compound unauthorized immigrants' fears—especially, according to non-HOC physician Sofia, those of "needier" ones like single men working as day laborers—thereby constituting a de facto barrier (Portes, Fernández-Kelly, and Light n.d.; Portes, Light, and Fernández-Kelly 2009; Walter and Schillinger 2004). Indeed, while social worker Dawn targeted her greatest frustrations on the strict eligibility requirements built into federal and state insurance programs like Medi-Cal, 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.

5.4 Constraining Deservingness: Drawing Lines Beyond Primary Care

A second way that San Francisco's inclusive local policy environment constrains HOC providers' aspirational views of unauthorized immigrants is by explicitly delimiting the access of even those unauthorized immigrants who are deemed "local community residents" to the realm of select primary medical services. As a universal access model, HSF remains "categorically unequal" (Light, Portes, and Fernández-Kelly n.d.) to other forms of public health insurance (even to Medi-Cal and Healthy Families) in that it includes mostly primary care services provided by participating health care institutions or otherwise funded by HSF monies.

Consequently, as they move across two critical junctures—the first between primary and specialty medical care, the second between primary medical and ancillary social support care—HOC providers reported that the range of resources they can offer to unauthorized patients is restricted and that their efforts to buffer and advocate for individual unauthorized patients are dampened. For example, whereas physician Elena reported that she 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."

In these realms of specialty care and ancillary services, respondents saw clear patterns of "blocked access" by legal status emerge for unauthorized patients, despite their best efforts to "twist some arms" and find ways to link their unauthorized patients up to care. In a few cases their efforts have been successful. For example, resident Laura convinced an external allergist to see one her unauthorized patients who had recurrent anaphylaxis, but such successes result from "voluntary" and "discretionary" actions rather than systemic ones. Moreover, they decline noticeably as the cost of the specialty procedure rises or when the rules regarding social support services are most strict. In most situations respondents felt that their "hands are tied."

6 Conclusion

I have examined how San Francisco's inclusive local policy environment both reinforces and constrains safety-net primary care providers' aspirational views of unauthorized immigrants as morally "deserving" patients, and how it operates

to help provide care to unauthorized immigrants. On one hand, this environment reinforces providers' views by creating a more legal-status-blind environment that encourages unauthorized immigrants to come in for care, and by facilitating their abilities to offer key services to and advocate for unauthorized immigrant patients. On the other hand, this environment constrains providers' views by operating through an institutional structure whose bureaucratic rules effectively deter some unauthorized immigrants from accessing care, and by explicitly delimiting unauthorized immigrants' access to care to the realm of select primary medical services.

These results carry important practical and theoretical implications for policy makers, health care providers, and advocates alike. First, they highlight the very real potential for subnational states and localities to play a positive role in enacting and implementing local "right to care" strategies that help to overcome some of the barriers to access and utilization present in a still hostile American federal environment. Even if such strategies are politically and financially difficult to enact elsewhere, they give providers greater ability to help reduce disparities by legal status, and therefore give patients more access to and utilization of care at a systemic (and not just discretionary) level. In this regard, San Francisco can serve as an important model for states and localities throughout the United States as they search for practical ways to respond to unauthorized immigration. Unless they are willing to let unauthorized immigrants die in the streets, such places already pay for their treatment somehow, usually in ways that are unduly expensive and less efficient than in the San Francisco case. If local actors are concerned about reducing disparities by legal status, then creating a relatively protective civic environment and focusing on expanding and integrating access to primary care can help.

At the same time, however, these results also highlight some of the thorny internal dilemmas constituting subnational "right to care" strategies. Clearly, subnational 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 programs. Even in San Francisco, it is "access" rather than insurance that is the goal, since full insurance is still deemed to be "unaffordable" (Scott 2010). Thus the continued exclusion of unauthorized immigrants from federal programs means that even in San Francisco providers still face difficulties "working around" both specialty and "non-health" ancillary problems in order to care for unauthorized immigrants. Additionally, these providers face difficulties "working around" existing institutional structures that not only gatekeep entry to safety-net health care institutions based largely on market priorities, but also fail to accommodate the special difficulties that unauthorized immigrants face in meeting seemingly "standard" bureaucratic requirements. To fully overcome all of these barriers, respondents argued that, ultimately, the American public must change its mind-set about unauthorized immigrants and see them as more deserving of inclusion and investment.

