Structural Violence, Politics and Notions of Healthcare Deservingness for Undocumented Latino Immigrants in Indiana vs. Illinois

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Abstract

Undocumented Latino immigrants are among the most underpaid, uninsured laborers often working in extremely dangerous industries which places them on the receiving end of the consequences onslaught by an unjust hierarchical system. Among these consequences is the limited access to and utilization of health services. Through conducting semi-structured interviews with health care advocates, providers, policy makers and undocumented immigrants and providers, this comparative study gives insight into the landscape of healthcare access and resource allocation in Indiana and Illinois and assesses what the differences are attributable to. Using Erving Goffman's 'framing theory' and Johan Galtung's theory of 'structural violence' this study concluded that the evident differences in healthcare access between Indiana and Illinois were due to the fact that the two states possessed fundamentally different rhetoric about health and notions of deservingness. This then reflects itself in the politics of allocating health care resources and fighting for increased access to health care for undocumented individuals.

Introduction

Undocumented Latino immigrants are among the most underpaid, frequently uninsured laborers often working in extremely dangerous industries which places them on the receiving end of the consequences onslaught by an unjust hierarchical system. Among these consequences is the limited access to and utilization of health services. While there are federal mandates that dictate the general guidelines of eligibility to federally funded healthcare benefits, each state also has the discretion to modify these policies as they see fit, making it harder or easier for undocumented immigrants to access healthcare benefits. As such, the proximal states of Indiana and Illinois, have vastly differing health policies that dictate the eligibility of undocumented immigrants to accessing healthcare. Conversations about increasing access to healthcare for undocumented immigrants in Indiana hinged on statements like "it is short of a miracle… especially if it costs the state money". Whereas 90 miles away in Illinois, conversations were starkly different as can be evidenced by the presence of organizations that sued the federal government in 2019 for trying to pass the Public Charge rule, a piece of legislation that would

indirectly affect undocumented immigrants access to care. Conversations with medical professionals as well as healthcare policy officials allowed for an assessment of the landscape of healthcare availability in both states and the local politics that undergird discourses about allocation of federal and state funded healthcare benefits. More fundamentally, however, it allowed for the realization that the evident differences in the two states were not attributed to the disparities in health care access. Rather, they were due to the fact that these states possessed fundamentally different rhetoric about health and notions of healthcare-related deservingness which then reflected itself in the politics of allocating health care resources and fighting for increased access to health care for this population. The most common line of thought that policy makers and health care professionals used to understand health care in Illinois was the understanding that healthcare is a basic human right. This had direct implications for the kinds of advocacy efforts that individuals in Chicago partake in. The rhetoric in Indiana is a little different as it is founded on notion that undocumented immigrants are not deserving of health care benefits and has been internalized and normalized by the immigrants themselves. This research paper aims to lay bare the differing rhetoric in Indiana and Illinois and the implications and impact that they have on statewide health policy debates. By doing so, this paper will argue that healthcare is a fundamental human right that all persons should be entitled to, regardless of their immigration status. Furthermore, advocacy efforts that are not rooted in this fundamental understanding risk misrepresenting immigrants as commodities that should be granted healthcare benefits collaterally in the interest of the American public, and the American economy. Thus, propagating the very structures of systemic injustice that they are aiming to dismantle.

This research paper will outline the emergence of mass undocumented migration from Latin America to the U.S. to make evident the historical reasons for the millions of undocumented Latinos that currently reside here. Immigration will be then discussed as a social determinant of health in its own right since both the process of immigration and the policies that govern immigrants' lives once they are in the U.S. have grave implications for health and health access. Following this, a discussion of the numerous barriers to healthcare access that undocumented immigrants face will then ensue. Despite the barriers that the undocumented face, there ways to get healthcare at an affordable rate. Healthcare access points in both states that provide care for impoverished undocumented individuals will be discussed in the following section to determine the kind of care undocumented immigrants have access to. From a clear understanding of what is provided for, it will be possible to discuss what the gaps in care are and the policies in each state that govern them. The Public Charge Rule, mentioned earlier in this introduction, will be discussed at length since it has far reaching implications for immigrants' utilization of the little healthcare resources that are available to them. Finally, with a full picture of what healthcare provision and restrictions are in each state, it will be possible to discuss the possibility of policy change to give undocumented immigrants insured access to healthcare.

Methods

This research study conducted interviews with medical and administrative professionals that worked at two Federally Qualified Healthcare Centers (FQHCs) in Illinois (Alivio Medical Center and Esperanza Health Centers) and four in Indiana (HealthNet, Inc, Maple City Health Center, Indiana Health Centers, and Eskenazi Health Centers) since they served majority Latino populations. This study also looked at a charity health care clinic in South Bend, Indiana, the

Sister Maura Brannick Health Clinic, that offers similar provisions to the FQHCs, but differs slightly in its funding source, which is solely reliant on fundraising efforts and the generosity of donors. Medical personnel from each of these organizations were able to offer insight about the measures that their organizations take to mitigate the unique challenges that their patients face in attempting to access healthcare. Additionally, this research study also conducted interviews with advocacy organizations and key individuals that have a voice in the public policy sphere in both states. In Indiana, officials from La Casa de Amistad and the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) were interviewed. In Illinois, individuals from the Illinois Coalition for Immigrant and Refugee Rights (ICIRR), the Healthy Illinois Campaign, and the National Immigration Justice Center (NIJC) were interviewed. Lastly, two undocumented immigrants were interviewed in both states in order to offer an inside perspective on the experience of seeking healthcare as an undocumented immigrant in Indiana vs. Illinois.

Background

The term "migrant" has had multiple connotations depending on the context under which it is being used. Broadly speaking, a migrant can be defined "by foreign birth, by foreign citizenship, or by their movement into a new country to stay temporarily (sometimes for as little as a year) or to settle for the long-term" (Anderson and Blinder, 2015). For the purposes of this paper, the definition of migrant that is being employed refers to undocumented Latinos, specifically Mexicans, who migrate to the United States in search of better opportunities for themselves and their families, settle for the long-term and are "subject to immigration control" (Anderson and Blinder, 2015). This paper focuses on Mexican migration due to the relative abundance of reliable research available on undocumented Mexican migrants, as well as the

large representation of Mexicans in the interview data that was collected in conducting this project. Although this paper chooses to myopically focus on undocumented Mexican immigration to the U.S., it is important to note that illegal immigration is by no means stemming solely from one country, namely Mexico. As Portes notes, "the overwhelming representation of Mexico in apprehension statistics is, in part, a function of the deployment practices of the Border Patrol, which tends to concentrate its efforts along the southern border" (1979). Although the large majority of undocumented immigrants are of Mexican origin, immigrants from other peripheral societies, like the Caribbean and more recently Central American countries, are not insignificant. However, according to research done by the Pew Hispanic Center, "the U.S. today has more immigrants from Mexico alone than any other country in the world has from all countries of the world" (2012). For this reason, all of the historical data on undocumented migration is skewed toward Mexican migration. There has been a long history of both legal and illegal migration from Mexico to the United States. Between 1990 and 2010, the U.S. witnessed a surge of foreign-born Hispanics, especially Mexicans, doubling from 8.4 to 21.2 million and an associated "sharp rise in both the absolute and relative share of the undocumented population, [then] estimated to number over 11 million, including 6.5 million Mexicans" (Passel and Cohn 2011;(Flippen, 2012). Whereas in the period between 2010 to 2018, there was a decline, albeit not as sharp, in the number of undocumented individuals, now closer to 10.5 million, due to the reverse migration of Mexican nationals. The overall number of undocumented individuals has not changed significantly because there has been an increase in immigration of undocumented individuals from countries like China (22%), India (59%), Venezuela (164%), El Salvador (13%), Guatemala (23%) and Honduras (24%). Warren reports that "a total of 2.6 million

Mexican nationals left the US undocumented population, [with] about 1.1 million, or 45 percent of them, return[ing] to Mexico voluntarily" (2020). A report from the Pew Center shows that deportation comprised only 5-35% of the return migration to Mexico during this time period. Immigration between these two countries has always been circular, with greater immigration from Mexico than emigration. However, studies have shown that there were historically high numbers of people (until the Trump administration set new records) apprehended at the Southern Border due to the strengthening of the US Customs and Border Patrol enforcement during the Obama administration. This decreased immigration from Mexico, leading to a net zero of migration flow. (Passel, Cohn and Gonzalez-Barerra, 2012). An overview of the intended and unintended impacts of U.S. policy on patterns of migration will help to shed light on the downstream consequences of these policies on the economy as well as on individual's lives. For instance, according to the economic analysis performed by Chassamboulli and Peri in the US and Mexican economies during the 2000-2010 period of Mexican reverse migration, restrictive policies that increase border patrol enforcement and deportation have, "a depressing effect on the wages and employment of skilled [US] workers (who are complementary to the unskilled) and on firms' profits (benefiting from the cost-reducing effect of illegal immigrants)" (2015).

Immigration Past: An Overview of Pre-1986 Immigration and Impact of US Policies

Although Mexican migration to the U.S. can be dated back centuries before the initial point mentioned in this analysis, Mexicans began to immigrate in significantly large numbers to the U.S. in the early 20th century after the Mexican revolution of 1910. The revolution had caused great economic instability in the nation and the rural poor bore a great portion of the burden, since they comprised the bulk of the labor force upon which the Mexican economy

rested (Knight, 1980; Donato, 1994). Thus, in search of relief and better economic opportunities, many Mexicans fled to the U.S. Immigrants from all over the world flocked to the U.S. during the early 1900's, and the U.S. reached a record high of having 1.2 million immigrants. This led to the institution of visa requirements for entry in 1924 and novel quotas on immigration from certain countries, greatly impacting immigration from countries in the Eastern Hemisphere. Since Mexico was not a part of this quota restriction, immigration continued unfettered until 1930. However, during the Great Depression (1929-1940) many migrants were deported due to rising unemployment and economic instability within the American economy and many willingly returned to Mexico following governmental promises of land reform (Donato, 1994). Although Mexican immigration to the U.S. until the 1940s had primarily been flamed by economic instabilities within Mexico, it is necessary to consider that immigration of large numbers of people is never one sided. As Portes notes, "illegal immigration is not only caused by "push" forces in the original countries, but by the needs and demands of the receiving economy" (1979). This notion is what characterized the next wave of Mexican immigrants that were in high demand in the U.S. due to labor shortages that were caused by the Second World War. These migrants were recruited for and primarily employed in the agricultural industry, hence the misrepresentation of all Mexican migrants as 'migrant farm workers'. Employment patterns of migrants throughout the years have shifted significantly in response to immigration and labor policies and comprise more varied labor than just agriculture; this will be described in greater detail later. However, for the purposes of this section, it is possible to make the generalization that a significant portion of migrants were initially employed in agricultural settings.

Migrant farmworkers, working in 42 out of 50 states across the continental US, are some of the most essential contributors to the proper functioning of the burgeoning food industry in the United States. Data collected from the National Agricultural Workers Survey (NAWS) in 1995 show that 90% of migrant farmworkers in the US are Latino, with 70% of these migrants being of Mexican descent (Arcury and Quandt 2007). Of the migrants that work in the U.S., 53% work in the country without authorization (Arcury and Quandt 2007). According to the 1995 NAWS report, only 2% of total migrant farmworkers were from Central American countries, hence a significant portion of the 53% that work without authorization are also of Mexican descent. A study from 2011-2012 when the reverse migration of Mexicans was at its peak shows that, still, 64% of migrant farmworkers were from Mexico and 47% were undocumented. Only 6% of farmworkers were from Central American countries (Hernandez et al, 2012).

This disproportionate amount of illegal Mexican farmworkers was in fact born out of a legal temporary work authorization that was instituted in 1942 in response to the labor shortages caused by US involvement in World War II. The Bracero program was a wartime measure to "institutionalize and regiment the supply of Mexican/migrant labor for US capitalism (principally for agriculture but also for the railroads)" (De Genova 2004). It allowed for the large influx of migrants, both legal (braceros) and illegal due to the relationships that the migrants had with their contractors and the nature of the migration infrastructure that was created. Contractors encouraged migrant farmworkers to overstay their legal allowance, thereby producing illegality; oftentimes, they even preferred working with undocumented migrants because they did not have the same safeguards and regulations as the braceros. Additionally, in 1954, Border Patrol itself instituted an "open border policy" and actively recruited undocumented migrant farmworkers

following the U.S.- Mexico arrangements to provide migrant farmworkers with minimum wage, encouraging the unilateral and targeted recruitment.

For a long time, the recruitment of braceros by the U.S. government went unnoticed by the public as they were "whisked across the border and taken directly to the fields, bypassing large urban population centers" (Massey, Durand and Malone, 2002). However, with the growing Civil Rights movement that demanded an end to legalized racism in the U.S., the future of the Bracero program started to look gloomy. Since Mexicans had become allies to African Americans in their fight for equality, the media began uncovering Mexican stories and exposing the poor working conditions and mistreatment of migrant farmworkers. As the civil rights era progressed, the public started viewing the Bracero program as "an exploitative and discriminatory system detrimental to the socioeconomic well-being of Mexican-Americans" (Massey, Durand and Malone, 2002). With the combined lobbying efforts of labor unions, religious organizations and civil rights groups, the number of bracero visas granted to Mexicans started to whittle down starting in 1959. The Bracero Program officially came to a close in 1964 and resulted in the deportation of over 2 million illegal immigrants in what was known as the "Operation Wetback" campaign. This legislative measure to increase Border Patrol funding was drafted by Attorney General Brownell and was derived from the offensive term , 'wetback', that was used to characterize immigrants that illegally crossed the border between Mexico and the U.S. through the Rio Grande (Funderburk, 2017). Regardless of these measures, however, the dangerous trails traversed to secure employment as a migrant farmworker had become normalized for decades to come (De Genova 2004; Scheder 1988). This can be evidenced by the fact that in the period immediately following the end of the bracero program from 1965-68 "the

percentage of migrants leaving Mexico without documents jumped from 37 percent in the bracero period to 53 percent in the 1965-68 period" (Donato, 1994).

Following the termination of the Bracero program, the United States implemented a revision to an immigration policy first introduced in 1952, the Immigration and Nationality Act (INA), that was aimed at increasing regulation on legal immigration. However, this policy also had an effect on illegal migration. The 1965 INA revision lifted the initial immigration quotas established in 1924 and allowed for immigration on a first come first serve basis from both the Western and Eastern hemispheres based upon a seven preference system (for example, spouses of immigrants that had established permanent residency or citizenship in the U.S., and parents of U.S. born minor-children). The first come first serve nature of visa allocation meant that fewer Mexican migrants were able to attain visas and thus remained separated from their spouses and children. The greater demand for visas and the inability of the U.S. government to provide them due to a backlog in the preference system led to an influx of undocumented migration from Mexico. As noted by Gary*[1], an interviewee that worked for the AFL-CIO (American Federation of Labor and Congress of Industrial Organizations), "the demand for, as well as the ability to absorb immigration is well beyond the number of visas that the law is allowing in general to this day, and the reason why immigration remains a crisis, still unreformed, [is because] the number of visas is still totally inadequate to demand."

A few years later, Congress made yet another revision to INA in 1976 in an attempt to equalize immigration influx from both hemispheres and give equal opportunity for legal migration. However, according to Donato, "beginning in late 1978, Congress created a global

[1] *All interview respondents have been assigned pseudonyms in order to maintain confidentiality of individuals as outlined in the IRB protocol.

admission policy so that all visas were now allocated through preference categories and persons in the non-preference category, primarily Mexicans, were virtually unable to obtain visas" (1994). Wives and children of Braceros who wanted to join their loved ones in a legal manner could not, and thus decided to take matters into their own hands and illegally traversed the dangerous trials to be reunited with their families. Albeit unintended, the trickle-down effects of this policy exacerbated undocumented migration to the U.S.

Post 1986 Policies and Their Impacts on Mexican Immigration Flow

The inability of the several revisions of INA to control undocumented migration to the U.S. led to the institution of a new policy in 1984, the Immigration Reform and Control Act (IRCA) in an attempt to regulate undocumented migration. IRCA "increased border enforcement, offered amnesty to migrants already resident in the United States, and established employer sanctions against those who knowingly hire undocumented migrants for work" (Donato, 1994). By the late 1980s, there were nearly 3 million individuals that filed for amnesty and received legal documentation, 2 million of these applications came from Mexicans (Donato et al, 2008; Donato 1994). The IRCA program is conceived to have feminized the migration from Mexico as more women started migrating to the U.S. either through legal sponsorship or through illegal means to join their families. Although there were greater numbers of migrants intercepted at the border since the institution of IRCA, there were still debates over the amounts of illegal migration which led Congress to pass the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) in 1996. The IIRIRA was a stricter modification of IRCA and included measures such as "allocat[ing] more resources to border enforcement... expedit[ing]

removal of immigrants without, or with fraudulent, documents…[and] levying harsher costs and criminal penalties on unauthorized immigrants" (Donato et al 2008).

As mentioned previously, with the passage of time, the labor market for undocumented migrants began to diversify. Whereas early migrants were primarily employed in agricultural settings (75%), in 1965 (the end of the Bracero program), the number of migrants working in agriculture dropped by 30 points and continued to drop after the post IRCA period (Donato 1994). The new labor market for migrant workers that took over agriculture was the low-wage job market including jobs like construction, meatpacking, household labor etc. Albeit unintentionally, the sanctions that were put in place by IRCA and further strengthened by IIRIRA, "have encouraged employers in immigrant-intensive areas to switch to subcontracting and other practices that insulate them from the risk of sanctions" (Flippen, 2012). This allowed for a shift in the labor market away from "jobs that once provided good wages, stability, health insurance and pensions, and the potential for upward mobility" towards more "[non-standard work arrangements]… that do not provide any of those things" (Flippen, 2012).The increased informalization of the low-wage labor market has been tied to the rise in the undocumented population in the U.S, although it is not possible ascertain a clear cause-effect relationship. However, as Flippen notes, "regardless, the end result is that labor markets are increasingly stratified on the basis of citizenship and documentation status" (Donato et al 2008).

The loopholes that were created allowed employers to keep hiring undocumented migrants but also led to increased discrimination and mistreatment as well as decreased wages for these migrants. These turn of events mirror those that were taking place in the bracero period: employers opting to hire undocumented workers because they could pay them less and not be

held accountable by law to pay them decent wages. Since migrant workers had no other means of employment, they accepted their fate and continued to be employed under these inhumane conditions of modern quasi-slavery.

Overview of Current Immigration Policies that Impact Undocumented Immigrants

The Development, Relief and Education for Alien Minors (DREAM) Act, initially proposed in 2001 and re-proposed by the Obama administration in 2010, intended to provide a pathway to citizenship for undocumented minors (under the age of 16) who were brought to the U.S. as children. The Act as it was proposed in 2010 would have allowed these immigrants (sometimes referred to as DREAMers) to receive "certain tax credits, Social Security, Medicare benefits, and federal student loans" (Barron, 2011) and would have served as a settlement to contentious domestic policy issues regarding immigration, jobs, education and receiving public benefits. Despite its stringent prerequisites for enrollment, and its perceived benefits in bolstering the U.S. economy, many nationalists thought of this Act as a "'back-door amnesty' that will reward the violation of immigration laws, encourage 'chain migration' and 'exponential population growth' and 'transfer [higher education] seats and tuition subsidies to illegal aliens" (Barron, 2011). Although 54% of the American public supported the passing of the Act, believing that DREAMers should not be punished for their parents' choices, a Senate filibuster comprising representatives from both parties prevented the last opportunity that the Act had to pass as law. In an attempt to offer relief to vulnerable DREAMers that have been living in constant threat of deportation, the Obama Administration issued the Deferred Action for Childhood Arrivals (DACA) on June 15, 2012 as a memorandum via executive action through the Department of Homeland Security (DHS). It is important to note, however, that "DACA is a

non-legislative policy directive by the DHS guiding its departments of ICE, Customs and Border Protection (CBP), and U.S. Citizenship and Immigration Services (USCIS) to exercise prosecutorial discretion by deferred action when enforcing the immigration laws against certain young people who were brought to the United States as children" (Cobb, 2012). The goal of the policy was to provide humanitarian relief in the meantime until the U.S.'s broken immigration could be holistically reformed. DACA allows its recipients to have temporary renewable protection from deportation for a period of two years at a time as well as grants work authorization. However, since DACA does not confer any legal immigration status, recipients do not have access to benefits of citizenship, such as having social security, health care benefits or becoming eligible for federal jobs. For this reason, Cobb describes the policy as "a means to an end that misses the bull's eye." Temporary though it may be, the DACA program offered relief to 728,285 DREAMers as of March 16, 2016 according to USCIS records (Hipsman et al, 2016). However, on September 5 2017, the Trump administration rescinded DACA and began to take measures to wind down the program by refusing to accept any more new DACA applications (McCament, 2017). DREAMers that had already applied for DACA before the memorandum was released were still eligible for protection from deportation until their authorization expired but would not be allowed to renew their applications. The initial plan was to eliminate all vestiges of the DACA program by March of 2018; however, Congress has yet to make a definitive decision on the future of the DACA program and current DACA recipients. This ticking time bomb has increased the structural vulnerability of DREAMers who were once eligible for governmental protection and has become a reason for immense uncertainty and anxiety.

Among the last pieces of legislation that has targeted effects on undocumented immigrants that will be discussed in this paper is the recent revision to the Public Charge rule passed by the Trump administration in 2020. "Public charge" referred to a ground of inadmissibility that could either prohibit an immigrant from obtaining a visa or an adjustment of status if the government deems that immigrant "likely to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense" (Immigrant Legal Resource Center, 2019). However, the draconian rendition of the Public charge rule proposed by the Trump administration will be discussed in a later section.

Immigration as a Social Determinant of Health

As essential as migrant farmworkers are to the proper functioning of our capitalistic society that asks them to risk their lives for our food, their health and well-being are not viewed as essential enough. Despite the myriad of consequences that illegal immigration has on an individual's health, both the dangerous process of leaving one's homeland and the life that awaits on the other side, there is a considerable lack of coordinated policy and programs to address these health effects. As Castañeda et al have noted "policy making on migration has been conducted generally by institutions composed of international aid, security, immigration enforcement, trade, and labor, which rarely include the health sector and often have incompatible goals" (2015). Since these immigration policies do not have the health of the individuals that they target in mind, they incur many negative impacts on the health and well-being of undocumented immigrants as well as decrease their ability to access the health care that they

need. Research has shown that both immigration and immigration status affect health via different mechanisms including increased "fear, stress, differential access to resources, experiences of prejudice and violence and differential access to safe work and housing conditions." (Castañeda et al, 2015). As the above section has shown, immigration is a phenomenon driven by social determinants such as economic and political instability as well as lack of occupational and educational opportunities. However, as much as it is socially determined, it must also be viewed as a social determinant of health in light of the impacts that it has on immigrant health and access to health care benefits. For this reason, immigration policy is a topic that is salient for public health officials, and the emergence of new immigration policies ought to consider the repercussions of these policies on the health of "the [10.5] million undocumented people who live under discriminatory policies, experiencing prejudicial attitudes, and lacking access to critical health resources" (Castañeda et al, 2015). Due to their status on the social totem pole, undocumented immigrants face very limited access to health care benefits; moreover, what little chance that they have to access health care is impeded by many barriers that impinge on positive health behavior.