References:

Berk, M. L., C. L. Schur, L. R. Chavez, and M. Frankel (2000), "Health Care Use among Undocumented Latino Immigrants," Health Affairs, Vol. 19, No. 4, pp. 51-64.

Bitler, M. and W. Shi (2006), "Health Insurance, Health Care Use, and Health Status in Los Angeles County," Research Brief, Issue 112, Public Policy Institute of California, San Francisco, CA, December.

Coyle, S. (2003), "Ethics Case Study: Providing Care to Undocumented Immigrants," The Hospitalist, July/August, pp. 24-27.

de Graauw, E. (2009), "Documenting the Undocumented: Nonproft Organizations and Intergovernmental Tensions over Municipal ID Cards in San Francisco," presented at the conference "Undocumented Hispanic Migration: On the Margins of a Dream," Connecticut College, New London, CT, October 16-18.

Dow, W. H., A. Dube, and C. H. Colla (2009), "A Public Option That Works," New York Times, August 22.

Dwyer, J. (2004), "Illegal Immigrants, Health Care, and Social Responsibility," Hastings Center, Vol. 34, No. 6, pp. 34-41.

——— (2009), "When the Discharge Plan is Deportation: Hospitals, Immigrants, and Social Responsibility," Bioethics, Vol. 23, No. 3, pp. ii-iv.

Fox, C. (2009), "A New Nativism or an American Tradition: Federal Citizenship and Legal Status Restrictions for Medicaid and Welfare," presented at the 2009 meeting of the Robert Wood Johnson Foundation Scholars in Health Policy Program, Aspen, Colorado, May 27-30.

Frates, J., J. Diringer, and L. Hogan (2003), "Models and Momentum for Insuring Low-Income, Undocumented Immigrant Children in California," Health Affairs, Vol. 22, No. 1, pp. 259-263.

Fremstad, S. and L. Cox (2004), "Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance," Kaiser Commission on Medicaid and the Uninsured, Washington, DC, November.

Goldman, D. P., J. P. Smith, and N. Sood (2005), "Legal Status and Health Insurance among Immigrants," Health Affairs, Vol. 24, No. 6, pp. 1640-1653.

——— (2006), "Immigrants and the Cost of Medical Care," Health Affairs, Vol. 25, No. 6, pp. 1700-1711.

Grove, N. J. and A. B. Zwi (2006), "Our Health and Theirs: Forced Migration, Othering, and Public Health," Social Science and Medicine, Vol. 62, No. 8, pp. 1931-1942.

Heyman, J. M., G. G. Núñez, and V. Talavera (2009), "Healthcare Access and Barriers for Unauthorized Immigrants in El Paso County, Texas," Family and Community Health, Vol. 32, No. 1, pp. 4-21.

Jackson, J. and J. Nolen (2010), "Health Care Reform Bill Summary: A Look at What's in the Bill," Political Hotsheet, CBS News, Blogs, March 21.

Katz, M. H. (2008), "Golden Gate to Health Care for All? San Francisco's New Universal-Access Program," New England Journal of Medicine, Vol. 358, No. 4, pp. 327-329.

Kuczewsku, M. (2000), "The Undocumented Alien Who Needs Surgery," Cambridge Quarterly of Healthcare Ethics, Vol. 9, No. 1, pp. 128-135.

Kullgren, J. T. (2003), "Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform," American Journal of Public Health, Vol. 93, No. 10, pp. 1630-1633.

Light, D. W., A. Portes, and P. Fernández-Kelly (n.d.), "Categorical Inequalities, Institutional Ambivalence, and Permanently Failing Social Institutions: Immigrants and Barriers to American Health Care," under review.