Barriers to Health Care Access for Undocumented Immigrants

The numerous barriers that undocumented immigrants face span beyond those incurred by draconian policies, be it health policies or immigration policies that have been shown in the previous section to have negative trickledown effect on health and health access. Although the lack of insurance is one of the most prominent barriers to accessing health care, even in the presence of some form of healthcare availability, migrants face numerous barriers to healthcare access including financial limitations, lack of social capital to help navigate healthcare systems,

limited access to overtaxed safety net providers, discrimination, cultural differences and fear of deportation (Hacker et al 2015). This section will explore the effects that these barriers have on undocumented immigrants' ability to access healthcare by offering first hand vignettes from the accounts of immigrants and their medical providers.

It is known that undocumented immigrants in the U.S. have very limited access to health care in most states (Arcury and Quandt 2007; Castañeda, Heidi et al. 2015) and that Latinos in particular have the lowest rates of health insurance among all immigrants (Ku and Matani 2001). An interview with Patricia, a pediatrician that works at Eskinazi Health, echoed these research findings. She noted that "sometimes [undocumented immigrants] are eligible for health insurance [through our hospital], but they don't know about it because they are too afraid to reach out… We connect them with social workers and financial counselors to help, but they can't do everything because it's up to the families to follow up but that doesn't always happen. [The patients] change their phone numbers and addresses a lot and it's hard to get to them." Fear of the officials in conjunction with limited information about their rights and privileges, albeit limited, make it more difficult for undocumented immigrants to access necessary healthcare benefits.

One of the informants of this study, Jose, shared a heart wrenching story of a near death encounter that can shed light on the real-life effects that lack of insurance, financial instability, and fear of discovery by officials have on undocumented migrant's lives. Jose's mother has severe allergies to shellfish and her allergies flared up when they were having food at a Chinese restaurant one night earlier last year. Jose describes how "her face and throat swelled up, and [her airways] began to close. She was wheezing and could barely breathe." Luckily for them,

they were 3 minutes away from a hospital so he rushed her over to the ER. Jose mentioned in passing that his mother had a South Bend ID card, which helped them facilitate the process of being admitted into the ER. The SBID is an identification card that was set up by La Casa de Amistad in South Bend to alleviate the anxieties of the undocumented population. It offers them a form of identification that is locally recognized by businesses and important organizations in lieu of a legal ID which most of them do not have access to. After 24 hours of monitoring his mother in the ER and stabilizing her to a point where she could breathe just barely, the attending physician informed Jose that "she has to go to the ICU, because if she leaves she may not make it back the next time around." Jose's mother initially resisted saying "I'll be fine. If I have to come back, I'll come back" because she could not handle the financial burden this would incur. However, she quickly realized that her resistance was equivalent to issuing her own death sentence. The costs didn't stop there, the prescriptions for single use epinephrine pens, ones she had to use for the next 2-4 weeks due to the severity of her reaction, were upwards of $800. Luckily for them, Jose happened to have friends with children that also suffered from allergies and offered to get them epinephrine pens at a discounted rate using their insurance. Had it not been for the generosity of this family, Jose's family could have easily been driven to absolute poverty and potentially even homelessness. These kinds of financial burdens make it near impossible for undocumented immigrants to get the care that they need in times of emergency, and the lack of insurance makes it near impossible for them to get the care that they need before it becomes an emergency.

As will be discussed later, some immigrants qualify for Emergency Medicaid insurance coverage if they fall under a certain income bracket, however, as internal medicine doctor,

Richard, noted, “they don’t want to sign up for it anyway because they don’t want to be identified.” However, certain migrants, such as DACAmented individuals, that do not fall under these income brackets, usually 100-200% of the federal poverty line, end up falling through the cracks of the very narrow safety net that is cast to offer emergency assistance to undocumented individuals under Emergency Medical Treatment & Labor Act (EMTALA). EMTALA was established in 1986 by Congress to ensure public access to emergency services regardless of ability to pay. The Social Security Act outlines that Medicare-participating hospitals are required to provide a medical screening examination (MSE) for any patient requiring emergency services and obligates them to provide stabilizing treatment for these patients (Center for Medicaid and Medicare Services website, 2012). However, this Act only requires the ER to provide stabilizing treatment and any treatment required beyond this is up to the patient to cover. Additionally, DACAmented are ineligible for any sort of primary care assistance through an FQHC. Jose made the tragedy of this condition evident when he shared that “Who is to say? I think I’m okay, but I’m probably diabetic or I’ve got another serious condition that I’m just not following or taking care of. I have no way of telling, because my access to any type of healthcare is when the Saint Joseph County Health Department has a vaccination drive and I go to get all my vaccines, but I don’t get an annual checkup.” Their ineligibility for these services is twofold. One the one hand they are able to earn decent and livable wages because they have work authorization, courtesy of their DACA status and are thus financially ineligible for insurance benefits that were instituted for very-low income individuals. According to the U.S. Department of Health & Human Services, the 2020 federal poverty line (FPL) guidelines show that for one individual being 100-200% of the FPL means earning between $12,760-$25,520 (Button, 2020). On the other

hand, the work authorization document that grants them the ability to earn wages makes it clear that it does not confer any legal status, and therein lies the second part to understanding their ineligibility. As Jose noted "you do get a social security number [as a DACA recipient], but it has stamped on the front of it [something to the effect of] 'only authorized for work'." The irony of this arrangement is that although they cannot have access to any federal benefits, their money still goes into the tax pool that provides for so many Americans social security benefits.

Most low-income undocumented Latino immigrants speak only Spanish or other indigenous languages that make it hard for them to communicate with medical professionals, in the absence of a translator who is trained in Spanish (Arcury and Quandt 2007; Holmes 2013; Castañeda, Heidi et al. 2015). Several doctors that worked with undocumented Latino migrants echoed this finding in stating that "language is a very big barrier and it's hard to tell what [the patient's] concerns are because they usually don't speak English". What is more, cultural differences between the healer and the patient sometimes create situations in which biomedical diagnosis and treatment conflict with a patient's interpretation of illness and their experiences (Holmes 2013). As Manuel, a community health worker that works for the Indiana Minority Health Coalition noted, "they don't want to access care because there are a lot of individuals that think [their ailment] is more spiritual." Additionally, as Jose noted, machismo is a big part of Latin American culture that prevents men from showing emotion and weakness and admitting that they need help, even medical help. Jose noted in our interview that "I just think [we need] to eliminate some of those cultural barriers that have been set for such a long time and recognize that it's okay to seek help and that there's nothing wrong with doing so." Overcoming those cultural beliefs that have been engrained for a long time can pose to be challenging and act as a

barrier to seeking health care. One of the most noteworthy barriers to healthcare access for undocumented migrants is the fear of being reported to the officials, which keeps them away from hospitals (Hacker et al 2015; Arcury and Quandt 2007). As Dr. Patricia pointed out "some clinics have police as security for the building and getting caught by them is something that [undocumented patients] fear". In steering clear of these facilities, they safeguard their anonymity, but risk further compromising their health.

As has been made evident, undocumented immigrants face great difficulty in trying to attain what limited healthcare benefits they have access to in spite of their lack of insurance. When considering the non-issuance related barriers, however, it is important not to fall into the trap of perceiving them as easily overcomable if only undocumented immigrants would put concerted effort into surmounting them. Viewing the health outcomes of migrant populations as solely determined by individual responsibility (such as incapacity to speak the language, the avoidance of health facilities etc), factors associated with biculturalism or ineptness at "acculturating" (maintenance of cultural practices such as mal ojo, machismo etc) eschews the role that social inequalities and determinants play in the health seeking behavior of migrants (Castañeda et al 2015).

An Overview of ICE and its Impacts on Health and Healthcare Access

As a great deal of the institutions that offer medical assistance to undocumented immigrants are federally funded, many immigrants prefer to remain incognito than risk their personal information being intercepted by the government. The plummeting numbers of immigrants that utilize available medical centers and resources since the beginning of the Trump presidency is a testament to the grave effects that the U.S Immigration and Customs

Enforcement, more commonly known as ICE, has on immigrants' health and their agency to access existing health care benefits. ICE poses numerous threats to individual health in both a physical and psychological manner and incites significant fear in undocumented immigrants' that keeps them from accessing the healthcare that they need. This section will outline the inception of ICE and how it carries out its operations to shed light on the ways in which it affects immigrants' health.

ICE was established in 2003 through the merging of the former U.S. Customs Service and the Immigration and Naturalization Service in an effort to combine their investigative and interior enforcement functions. Every year, a budget of about $6 billion is directed towards the law enforcement agency which carries out its functions through three main directorates: Homeland Security Investigations (HSI), Enforcement and Removal Operations (ERO) and Office of the Principal Legal Advisor (OPLA). For the purposes of this study, I will focus on the operations of the ERO as that is the branch that undocumented immigrants who are being monitored, detained in holding facilities and/or deported, come into contact with the most. According to what is outlined on the official website of the Department of Homeland Security, the role and purpose of the ERO directorate is to "[uphold] U.S. immigration law at, within, and beyond our borders" (Department of Homeland Security website, 2020). In their mission statement, ICE outlines ERO's importance to maintaining border security and states that "the ERO's work is critical to the enforcement of immigration law against those who present a danger to our national security, are a threat to public safety, or who otherwise undermine the integrity of our immigration system" (Department of Homeland Security website, 2020). The language that is used here-- "the integrity of our immigration system"-- indicates that ICE does not want

undocumented immigrants compromising the normal, "integrous" guidelines that govern legal immigration. The rhetoric holds that undocumented immigrants are not dealt with appropriately; it could encourage things like chain migration and further breaches that undermine the morally upright system of immigration that the U.S has so carefully crafted.

However, the problem with these guidelines is that although ICE assures us that they are playing the 'good cop' and protecting the US from the dangerous immigrants, they leave out the fact that a significant number of undocumented immigrants that fall into the hands of ICE do not pose any threat to national security. Under the Surge Operations put in place by President Donald Trump and Secretary of the Interior, Ryan Zinke, detention of immigrants has risen by 4000% within the span of time between May 2018 and October 2018 as compared to the same period in the year 2016 under the Obama administration (U.S. Department of the Interior, 2018). Given these statistics, one can understand why undocumented immigrants live in fear and go to great lengths to safeguard their anonymity, even if they risk further compromising their health.

An immigrant can be placed in an ERO run detention facility for the most minor infractions including but not limited to committing crime(s) (being caught with illicit drugs being the most common offense), a present or past deportation order, or missing prior immigration hearing dates. In line with National Detention Standards (NDS), ICE is required to ensure that its detainees are "in safe, secure and humane environments and under appropriate conditions of confinement" (Department of Homeland Security, 2020). However, an interview that I conducted in the early stages of my research with Olivia*, a paralegal for asylum seekers at the National Immigrant Justice Center in Chicago, exposed that the reality in these detention centers does not always map neatly onto the idealistic regulatory guidelines set out by the NDS. Just as there are a

myriad of ways that one can get into a detention center, there are also multiple ways out, the most common being deportation. Among the ones that are less commonly talked about are the Alternatives to Detention Programs (ATDPs) that allow for "expanded options for the release of adult aliens by assisting officers in closely monitoring aliens released into the community" (Lee, 2005). Pregnant women and persons with preexisting medical conditions are among the individuals that qualify for enrollment into the Intensive Supervision Appearance Program (ISAP) and the Electronic Monitoring Device (EMD) Program which were both developed in the early 2000s to accomplish the aforementioned goal of the ATDPs. Undocumented immigrants that are allowed to be released into the community are usually perceived to be a "travel risk", which indicates that the released detainee could likely move to a different state where they could pose a threat to public safety. Accordingly, they are required to wear ankle monitors for a duration of anywhere between 2-8 months based on the discretion of the ICE officials. As noted by Olivia, these ankle monitors are heavy, uncomfortable and often placed too tightly on immigrants. Tampering with them in an attempt to alleviate pain could lead to serious consequences for immigrants since their efforts could be misinterpreted as an attempt to break free.

Olivia shared the heart-wrenching story of one of her other clients at NIJC that faced severe medical complications due to the ankle monitor that she was required to wear. Ironically, Olivia's client was allowed back into society on the basis of having a pre-existing medical condition: hypertension. Hypertension is a medical condition associated with a high cardiac output (high volumes of blood being pumped out from the heart) through constricted blood vessels which results in having elevated blood pressures of over 140/90 mmHg. Given this

general understanding of hypertension, one can probably extrapolate the kinds of complications that would arise from wearing an ankle bracelet that further restricts arterial flow of blood and thereby increases blood pressure even more than natural. Olivia's client tried to ask the ICE officials to loosen her ankle monitor because it was placed too tightly and was causing her pain. They chose to disregard her pleas.

Inevitably, the arteries in her ankle burst under the pressure and caused a mess of internal bleeding in her ankle for which she had to be hospitalized in the Emergency Room. Due to this hospital visit, she is now $20,000 in debt with no way of being able to pay it off as she is still an undocumented immigrant without legal work authorization. This kind of treatment is reflective of the notion that undocumented immigrants are deserving of the suffering incurred, incidentally or intentionally, because of their unlawful presence. It follows the rhetoric that if an immigrant was found on U.S. territory unlawfully, they had it coming for them and any complaints from them about mistreatment are almost seen as an affront to the officials. By normalizing their suffering, ICE officials invisibilize immigrant's pain and end up treating them as subhuman especially with respect to their medical needs.

Aside from the physical complications that arise in ICE custody, there are also substantial mental health problems incurred by detention and monitoring or even the mere threat of it. When the ankle monitors detect that the immigrants have ventured outside of the allowable perimeters set by ICE, they begin beeping and repeating a prerecorded message in English. This message is intended to let the immigrant as well as the officials know that the rules have been broken and allows the ICE officials to GPS track immigrants. However, these fickle contraptions often malfunction and incorrectly detonate their warnings that compound the immigrants' stress

because they are spoken in a language that is often incomprehensible to them. Children of these immigrants also experience undue anxiety whenever this occurs, because the beeping sound incites fear in the children that their parents might die.

ICE acts as a barrier to immigrant's health and health care access in a myriad of ways that are not conventionally perceived. Given the current political climate and national rhetoric that surrounds undocumented immigrants, they lead a life muddied by constant fear and anxiety of being discovered and potentially deported and separated from their families. For this reason, Hacker et al have noted that "undocumented immigrants reported avoiding health care and waiting until health issues were critical to seek services" (2015). Studies have also shown that undocumented parents refrain from taking their U.S. born children to get care due to their fear that they might run the risk of being separated from them if they are discovered. However, there are ramifications to these kinds of fear-based decisions which "might include a risk to the public's health when communicable diseases are involved or a risk for more serious issues when health care is deferred" (Hacker et al, 2015). Compounded with the barriers to health care access discussed above, accessing the healthcare that they need is a near impossible feat for many undocumented immigrants.

Health Access Points in Both States: Federally Qualified Health Care Centers

Federally Qualified Healthcare Centers (FQHCs) are among the few places that undocumented immigrants can go to receive affordable primary health care. FQHCs are " non-profit, community directed health care providers responsible for improving primary care access to millions of Americans, regardless of their ability to pay" (Hennessy, 2013). According to Hennessy, these safety-net providers were originally established as a part of the war on

poverty in the 1960s. Although they started out as "fringe providers", with reforms and expansions to Medicaid as well as an increased demand for free or low-cost healthcare since their inception, "FQHCs shifted… to anchors of many local healthcare systems" (Hennesy, 2013).

In 1989, Congress drafted FQHC-enacting legislation in the revision to the Social Security Act. Subsequently, the guidelines that define FQHCs, govern their operations, as well as the types of services that they provide were outlined in the Public Health Service Act. FQHCs are health centers that receive government funding and are required by statute to be located in a deeply impoverished community with a large medically underserved population. The Secretary of the Department of Health and Human Services (DHHS) defines medically underserved populations as "population of an urban or rural area designated as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services" (Public Health Service Act, 2020)." The PHSA goes on to further the population that is served by FQHCs by adding that these centers are also intended to serve "special medically underserved populations comprising migratory and seasonal agricultural workers, the homeless, and residents of public housing" (2020).

Although these guidelines do not explicitly make provisions to provide aid to undocumented immigrants, the recognition of seasonal agricultural workers as medically underserved populations and the mandate to provide services to all regardless of ability to pay opens the gate for a larger array of undocumented immigrants to benefit from these services. FQHCs are required to provide primary health care services and, upon the discretion of each individual FQHC, additional services that are deemed "necessary for the adequate support of the

primary health services". As outlined in the PHSA, comprehensive primary health services include, but are not limited to, health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, diagnostic services, preventive health and dental services and emergency services. In addition to in-house services, FQHCs are also required to provide referrals to hospitals in the area for specialty care, but as will be discussed later, this can pose to be challenging. Another feature that makes these health centers unique is that they provide case management services that help individuals maximize on the services offered by FQHCs (i.e. transportation services). FQHCs also have availability of personnel fluent in the language of the primary patient population of the clinic. Additional services that a center may choose to provide include "behavioral and mental health and substance use disorder services, recuperative care services and detection and alleviation of unhealthful conditions associated with different environmental health hazards." The services offered at FQHCs span a wide range of primary medical needs that a person needs to stay healthy and have been shown to reduce emergency medical visits. Although these centers offer comprehensive primary care, any form of specialty care is not as readily available to the patients that utilize their services. Most times, specialty care is performed upon referral to other hospitals and is not housed on site at FQHCs. For this reason, an undocumented immigrants' ability to get specialty care treatment is mostly dependent on the willingness and flexibility of specialty care physicians to work with FQHCs and potentially receive little or no compensation for the work they will do.

According to the 2018 Health Center Program Awardee Data report from the Health Resources & Services Administration, there are a total of 25 FQHCs in Indiana and close to twice as many FQHCs, 44, in Illinois (HRSA, 2018). As noted earlier, although these

organizations were not intentionally set up to be of service for the undocumented, medical professionals and administrative personnel from FQHCs included in this paper (see methods section) have picked up a few tricks along the way to make health care more easily accessible for their undocumented patient population. The following vignettes outline the kinds of measures that these FQHCs have taken to facilitate healthcare access.

John, the practice manager at Indiana Health Centers spoke about how his organization attempts to mitigate the transportation barriers that prevent undocumented immigrants from coming to the clinic. He notes "one thing that one of our clinics has done for several years now is that they have a mobile van that will go out to [the campsites where migrant farmworkers live]." This not only solves the problem of lack of transportation, but also lessens the unease that comes with having to take time off work for migrant workers that already have unlivable wages. Moreover, it helps them to believe that they do indeed have a right to healthcare and are not partaking in illicit actions by wanting to see a doctor. Patricia, a pediatrician from Eskenazi Health, mentioned how their organization helps to mitigate the incumbent costs of care that can be a potential impediment to healthcare access. She pointed out that "[Eskenazi] has a social worker in each clinic that offers financial assistance and connection to other services [undocumented immigrants] might be eligible for." As mentioned earlier, however, it is somewhat challenging to get undocumented families to follow up with these social workers because they fear divulging their information and consequently being discovered by ICE. Rebecca, another pediatrician at Eskenazi, pointed out that "Eskenazi provides our own kind of insurance that can write off costs for these families." These costs are either entirely written off or highly reduced on a sliding-scale fee system that is in accordance with federal regulations that

guide how much an individual/family can be subsidized depending on their income levels. She also added that "Eskenazi does a good job of going out into the community so that they can know where to reach us and utilize our services." This is especially impactful for Latinos because their lack of social connectedness with the communities they live in can make it harder for them to attain the services they have the ability and right to access.

Richard, an internist and Chief Medical Officer at HealthNet, elaborated that his organization offers affordable and easily accessible prescription medication to their undocumented patients. He mentioned that "there are usually a lot of cheaper medicines and we partner with Walgreens and LabCorps so that patients can get medicine at a low cost and labs at basically no cost." However, as mentioned above, getting any sort of specialty care or specialty diagnostics like MRIs and CT scans can prove to be challenging because as Richard explained, "you can't use county money for undocumented patients, [so] we can't pay for patients to go to some specialist." In instances where his undocumented patients are in need of specialty care, he feels like he is "at the mercy of the system" because some specialists (like orthopedic surgeons) ask for "at least $200 upfront just to [see patients]" making it hard for FQHCs like HealthNet to "provide the care that [they ought to]." Despite the injustice of the medical reality that undocumented patients face, Richard noted that the corporatization of hospital systems is at the real core of the issue. Since "it's not that [specialty care doctors] are unwilling to help immigrants, it's that the larger group that they are governed by will not allow them to." Although some specialty care doctors may feel inclined to help an undocumented immigrant that has no insurance, the policies that are set up by their practice may prohibit them from providing this care because doing so is not profitable for the business.

Gregory, a family practice doctor at Maple City Health, discussed the plethora of both medical and more social ways that his organization facilitates healthcare access and well-being for the undocumented patient population. The staff at this medical practice is "about 60-70% Latino… [and is] a fully functioning bilingual office" which makes it considerably easier for patients to feel safe, understood and well-taken care of. Maple City also offers free bilingual doula services to their pregnant patients that are in labor. "A doula is somebody who is trained to accompany a woman in labor and help her with issues of comfort and position changes and having safe labor." Gregory mentioned that offering these services serves a consolatory purpose and ensures that doulas "function as an interpreter for [the patients] in a strange, weird English only hospital environment." Similar to Richard, Gregory mentioned how Maple City used to have trouble getting patients any kind of affordable care outside of their four walls and that it took a financial toll on them to just try and cover the costs themselves. However, an additional barrier to the cost incurred at these specialty care visits was issues with identification. Gregory noted that larger hospitals tended to ask to see paychecks of undocumented patients who were usually working under a different person's social security number. The discrepancy between the name presented on the ID and their pay stubs made hospital officials think that the patients were being fraudulent and would refuse to give them a discount for any hospital services. However, Gregory ended up striking a deal with the local hospitals where Maple City was able to issue undocumented patients "a letter that says, 'this family is at 150% of the federal poverty level and should qualify for discounts.'" This letter was accepted by the hospital systems as sufficient proof and allowed undocumented patients to qualify for discounts and gave them access to the whole hospital system.