Marshall, K. J., X. Urrutia-Rojas, F. S. Mas, and C. Coggin (2005), "Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women," Health Care for Women International, Vol. 26, No. 10, pp. 916-936.

Nandi, A. et al. (2008), "Access to and Use of Health Services among Undocumented Mexican Immigrants in a US Urban Area," American Journal of Public Health, Vol. 98, No. 11, pp. 2011-2020.

Newton, L. and B. E. Adams (2009), "State Immigration Policies: Innovation, Cooperation, and Conflict," Publius: The Journal of Federalism, Vol. 39, No. 3, pp. 408-431.

Ortega, A. N. et al. (2007), "Health Care Access, Use of Services, and Experiences among Undocumented Mexicans and Other Latinos," Archives of Internal Medicine, Vol. 267, No. 21, pp. 2354-2360.

Passel, J. S., and D. Cohn (2009), "A Portrait of Undocumented Immigrants in the United States," Pew Hispanic Center, Washington, DC.

Pear, R. and D. M. Herszenhorn (2010), "Obama Hails Vote on Health Care as Answering 'the Call of History'," New York Times, March 21.

Portes, A., P. Fernández-Kelly, and D. W. Light (n.d.), "Life on the Edge: Immigrants Confront the American Health System," under review.

Portes, A., D. W. Light, and P. Fernández-Kelly (2009), "The U.S. Health System and Immigration: An Institutional Interpretation," Sociological Forum, Vol. 24, No. 3, pp. 487-514.

Quill, B. E., L. A. Aday, C. S. Hacker, and J. K. Reagan (1999), "Policy Incongruence and Public Health Professionals' Dissonance: The Case of Immigrants and Welfare Policy," Journal of Immigrant Health, Vol. 1, No. 1, pp. 9-18.

Ridgley, J. (2008), "Cities of Refuge: Immigration Enforcement, Police, and the Insurgent Genealogies of Citizenship in U.S. Sanctuary Cities," Urban Geography, Vol. 29, No. 1, pp. 53-77.

Romero-Ortuño, R. (2004), "Access to Health Care for Illegal Immigrants in the EU: Should We Be Concerned?" European Journal of Health Law, Vol. 11, No. 3, pp. 245-272.

Ruiz-Casares, M. et al. (2010), "Right and Access to Healthcare for Undocumented Children: Addressing the Gap between International Conventions and Disparate Implementations in North America and Europe," Social Science and Medicine, Vol. 70, No. 2, pp. 329-336.

San Francisco Department of Public Health (DPH) and San Francisco Office of Labor Standards Enforcement (OLSE). "Status Report on the Implementation of the San Francisco Health Care Security Ordinance," presented to the San Francisco Board of Supervisors, San Francisco, CA, June.

Schwartz, K., and S. Artiga (2007), "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen Children," Policy Brief, Kaiser Commission on Medicaid and the Uninsured, Washington, DC, June.

Scott, P. (2004), "Undocumented Migrants in Germany and Britain: The Human 'Rights' and 'Wrongs' Regarding Access to Health Care," Electronic Journal of Sociology, www.sociology.org/content/2004/tier2/scott.html.

Tickten, M. (2006), "Where Ethics and Politics Meet: The Violence of Humanitarianism in France," American Ethnologist, Vol. 33, No. 1, pp. 33-49.

Tramonte, L. (2009), "Debunking the Myth of 'Sanctuary Cities': Community Policing Policies Protect American Communities," Immigration Policy Center, Washington, DC, March.

Walter, N. and D. Schillinger (2004), "Frontline Bureaucracies and the Moral Mechanics of US Health Care," Medical Care, Vol. 42, No. 4, pp. 303-305.

Ziv, T. A. and B. Lo (1995), "Denial of Care to Illegal Immigrants—Proposition 187 in California," New England Journal of Medicine, Vol. 332, No. 16, pp. 1095-1098.