Maple City Health has also been able to further advocate for its undocumented patients that now have access to a larger array of medical professionals but are required to provide local ID upon visit. The local OB-GYN group insisted on seeing local ID of undocumented patients and would refuse to see them if they were unable to provide identification. Gregory confronted the group by telling them that "the only legitimate reason to ask for ID is that you want to make sure that you're actually seeing the person I refer to you, right? Well, I mean, who else was going to show up?" So Gregory negotiated for the OB-GYN group to accept the image that is attached to the referral letter sent from Maple City Health as valid enough identification and told them that "if when they show up, they look like [the picture], then that's who I'm sending over. Don't ask questions, just accept it." Gregory has been able to use his position as leverage to advocate for his undocumented patient population. As important as advocacy is, Gregory also mentioned that trust building is an integral part of forming authentic relationships with his patients so that they could feel safe coming to his clinic. He mentioned how the little things make a big impact, for example "if people need a [doctors note to present to their boss] I ask, 'what name would you like that under' so they don't have to initiate that conversation." Gregory stated that "we want people to feel safe to know that this is a place where they can trust us where we don't care about their immigration status, and … we want them to be full members of the community."

At Esperanza Health Centers in Chicago, Julia, a behavioral health specialist, described the steps that her health system takes to mitigate challenges that undocumented immigrants face in accessing mental health care. As Julia pointed out "there is a really high stigma around mental health in [the undocumented Latino] community… that can be a little bit more disproportionate [than for the general public]". However, "having behavioral health embedded within the medical

care clinic makes it a lot more comfortable, friendly and accessible," she noted. Julia mentioned that in Latino communities there is usually deference to authority figures, like doctors. Thus, if a medical professional suggests that a patient meet with someone from Julia's team "that increases the chances that they're going to at least do it that one time". This kind of set up allows undocumented immigrants to seek mental health services that they might not have otherwise sought out. Additionally, it is immensely difficult for an undocumented immigrant to get appropriate mental health services outside of FQHCs, and certain community mental health centers. Since hospitals cannot be reimbursed for nursing an undocumented immigrant in the psychiatric ward, should an immigrant have any serious mental health concerns, they are likely going to be seen in state run psychiatric facilities that are the last vestiges of the old mental health care institutions present in the U.S. prior to the reformation in the 1950s-60s. This will be discussed in further detail in the section on structural violence.

Aside from this tactic to make mental health services more desirable and attainable for undocumented immigrants in Illinois, other medical professionals from Esperanza as well as Alivio Medical Center kept referencing state or county measures that had been put in place to facilitate access to care. These policy measures that Illinois has taken to give undocumented immigrants access to care will be explained further in next section. In one way this phenomena serves as further proof to show that the general mindset in Illinois upholds health care as a basic human right, unlike in Indiana where doctors have to fight against a state that operates under the rhetoric that healthcare is a privilege granted to those that lawfully reside in the U.S. The state of Illinois has made strides to provide affordable healthcare access to more people (children under 18, undocumented immigrants in Cook county), and this is commendable. Nonetheless, there is

still a long way left to go before every resident of Illinois can access healthcare freely, and this leads to the second observation which is that there is an apathy of plenty. Pointing only towards state measures as evidence of the strides made to increase undocumented immigrants' access to healthcare may lead down the dangerous slope of being complacent with what is in place and consequently forgetting that health equity cannot be achieved until disparities are no longer a topic of conversation.

Contrasting Health Policies in the Two States

I. Indiana

Federal health insurance policy has had a long and complicated history and will be mentioned only briefly in this paper in order to give context for the small portion of insurance that undocumented immigrants are eligible for. Medicaid was established in 1965 and "is a federal- and state-funded insurance program offered to low-income individuals" (Salami, 2017). Under the initial guidelines that governed Medicaid eligibility, an individual had to meet certain restrictive financial requirements of being under 100% of the Federal Poverty Line and fall into certain categories (ie children, parents of dependent children, pregnant women, people with disabilities and the elderly) to qualify. While the federal government outlined the governing rules, states were allowed to use their own discretion to expand Medicaid coverage beyond these basic criteria and use state-funds to provide additional care. "Qualified immigrants" (those that possess a green card, asylum seekers, victims of domestic abuse and human trafficking) were initially allowed to access Medicaid much the same way as U.S. citizens. However, in 1996, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) which "added restrictions on legal immigrants' eligibility for Medicaid" (Salami, 2017). This Act saw to it that there was a 5-year ban placed on immigrants before they were

eligible to access healthcare, even if they were legally present. There is no logical reason for why this arbitrary amount of time was chosen aside from the potential desire to dissuade immigration for healthcare purposes. Some immigrant groups, like refugees and veterans, were exempt from this 5-year ban, but, again, states were given the discretion to "provide or limit public benefits to immigrants." In 2010, the Obama administration passed that Affordable Care Act which sought to expand Medicaid access to a larger population of low-income Americans and also for lawfully present immigrants by "allow[ing] states to use federal money to cover all individuals up to 138 percent of the FPL, regardless of whether they fit into one of the [abovementioned] categories" . The term "lawfully present immigrants" was more comprehensive than the initial eligibility guidelines set out by Medicaid and included "certain immigrants with permission to live and work in the U.S.," not including DACA recipients. However, in 2017, the House and the Senate each proposed new bills to reform the ACA: the American Health Care Act (AHCA) and The Better Care Reconciliation Act (BCRA) respectively. The changes in the language of the ACA proposed by these two bills ultimately led to more restrictive interpretation of qualifying immigrants making it so that "many immigrants who were able to buy insurance through the Marketplace exchanges would be either ineligible or unattainable under both bills" (Salami, 2017). Hence, the current polarizing anti-immigrant climate in the U.S. not only affects eligibility for undocumented immigrants, but also eligible, lawfully present, low-income immigrants.

While undocumented immigrants have historically been ineligible for federally funded healthcare benefits, they are eligible for temporary emergency health care insurance through discreet Medicaid sponsored programs like Emergency Medicaid, Presumptive Eligibility or an

expansion of the Children's Health Insurance Program developed specifically for pregnant women. As explained by Melissa, a trained Medicaid navigator at HealthLinc, an FQHC in St. Joseph County, undocumented immigrants can apply for Presumptive Eligibility or Presumptive Eligibility for Pregnant Women as long as they meet the income requirements in order to get immediate assistance. Their application for PE or PEPW has to be filed in conjunction with an application for Medicaid. However, she noted that "PE is a one-time deal and one time only. It only lasts 45 days, or to the end of the next month depending on start date." The Indiana Medicaid guidelines also specify that "your short-term coverage will end if you do not complete an Indiana application for health coverage or are found to be ineligible based upon your full application" (Indiana Medicaid, 2019). Although pregnant women could receive coverage for their prenatal care through this program, it would be tremendously transient, because the minute they are discovered to be ineligible for Medicaid, they are cut off from access.

Emergency Medicaid is another program that offers coverage to undocumented immigrants on a year-to-year basis upon reapplication. As the name indicates, it is only used for emergencies and thus cannot be used to cover prenatal care for women or any kind of preventative/routine care for other individuals. As Gregory mentioned, " In Indiana, the only thing that's really covered for is the delivery fees for pregnant women. When a baby is born here all of a sudden that baby is eligible for Medicaid and they will pay for the NICU charges that might result from her not having prenatal care, but they won't pay for the care that will prevent [complications from happening]." As mentioned above, states can provide or restrict care to certain immigrants upon their discretion. In accordance with this loophole, as Olivia noted "Indiana does not provide Medicaid coverage for asylum seekers."

In addition to insurance and healthcare related policies put in place, the mindset in less immigrant friendly states like Indiana reflects a similar degree of aversion to assisting immigrants in any significant way even outside of hospitals. For instance, in 2014, under then Governor Mike Pence, the state of Indiana became one of the few states that began to require low income persons that were applying for assistance through the Supplemental Nutrition Program for Women, Infants and Children (also known as WIC) "to affirm their citizenship or "qualified alien" status on WIC intake forms", effectively prohibiting any undocumented mothers from getting the assistance that they need (Baumgaertner, 2018).

These health policies that have been instituted in Indiana make evident the rhetoric that healthcare is a right only to citizens and "qualified aliens" and is a privilege denied to all other persons. Healthcare is seen as a privilege meted to those predestined to be worthy of it by virtue of being born in the U.S., and to the ones who have proven to be deserving of it by virtue of their honest adherence to legal forms of immigration and their patience to wait for 5 years to receive the benefits. The other lot that do not have a right to be in this country, on the other hand, do not have access to the amenities that come with it because they do not merit it by virtue of their illegality. Within this framework, doctors that work at FQHCs act as skilled medical providers that navigate the convoluted maze of the American healthcare system to find ways to provide affordable healthcare despite the hedges of barriers that seem to pop up from the pavement. Moreover, they act as relentless advocates that fight for undocumented immigrants right to healthcare despite ample backlash and resistance.

II. Illinois

Illinois on the other hand has a set of healthcare policies that facilitate, rather than encumber, care for undocumented patients. Illinois is one of 16 states that uses its discretionary power to provide prenatal and delivery coverage for undocumented mothers who were below 200% of the poverty line using an expansion of the CHIP program that was proposed in 2002. The CHIP Unborn Child Option "allows states the option of receiving a 100% federal match to provide prenatal coverage to income-eligible pregnant women regardless of their immigration status." The program does so by providing states the option to provide care for "a pregnant woman's fetus, which does not have an immigration status and is not subject to the restrictions" (Pintor and Call, 2019; Ross and Marks, 2009; Fremstad and Cox, 2004). Additionally, Illinois is one of 7 states in the U.S. that has expanded its Medicaid program in recent years to "provide insurance to all income-eligible children, regardless of immigration status" giving children access to insured care. Moreover, unlike Indiana, Illinois does provide Medicaid access to asylum seekers (Salami, 2017).

The Illinois Coalition for Immigrant and Refugee Rights was a participating organization in passing the Charity Care Law guided by two pieces of legislation: the Hospital Uninsured Patient Discount Act and the Fair Patient Billing Act that addressed public and private hospitals respectively. The HUPDA outlined that a hospital "shall provide a charitable discount of 100% of its charges for all medically necessary health care services exceeding $300 in any one inpatient admission or outpatient encounter to any uninsured patient who applies for a discount and has family income of not more than 200% of the federal poverty income guidelines." The Act also set in place regulations that mandated public hospitals to institute payment plans for these uninsured patients and set the maximum amount of collection within a 12-month period to

be no more than 25% of the patient's family income. They were able to do this by allowing local hospitals to be exempt from paying property taxes. The second piece of legislation mandated that private hospitals "should employ responsible standards when collecting debt from their patients." Additionally, this Act also outlined that hospitals are required to publicly advertise to patients that they may be eligible for financial assistance in order to ensure that an eligible uninsured patient is not missing out on assistance for lack of knowledge. Both of these pieces of legislation were instrumental in setting up charity care laws across Illinois hospitals that mandated them to provide financial assistance to those who qualify regardless of their immigration status. Although this legislation reduces the financial burden that undocumented patients face when going to the hospital, as Lorena, the Health Policy specialist at ICIRR, notes, "usually [the care provided] is not comprehensive and a lot of the time it's limited to the emergency room."

The ICIRR has been a part of a coalition of 45 organizations that came together to find a way to provide more comprehensive care provision for poor families in Illinois regardless of their documentation status. Unfortunately, during the time that they were advocating for this expansion in care, the state of Illinois was the only state in the U.S. that did not have a budget, making it impossible for them to do any statewide advocacy. So, they decided to start at the county level and chose Cook County because, as Lorena disclosed, "there are about 315,000 uninsured undocumented in Illinois, and over 60% of them live in Cook County." The Cook County Health system, comprised of 2 large hospitals and 16 clinics, was not a "proactive health care system" and provided care retroactively to undocumented immigrants that ended up in emergency rooms. However, with the collaborative effort of the coalition members assigned to

lead this effort, they were able to set up County Care. As Lorena mentioned, County Care is a direct access program that is "not health insurance, but works very similar to a Health Maintenance Organization" which is an insurance structure that offers access to a network of providers. Through this direct access plan, undocumented immigrants were able to receive a sort of membership card that gave them access to all kinds of primary and emergency care services across the entire Cook County Health system at a more affordable rate.

These policies that have been set in place, and the continued advocacy efforts of organizations like ICIRR, Healthy Illinois Campaign, the NIJC and countless other non-profits, make evident the rhetoric that health care is seen as a basic human right that every person deserves regardless of immigration status. Deservingness, in the context of Illinois, is not something that is merited by anything other than the mere fact of one's humanness. It is not regarded as a privilege that one attains by meeting certain criteria outlined by public officials that are subject to change. It is rather rooted in the unchanging, inalienable worth of a human being that outlives legalistic parameters of ineligibility based on socially constructed, fickle understandings of il/legality.

Public Charge Rule and Implications for Health Access

"Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost to me,
I lift my lamp beside the golden door!"

-Emma Lazarus

The experience of being an undocumented immigrant in the United States of America, especially in the current political climate, is one that is emotionally, psychologically, and physically taxing. The land that was built by immigrants and had opened its borders so warmly

to them for decades now has new criteria that barricade the pearly gates to the land of dreams for immigrants based on identifiers like their country of origin and socioeconomic status. From immigration bans to the public charge rule, the revised New Colossus at the foot of the statue of liberty now likely reads “Give me your tired and your poor who can stand on their own two feet and who will not become a public charge” according to the revision suggested by acting director of US Citizenship and Immigration Services, Ken Cuccinelli (Cole and Kelly, 2019). The Public Charge Rule is not ‘new’ in any sense of the word, the policy actually dates as far back as 1882. It is rather the revised interpretation of the law that has appalling consequences for immigrants. This section will outline the historically intended definition of the policy in order to make evident the current day draconian re-interpretation (Katz and Chokski, 2018).

The Public Charge rule comes from clauses 3 and 19 of the Immigration Act of 1882. Clause 3 deals with the inadmissibility of "persons likely to become a public charge" whereas clause 19 deals with the deportability of immigrants who become a public charge within 5 years of being present in the U.S. "from causes not affirmatively shown to have arisen subsequent to landing" (Alpert, 1939). In the context of healthcare, this statement can be understood to mean pre-existing health conditions that would make one unable to be self-sufficient (disability, chronic illness) and thus require aid from the government; it also includes mental conditions that are deemed “hereditary” that prevent one from being a functioning member of society. These “affirmative” determinations are made by trained medical and/or psychiatric professionals. However, the language of the clause is insidious and leaves certain complex medical conditions up to interpretation. What does it mean that a medical condition has “arisen subsequent to landing” for a condition like cancer for instance, a sickness that is caused by gradually

accumulated genetic mutations over a span of one's lifetime? Would a person who developed leukemia after landing in the U.S. not be considered a public charge for needing long-term care or would they be deemed deportable because they carried precursor mutations in their defective white blood cells? Albeit subtle, this rhetoric has a discriminatory lens with which it views immigrants that are, for lack of a better word, “imperfect”.

To understand the potential outcome of these clauses in effect, it is necessary to understand what exactly was meant by becoming a “public charge”. According to Alpert, “"Public charge" has been defined as any maintenance or financial assistance rendered from public funds or funds secured by taxation” (1939). Public assistance under the 1917 rendition of the policy referred to “welfare relief, or home relief, that is the modern counterpart of the pauper, almshouse and charity concept” (Alpert, 1939). Although each state has a different criterion upon which to grant this kind of assistance, citizenship was usually not a requirement so long as the person in need could prove “destitution… with varying restrictions on employability”. As per these guidelines, the rule was supposed to be targeted towards forms of cash assistance which would make the immigrant in question dependent upon the state for support in the future. However, as Alpert notes, “if [public charge] covered jails, hospitals, and insane asylums, several of the other categories of exclusion [which specifically deal with such subjects] would seem to be unnecessary” (1939).

Turning attention to the categories of exclusion that deal with medical assistance shows that this rule was not intended to exert punitive measures on those that use reduced medical services. The public charge rule held that “if the state received payment for its [medical] services as billed, though not the equivalent to the state of the cost, the public charge clause is held

inoperative." It also holds that "if no billing was made, but the alien's relatives were willing to pay all along, the public charge clause again will not be applied" (Alpert, 1939). This can lead to the conclusion that unless an immigrant refuses to pay a bill that was sent to them by the state, they cannot be held as a public charge. The guidelines differ, however, for mental health cases and people that need to utilize state asylums. The public charge rule holds that immigrants "without normal mental stability, as certified by physicians, may be held afflicted with "constitutional psychopathic inferiority" and so deported or deported as public charges if they accept public hospital assistance within five years of entry." As outlined above in clause 19, this is possible because the clause allows for medical professionals to determine the origins of immigrants' health condition and uses this as conclusive evidence to say that the immigrant is likely to need public assistance that the U.S. need not be held responsible for since it did not originate as a consequence of the immigrants presence on U.S. soil. Their mental condition is considered to be "inherent in their nervous system" and thus can be said not to have arisen "subsequent to their landing." What makes this guideline more appalling, is the statement that was seemingly made in passing that such immigrants "may be… *deported* or deported as public charges." An immigrant may be held deportable, even if they do not accept public hospital assistance, on the basis of being "afflicted with constitutional psychopathic inferiority", or in other words, on the basis of being damaged goods.

There was initial resistance from several states, California, Washington D.C., Maryland, New York, that placed statewide and nationwide injunctions in October 2019 temporarily stalling the implementation of the new public charge rule. However, the injunctions from all three states were fully lifted on January 27, 2020 allowing the new Inadmissibility on Public

Charge Grounds to be put into effect. The rule went into effect in every state in the United States except Illinois due to a lawsuit that was filed on behalf of the ICIRR and Cook County "to halt the implementation of the public charge inadmissibility rule in Illinois" (Protecting Immigrant Families, 2020), After several appeals from the federal government, the injunction was finally lifted from Illinois and the Public Charge rule went into effect in every state on February 21, 2020.

The new revision of the public charge rule expands the definition of public assistance by interpreting it to include "non-cash benefits related to food and nutrition, housing, and healthcare, which bear directly on the recipient's self-sufficiency and together account for significant federal expenditures on low-income individuals" (Inadmissibility on Public Charge Grounds: Final Rule, 2019). This rule excludes immigrants that use public assistance that are pregnant women or women within the 60-day period beginning on the last day of the pregnancy, immigrants under 21 years of age, or those utilizing assistance for emergency medical expenses, from becoming a public charge. Additionally, asylees, refugees, domestically abused immigrants are among a few classes of immigrants that are not subject to becoming a public charge. The rule is intended to bar legal immigration, or deny an adjustment of status, for those that the immigration officials deem will become a public charge based on factors such as "age; (II) health; (III) family status; (IV) assets, resources, and financial status; and (V) education and skills."

Since undocumented immigrants usually are not able to directly benefit from these public forms of assistance, one could think to dismiss them from being affected by the Public Charge rule at all. However, the mass confusion about who this rule really affects has created a mess of

hysteria and anxiety that has impacted undocumented immigrant's health seeking behavior since this rule's proposal in 2018 and continues to do so since its going into effect in 2020. Although the Final Rule states that the Department of Homeland Security will not consider "benefits received on behalf of another as a legal guardian or under power of attorney for such a person" as reason to become a public charge, undocumented immigrants now would think twice before going to the emergency room for a pressing medical concern, or registering their U.S. born children for Medicacid or food assistance benefits. As Katz and Chokski outline "approximately 10.5 million children in families receiving such public assistance have at least one non-citizen parent. Many mothers and fathers would have to choose between accepting help for basic human needs (such as food, medicine, and shelter) and keeping their families together" (2018).

The Final Rule boasts that "self-sufficiency has been a basic principle of United States immigration law since this country's earliest immigration statutes and that it should continue to be a governing principle in the United States" (Inadmissibility on Public Charge Grounds Final Rule, 2019). However, the irony in this seemingly logical statement is that the U.S. depends on migrant labor, both documented and undocumented, for the proper functioning of its economy, but refuses to pay them living wages thereby rendering them a public charge and then audaciously deems them inadmissible because they lack self-sufficiency. Self-sufficiency however is not a genetic trait as this rule makes it seem but is something that is socially determined and made more difficult to attain by the systems of injustice that are stacked against immigrants.

Structural Violence and Notions of Deservingness

The narrative that self-sufficiency has long been and should continue to be a central tenet of immigration law obscures the fact that complex systems of injustice force undocumented immigrants to lead lives of what is perceived to be dependence but can be better understood as attempts at basic subsistence. Contrary to popular belief, the majority of immigrants are not “free-loaders" that come to the United States to take advantage of the welfare system. They did not leave their homes at the risk of never finding home again for the bleak opportunity of coming to the U.S. to lead lives of dignified poverty. They took calculated risks in search of a better life and daily go to extreme lengths to attain it. They work multiple jobs inconspicuously, sometimes on borrowed social security cards, and live frugally. But, even after all of this, they cannot manage to attain the highly esteemed moral principle of self-sufficiency. This, then, is not a deficiency of work-ethic, but rather a deficiency in the system that prohibits them from legitimizing themselves to the state and its entities in the same ways that their documented counterparts are entitled to. This section will look at the concept of structural violence and how it applies in the context of health care access for undocumented immigrants as well as notions of deservingness that precede and guide health policies on access.

Structural violence can be understood, simply, as avoidable harm and is “the violence of injustice and inequity embedded in ubiquitous social structures [and] normalized by stable institutions and regular experience” (Rylko-Bauer and Farmer 2016). The invocation of the word “violence” usually brings to mind images of physical harm; however, according to Galtung, it is the "avoidable impairment of fundamental human needs or ... the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible" (Farmer et al, 2006). Structural violence has become incorporated

in the public health lexicon and is more frequently used to describe what creates the underlying inequalities that lead to unequal health access. Poverty often makes individuals vulnerable to the highest forms of structural violence. The poor, and more specifically the undocumented poor, are in many ways placed at the very bottom of the social ladder and are subjected to "common forms of lived oppression" (Rylko-Bauer and Farmer 2016). Although it is important to acknowledge these social positionings that are the root cause of health disparities and limited access to care, it is not enough to just proclaim this fact because the acknowledgement of poverty as the "root cause of the problem" does not actually solve the problem at hand. It must be coupled with action to eliminate the barriers put in place by poverty to limit undocumented immigrant's access to care. As Farmer et al note, "as long as medical services are sold as commodities, they will remain available only to those who can purchase them" (2006). The availability of insurance benefits and other social safety nets discussed in this paper is of paramount importance because it propagates the idea that health is a right and not a commodity. However, "the lack of these social and economic rights is fundamental to the perpetuation of structural violence" (Farmer et al, 2006). The structural violence onslaught by poverty coalesces with the symbolic violence imbued through racism and exclusion, and "create[s] contexts of shame, stigma, humiliation, loss of respect and violation of self-integrity, which in turn affect[s] health [and] well-being" (Rylko-Bauer and Farmer 2016).

The common rhetoric regarding immigrants and their ineligibility to access health care benefits affects immigrants' understanding of their self-worth and their healthcare related deservingness. In an interview with Karla, an undocumented patient at the Sister Maura Brannick

Health Center, the question of what she would like to see change in the U.S. healthcare system brought to light a striking exemplification of this point:

> "Pues si que quisiera o no que nos brindarán la ayuda como a las personas que son de aquí, verdad? Pero, desafortunadamente nosotros somos inmigrantes indocumentados y pues a veces no se puede. Pero, sabemos. Y lo tenemos que aceptar.
>
> (Edited Translation): Well, whether or not we want to be given help like the people that are from here, unfortunately, we are undocumented immigrants and sometimes it is not allowed. But we know that. And we need to accept it."

They way that Karla proclaimed "we are undocumented immigrants, but we know that" is a clear indication that she has internalized and is trying to accept society's projection of her diminished sense of worth due to her immigration status. Her declaration that "we need to accept it" carries a tone of quiet defeat to the 'fact' that there is nothing that undocumented immigrants can do to change the system. These statements are a salient representation of Pierre Bourdieu's concept of symbolic violence. In his book *Fresh Fruit, Broken Bodies*, Seth Holmes defines symbolic violence as "the naturalization and internalization of social asymmetries" which makes the unjust social hierarchies of our world seem normal (Holmes, Chapter 6 2013). By propagating such ideas, states like Indiana are not only denying undocumented immigrants what ought to be fundamental human rights, and more fundamentally the "right to have rights in the first instance", but it is also denying immigrants "biolegitimacy" by "casting them outside the community of people whose health merits social concern" (Willen 2012a; Willen 2012b). Using immigrants' choice to come to the U.S. illegally as justification for their unworthiness of health benefits eschews the fact that immigration is determined by social, economic and political inequalities and is not a choice that is made to abuse the already overtaxed safety net, as noted

above. When "immigrants' circumstances are viewed as a choice, they are less likely to be viewed by policy makers as inherently deserving of social and health services" (Castenada, 2012).

What parameters is deservingness reckoned upon, by whom and what consequences do these labels engender? A discourse on health related deservingness using Erving Goffman's framing theory will help provide answers to these questions and paint a clearer picture of the problematic rhetoric in Indiana as well as the predominant rhetoric in the continental U.S. Framing theory was coined by Goffman in 1986 and was used to define "conceptual structures that organize discourses and assemble narratives amid patterns of selection and valuation" (Viladrich, 2012). In popular media, and as has been shown in this paper, undocumented immigrants are often framed as "non-contributing members", "uninvited guests", "freeloaders", "criminal aliens", "morally inferior and excessively demanding on the system"... or as "conniving and fraudulent strategizers who immigrate explicitly in order to receive social welfare benefits or deliver "anchor babies" who might secure residency claims" (Willen 2012a). The government uses these, among other frames, to justify that undocumented immigrants are not deserving of health care as well as other welfare benefits that have an impact on their health. As Willen notes, deservingness is assessed on the basis of one's (read U.S. citizens) own sense of what they deserve and their sense of "actual or presumed social connection to those whose deservingness is in question" (2012a). Discourses on the un-deservingness of immigrants are primarily explained in a subjective "vernacular moral register that is situationally specific and often context-dependent." Although public policy officials find it acceptable to "deny biolegitimacy" to immigrants as such, public health officials find it morally reprehensible and

have come up with alternative frames that have been used to advocate for more healthcare benefits for undocumented immigrants. While the outcome of increased healthcare access is a laudable achievement, it is important to pay close attention to the frames used and the notions of deservingness they reveal.

The first frame is that of the "effortful immigrant" and how they should be deemed worthy of receiving healthcare because of the (incognito) contributions that they make to society and the difficult living and working conditions that they endure while making these contributions (Viladrich, 2012). The "cost-saving frame" expands upon this understanding of an undocumented immigrant and argues that it would be more cost-effective to give undocumented immigrants access to insured primary care benefits so that health issues do not get out of hand. It holds that only providing emergency care for undocumented immigrants ends up being more costly for the hospital system that will usually use taxpayer dollars to cover the care, as well as to the economy at large, because one day spent at a hospital tending to an emergency is one less day spent working. Yet another frame is the "national security frame" that paints immigrants as a threat to the health of Americans because they bear a "disproportionate burden of undiagnosed illness including communicable diseases such as tuberculosis and HIV, and that they frequently lack basic preventive care and immunizations" (Viladrich, 2012). This can be further evidenced in the interview I had with Dr. Patricia, as she noted that "TB tends to stay alive more in [the immigrant community]... because, most of the time, they don't get vaccinations for TB". She also disclosed the story of a patient who had recently gotten a bad case of TB that "she probably picked up from someone else in the immigrant community that she lives in." This line of thought leads to the conclusion that undocumented immigrants should get care because treating them is

in the interest of the general public and can prevent them from being a public health threat. The last one, is the "maternalistic frame" which was used as a response to complaints from the American public that undocumented Latina mothers had "untamed reproductive ability" and "overuse[d] medical and social services" (Viladrich, 2012). This frame paints mothers as "carriers of unborn Americans" which entitles them to health care because they will bear U.S. children and it is in the public's interest to support the wellbeing of that child. This is the rhetoric that was used in expansion of the CHIP Unborn Child Option.

What all of these frames used in health access advocacy have in common is that they operate on the basis that immigrants are deserving of healthcare benefits to the degree of their usefulness. Insuring immigrants in consideration of the American economy, in the interest of the public health of Americans or for the sake of unborn American children are all rhetorics that are rooted in a self-interested agenda and not on the inherent worth of the immigrant. The suffering that immigrants endure on the sidelines of these discourses of deservingness do not seem to have any bearing on the policy decisions that are made. As Viladrich notes, "[all of these frames] fit into an overarching neoliberal paradigm that rewards individual responsibility and self-sufficiency" which is probably why they are "convincing" paradigms used for persuasion. This is not to say that there are not plenty of public health officials that believe in health care as a basic human right, but these frames of argumentation make apparent what is deemed persuasive in policy making circles on a federal level. On a state level, in Indiana, there is an invisibilization and normalization of undocumented immigrants' suffering on the basis that healthcare is a "justified need" that immigrants are not entitled to.

Willen notes that "'illegality' can operate simultaneously as a juridical status, a sociopolitical condition, and a mode of being-in-the-world". As mentioned earlier, since deservingness is partially determined by one's relative connectedness to the group whose deservingness is in question, Indiana policy makers hold that they have very little connection to such forms of "being-in-the-world" and thus see undocumented immigrants as undeserving of health benefits. One stark example that shows this is the CHIP Unborn Child Option that was mentioned earlier in the health policy section. This law allows for 100% federal reimbursement for monies spent in the care of pregnant women regardless of their immigration status in *every state;* but Indiana used its discretion to refrain from enacting this law in its jurisdiction. Refusing to provide affordable care to those in need is thus not rooted in the economic argument that the state is only responsible for its legal residents. It is founded on the premise that undocumented persons are undeserving of receiving provisions that makes them feel comfortable and at home here because they are "illegals" that are not supposed to be here in the first place. Another instance that makes apparent this line of thinking is the case of undocumented patients that are in need of renal dialysis. According to Dr. Gregory, hospitals in Indiana would try to cover undocumented patients for about a month or so until they can transition to commercial insurance, if they can afford it. If they cannot, however, "they fall through the cracks" because "Indiana will not cover them if they're undocumented." For this reason, there are several patients at Maple City Health that commute to Illinois three times a week for dialysis because "they can get services there". Lorena, however, pointed out that in order to receive charity care in a hospital in Illinois, one would need to prove their in-state residency. As cumbersome as it sounds, it is easier for undocumented immigrants to feign residency in Illinois and drive a

cumulative of 12 hours a week without a valid license to get the care that they need than it is for them to even think of getting the care in Indiana. Olivia has further pointed out that she has had clients that needed surgery that were advised to "move to Illinois [to get] healthcare".

Invisibilization of human suffering, however, does not only take place in Indiana. Illinois may have a myriad of provisions set in place to help the undocumented, but it is still not the beacon of perfection. As Lorena noted, just because Illinois has made a name for itself as a more immigrant friendly state does not mean that it is "easy to get care in Illinois". Earlier in the paper, it was outlined that Esperanza Health Centers acts as a safety net mental health provider for undocumented immigrants that would otherwise have no place to go, especially if they need chronic mental health care. Well, the fate of those that fall through the cracks is rather sobering. Dr. Julia disclosed that if an undocumented immigrant visits the ER during a mental health crisis that warrants hospitalization because they are an imminent threat to themselves or others, they can be "held and treated in the ER but they can't be admitted to the psychiatric unit because they don't have insurance and the hospital won't get any reimbursement for that care."

These patients have to wait to be transferred to state hospitals, but this could take a week, 10 days, perhaps even more time depending on the availability of beds at these state hospitals that are unsurprisingly overtaxed. Again, the interesting thing here, as with the case with the CHIP Unborn Child Option in Indiana, is that undocumented immigrants are indeed eligible to be seen at a reduced cost for any hospital service as long as they meet the income requirements. It is mandated by the aforementioned Charity Care laws. Thus, the hospital's refusal to provide care is not guided by prohibitive health policy, but a pure desire to not provide reduced care to the undocumented immigrant and is rooted in structural violence. The loophole, as Lorena noted,

lies in the fact that “the charity care law doesn't say how much and the law doesn't say what services [need to be provided]” and leaves it up to interpretation for each hospital. Moreover, the entity that is supposed to enforce the law and keep hospitals accountable, the Attorney General’s office, does not maintain strict oversight which reduces the amount of scrutiny hospitals are under. Since they can report a myriad of services as charity care [i.e. care provided in the community, doctors providing voluntary services], the hospitals use this to their advantage and can opt to not provide care when they see fit. It is economically clear that it would be more cost effective for the hospital to transfer the immigrant in distress to the psychiatric ward instead of keeping them in the ER. However, if the immigrant has a chronic mental illness and can perhaps be shown to be afflicted by "constitutional psychopathic inferiority" as the public charge rule points out, why bother anyway? They are ‘damaged goods’ and cannot even really benefit the economy so their pain can easily be thrown under the rug in the ER.

When brought to the light, all of these stories evidence the ways in which certain lives are valued over others solely on the basis of national origin. But, the worst thing about structural violence is that it is invisible to the unsuspecting eye. According to Farmer, “[the] experience of structural violence and the pain it produces [is] known as social suffering” (Rylko-Bauer and Farmer 2016). Social suffering, like structural violence evades neat categorization since it is dependent upon the large, intertwined systems of society, economics, politics, etc. However, it ties personal suffering to these larger societal systems and “challenges the problematic tendency in the social, health and policy sciences to focus mainly on the individual and ignore the broader determinants” (Rylko-Bauer and Farmer 2016). Moreover, as Seth Holmes points out “it is vitally important to understand how the ongoing mistreatment and suffering of migrant laborers

has been taken for granted, normalized and naturalized by all involved. This is a critical first-step in working for respect, equality and health in the context of U.S.-Mexico migration" (Holmes, Chapter 6 2013).

Future Prospects: Political Willingness to Change in Indiana and Illinois

Healthcare equity is a wonderfully idealistic concept that we can raise our hypothetical glasses to toast its commencement that will surely ensue once the systems of injustice are dismantled. However, for most people, this pretty picture is threatened when one raises the question of how it will become a reality given the political climate in the U.S. today. This research study asked participants if they believed that there could or should be policy change to give more access to undocumented immigrants and what it would take to bring about such change. The following section outlines the responses from participants to ascertain the political willingness to change in each state.

Indiana

"I think that what is in place now is adequate"
-John, Indiana Health Centers

The general prospect of policy change was met with a great deal of apprehension in Indiana from all participants of this research study. The idea of policy change was seen as an almost insurmountable task that was more wishful thinking than a real possibility. As Dr. Richard noted "the political atmosphere that we have today doesn't allow for any kind of advocacy for illegal immigrants." This sentiment is not only reflective of the federal administration but also references local politics. Respondents kept on referencing the fact that "Indiana is a conservative state" to justify their belief that policy change would not be imminently possible. Broadening healthcare access is seen as a bipartisan issue that is lauded by

the liberal democrats and irrationally resisted by the conservative republicans. Johnathan, a Health Policy professor, makes this evident in stating that "the reality [is that] we're in a republican state; we can advocate all we want, but [policy change] is never going to happen until we start changing more mindsets of those individuals who don't want [undocumented immigrants] here." However, I believe that it is less of a political issue and more of an ideological issue about the worthiness of undocumented immigrants that does sometimes blur party lines. But, how does one begin to change an ethos, an ingrained ideology of whose health merits concern and whose does not? Some, like Johnathan, believe that "you're not going to change [people who have their minds made up] suddenly" because it usually requires "some sort of an event that makes a catastrophic difference within them." For this reason, he believes that "patient persistence over time [is what will] create a sense of trust in terms of communication, and [create] a little bit of openness to different ideas." The cautious language that he uses indicates that there is not much that one can actively do to change "republicans' minds." There is an understanding that change will take time but there is also a lack of willingness to actually invest this time and effort that is agreed upon as necessary. Others, like Manuel, believe that time will be helpful for other reasons as can be seen in his bold declaration that "you're not going to change their minds. [It] doesn't matter what you say, it doesn't matter what you do. It's one of those things where that sort of mindset just has to die out."

Sergio was a respondent that works at La Casa de Amistad, a non-profit organization that has it as its mission to empower the Latino/Hispanic community within Michiana by providing educational, cultural and advocacy services. His sentiment towards the possibility of policy change was surprisingly pessimistic. Since insuring undocumented immigrants would require the

state to expend tax-payer dollars, he mentioned that advocating for legislative change "in terms of [his] time bandwidth, would not be a place where [he] would focus [his] energy because [he] just [doesn't] think it would happen." Justifying that undocumented immigrants cannot receive state funded benefits because it would require "tax payer dollars" obscures the fact that undocumented immigrants are taxpayers too. Recent data has shown that undocumented individuals "collectively contribute an estimated $11.74 billion to state and local coffers each year via a combination of sales and excise, personal income, and property taxes" (Gee et al, 2017). Although these contributions are significant and need not be ignored, I want to reiterate that undocumented immigrants should not be entitled to healthcare benefits because of their contributions to the economy but should be entitled to it because it is a fundamental human right. However, if the organization that is dedicated to advocating for the Latino community does not believe that this is something worth advocating for because it is a losing battle, what hope is there of change? Jorge, a professor of public health, went as far to say that "[policy change] is short of a miracle; there's nothing that can do it."

All of these statements communicate an utter destitution of hope and a sense that health equity is not something that can be attained, at least not in this lifetime. Though it may be a hard pill to swallow, the truth of the matter is that political change is forever going to lag behind a more social, grassroots type change. As Dr. Gregory beautifully noted,

> "I just don't think that political change is going to happen until we have the kind of grassroots understanding that these people are our people and we need to make sure that they have what they need…"

Until policy makers in Indiana start hearing the stories of undocumented immigrants and begin to find pieces of it that reflect their own reality, they will not be inclined to make any state-wide changes.

Illinois

"We cannot continue to fight for crumbs, or even a piece of the pie. We are going to fight for the whole pie"

-Jessica, Healthy Illinois Campaign

In Illinois, on the other hand, the respondents that were a part of healthcare organizations, as well as those that were a part of advocacy groups had notable hope in the possibility of policy change. While this "hope" is rooted in the fact that Illinois, more specifically Chicago, has the privilege of having more liberal political leaders that have shared interest in increasing access to healthcare, it is more fundamentally rooted in the belief that everyone, regardless of immigration status, deserves health care benefits. As Lorena noted, "some years are harder than others depending who has been in office, at the governor's level". As an example, she noted a successful legislative effort that ICIRR had been involved in a few years back: providing undocumented immigrants the right to have driver's licenses. It took 13 years to get approval for this law to pass, but they "kept focusing on it and made it a priority." Lorena also pointed out that having a immigrants' rights coalition that is dedicated to advocacy efforts is critical in making any significant strides forward. As she noted, collective power is what makes change attainable and this is achieved by registering eligible immigrants to vote and increasing voter education so that they can be empowered to make informed decisions about their leaders. This is important because if "any community that wants to pass any legislation that's going to benefit those that are seemingly undeserving, and that community is not voting or holding their elected

officials accountable, then those elected officials have no incentive to do anything for that community." This is in accordance with what was mentioned in the earlier section that policy change requires grassroots social change. Moreover, Lorena believes that the fight for more equitable healthcare access should not exclude immigrants because they are regularly stripped of the right to have rights in the first place. Rather, it should have them at the crux of its efforts. Lorena notes that, in order to be effective, advocacy efforts can not solely be rooted in an idealized notion of what an outsider believes the immigrants deserve but should give voice to immigrants as well. By empowering immigrants to reclaim their voices, coalitions like ICIRR and their partners are helping to break down the invisible structures of violence and helping immigrants realize that they and their health do indeed matter.

Additionally, Jessica, the cofounder of the Healthy Illinois Campaign, shared that her organization believes that they have to fight for healthcare "aggressively" because:

> "There are people in our community that are undocumented and that have pressing healthcare needs that cannot afford to wait. We feel a very deep urgency to make sure that the administration remembers that. That every day we don't make a move toward making this a reality is another day that someone is going about their life without health insurance, is another day that they are living a quality of life that is not humane, is another person whose life is lost."

Jessica realizes that advocating for state-wide coverage will require the state to make significant monetary contributions; she noted that "we are not blindly pushing for health care; we know that we need the fiscal reality to match up with our goals." However, she does not see this as a roadblock, but as a challenge to rise up to, as can be evidenced by the fact that her organization is engaged in advocacy efforts to shift the income tax structure in Illinois to make more funds available for statewide healthcare access. As pointed out earlier, just because Illinois is more

liberal does not mean that it is always easy to get politicians to believe in the values that an immigrant coalition upholds. However, when politicians refuse the see the Campaign's vision as either worthwhile or attainable due to their "political beliefs", Jessica does not see that as a reason to back down. She believes that "if [she] brings[s] them the right messenger, they will listen". It is only a matter of doing a power analysis to figure out who in the community has an opinion that matters to them (like religious organizations for instance) and finding out how those people can be convinced to change their minds. Jessica and Lorena both noted that the fight for equity in healthcare access is not something that will be achieved overnight, it is a long-term vision that is not in the slightest bit "easy". As Jessica pointed out:

> "there are many points at which you're asked to compromise and negotiate and take the crumbs instead. But it takes having a transformational imagination; we imagine big things and we don't lose sight of them in the process. We refuse to dream smaller because people tell us it is not possible… We cannot continue to fight for crumbs, or even a piece of the pie. We are going to fight for the whole pie"

The tenacity and dedication in Jessica's responses is further evidence of the fact that an ethos of healthcare that is rooted in fundamental human rights is what can make any real change manifest. Change is like rain in a sense: it is easy to think that it is something that pours down from above without any concerted, albeit imperceptible, effort from below. To the contrary, it will only pour down over wide areas if it is first collected from a pool of dedicated individuals that are relentlessly committed to make it transpire because they believe it is the right thing to do.

Conclusion

This paper started by outlining the reasons behind mass immigration of undocumented immigrants to the United States in the last century, and the policies that have, intentionally or

unintentionally, aided this migration. Organizations that seek to aid these immigrants as well as numerous restrictive policies that have denied immigrants "biolegitimacy" have also been discussed through the lens of numerous stories of immigrants' real life experiences. It is easy to get bogged down in the legalistic details of the policies that govern healthcare provision in Indiana and Illinois and consequently forget the bigger picture of why discussions about the differing ethos of healthcare is important in the first place. However, whether one chooses a path of complacency because of the perceived adequacy of current provisions, or a path of relentless advocacy for increased equity should not be a question of political preference because is a matter of life and death. This last story that Jessica shared about her life will exemplify this very point:

> "I am the daughter of undocumented immigrants and my experience is different because of where I happened to be born. My mother had overstayed her visa, and was undocumented when she had me. I was born premature, in California. If I had been born in a different state that didn't extend healthcare to pregnant women, maybe my mom wouldn't have felt comfortable going to the hospital. And who knows, maybe I wouldn't be having this conversation with you right now. I juxtapose that with my grandfather who was undocumented. He worked and lived in this country and was a wonderful person and he helped take care of me. He, unfortunately, died of cancer. But, if he had access to healthcare earlier on, I could still have him in my life. Instead, by the time that the costs were eligible to be covered, it was too late and we were considering hospice. I think for me, that's why [this cause] is so personal."

It is necessary not to forget the fact that the heated debates lofty policy officials engage in are about *people* that are suffering on the sidelines of the warfare of their political ideologies. "The capacity to suffer is, clearly, part of being human," as Farmer notes, "but not all suffering is equal, in spite of pernicious and often self-serving identity politics that suggest otherwise" (Farmer 1996). This kind of rhetoric blots out the fact that structural violence engenders

suffering of "vastly different severity" (Farmer 1996). Increased healthcare access has become, on the surface, a bipartisan issue, but is, at its core, much more than that. Individuals in both states noted that both federal and state politics makes it harder for them to achieve health equity. Whereas in Indiana the administration was seen as a concrete wall 50 ft high and a 1000 miles wide, in Illinois it was seen as a rock in the middle of the road that one could side step. This is a clear representation that what matters at the end of the day is the fundamental ethos regarding healthcare access: whether it is a considered a basic human right or a luxury afforded to one depending on their legality. Wherever one's political allegiances may lie, I believe that an immigrant's inherent worthiness should not be something that changes in the 90 mile drive between South Bend and Chicago. However, as Dr. Gregory poignantly noted:

> "Health policy is not going to change for any of these marginalized impoverished subpopulations unless we become a society of a greater sense of shared purpose, a shared picture [of togetherness], and a sense that justice is important. That we're only as strong as our weakest links."

In a country like the United States that was once dubbed "the nation of immigrants," this sense of shared purpose will not arise by the contempt bred by the two-faced dealings of the U.S. government. The U.S. cannot provide for immigrants' children that are U.S. citizens while at the same time telling those children that their parents, that have lived and worked here for years, are unworthy of the same treatment, because at the end of the day, they are one and the same. How does one begin to build this sense of shared purpose and unite the disjointed pieces of this nation amid the current political climate that has propagated so much hatred toward immigrants? What kind of individual and collective effort does it take to make a change? However, before any significant strides can be made in achieving health policy change, both public health and public

policy officials should start being aware of the invisible structures of violence that will continue to place them two steps back whenever they take a step forward. Future research endeavors on increasing healthcare access for undocumented immigrants in both of these fields would do well to incorporate anthropological understandings of structural, cultural and everyday violence that undergird the political debates about healthcare related deservingness. The task at hand is not to merely offer policy solutions that can be overturned by aggravated and emotional politicians making rash decisions "that frequently hinge on misrepresentations and distortions that contradict conclusions substantiated by economic and epidemiological research" (Willen 2012a). Rather, as Farmer notes, "the task at hand, if this silence is to be broken, is to identify the forces conspiring to promote suffering" and dismantle them.

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