1996

The Wrath of Ignorance: Schizophrenic Policies in Access to Health Care for Undocumented Latinas

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Digital USD Citation

Spadaro, Antonia J. EdD, "The Wrath of Ignorance: Schizophrenic Policies in Access to Health Care for Undocumented Latinas" (1996). *Dissertations*. 621.
https://digital.sandiego.edu/dissertations/621

THE WRATH OF IGNORANCE: SCHIZOPHRENIC POLICIES IN ACCESS TO HEALTH CARE FOR UNDOCUMENTED LATINAS

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Education

University of San Diego

1996

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ABSTRACT

THE WRATH OF IGNORANCE: SCHIZOPHRENIC POLICIES IN ACCESS TO HEALTH CARE FOR UNDOCUMENTED LATINAS

SPADARO, ANTONIA JOY, Ed.D. University of San Diego, 1996,
146 pp.

Director: Mary Abascal-Hildebrand, Ed.D.

This study focuses on the problems of health care access experienced by undocumented Latinas: women from Mexico, Central and South America, and the Caribbean. Those who are undocumented may encounter significantly reduced access to health care, for the risk of discovery causes them to be more furtive in their activities. Undocumented immigrants to the U.S., especially Latin women, confront myriad obstacles in obtaining health care that are sociocultural, political, economic, and personal. The problem of competing policies in the health care arena represents one of the most formidable obstacles for undocumented persons. These conflicting conditions are such that some services are easier to access, while other services are more difficult to obtain. For example, undocumented Latinas are likely to find family planning services easier to obtain than prenatal care under terms of the new federal welfare law that eliminates prenatal care for undocumented immigrants. Even health care providers appear to have limited awareness about competing policies. As such, this qualitative interview study illustrates that it is possible to promote greater knowledge and understanding about the problems of competing policies among a selected group of

health care administrators and providers. The data analysis portrays their new awareness for which policy revisions are needed to rectify and expand undocumented Latinas' access to health care services.

The data support the review of literature which together suggest that ignorance on the part of providers, the public, politicians, and the media is the most critical barrier preventing health care access for undocumented Latinas. Consequently, the participants promote education for themselves and for the community as the essential remedy to alleviate this population's pain, despair, and increased morbidity related to health care exclusion. Moreover, the participants believe education represents the crucial tool for subjugating this wrath of ignorance among the political elite.

The participants' recommendations point out that social justice perspectives are integral to redefining, reconstructing, and remedizing health care policy. Recommended remedies include: upholding Latinas' right to health care by expanding health care services, establishing universal access and universal health insurance, and promoting federalized reimbursement for health care. The recommendations center upon renewed emphasis in education, research, and leadership through empowerment from participation in coalitions and fora, volunteerism, partnerships between hospitals and the community, and knowledge distribution.

Preface

Vale, pero millones de veces mas, la vida de un solo ser humano, que todas las propiedades del hombre mas rico de la tierra.

(It is worth millions of times more, the life of a single human being, than all the riches of the wealthiest man on earth.) (The Presidents's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983, p. 106)

Acknowledgements

My dissertation journey became a reality due to the knowledge, wisdom, support, understanding, and patience of of many significant people including the participants in this study. My dissertation committee also played a crucial role toward this endeavor.

Dr. Mary Abascal-Hildebrand, dissertation director, offered challenging comments and made worthy suggestions to expand my thinking. This learning process "paved the way" for me to undertake my journey.

Dr. Mary Scherr, as a committee member, offered support and guidance. The knowledge she imparted about qualitative research enhanced my methodology and motivated me to continue my journey.

Dr. Diane Hatton, also as a committee member, served as an outstanding mentor from a nursing perspective. Her suggestions for categorizing data, creating guiding interview questions, and excellent resources in health care policy fueled the completion of my journey.

Likewise, Nancy Coffin-Romig, a fellow doctoral student and long-time friend, extended her time, support, and wisdom throughout my journey. Her willingness to share ideas, experiences, and numerous resources sparked my desire to pursue the doctoral program. Her husband, Doug Romig, offered his assistance to transform my journey into text. His instructions for computer programming enabled me to write the dissertation.

Additionally, Eileen Mullahy answered my prayers for an exceptional editor to conduct a critical appraisal of the dissertation. As a result, her efforts served to enhance its clarity and narrative presentation.

Finally, my aunt, Francis Calzone was a source of inspiration. She was very supportive and loving throughout my academic pursuits. Before her death, she told me, "Ninety percent of making your goal is shaping it, and everything will converge toward that end."... She was right.

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CHAPTER 1

The Problem

Immigrants in the U.S. are less likely to know about and use health care services due to a lack of money or facility in English, the language of most health care professionals. Undocumented immigrants in particular, are likely to limit their own access to health care, for the risk of discovery causes them to be more furtive in their activities. Accentuating these hardships is the U.S. health care system's inadequate response to immigrant needs, a product of competing policies. For instance, some existing U.S. health care policies create conflicting conditions wherein some services are made easier for undocumented immigrants to access while other services are made more difficult. For example, undocumented Latinas are likely to find family planning services easier to obtain than prenatal care under terms of the new federal welfare law that eliminates prenatal care for undocumented immigrants.

Furthermore, the illegal status of undocumented immigrants makes it extremely difficult for them to challenge competing policies, or to increase recognition among providers and politicians that competition among policies is a cogent issue demanding resolution. The focus of this study is health care issues of undocumented immigrants in the Latino population, which currently comprises a large proportion of the resident immigrant community in the southwestern U.S. The predominate loci of this focus are Latinas, females of Latino heritage who represent an especially vulnerable sector of this group.

The Latina occupies a key position within her family circle, a dominance produced both by the traditional matriarchal structure of Latino families and the fragmentation that characterizes undocumented immigration. Any illness, then, interferes not only with her ability to care for herself and for those who depend on her, but extends as well with her efforts to work in and contribute otherwise to the community--especially if she cannot readily obtain access to health care.

Undocumented Latinas, therefore, comprise an especially at-risk population, since they are even more susceptible to increasing fragility. In addition to their complex and tenuous status, the vulnerability of undocumented Latinas is compounded by competing policies that simultaneously make it both appropriate and difficult to provide them with health care. Such competing policies create an ongoing dilemma for undocumented persons requiring health care, one that limits the quality of care. As for examples, a policy such as the Primary Care Grant, which serves people who require health care services, coexists alongside policies, such as Proposition 187 that demand proof of residency, that seek to contain costs rather than to search and serve those who need care (Bergquist, 1993; Eisenstadt & Thorup, 1994).

As another example, policies concerning bilingual/bicultural competency for health care providers are nonexistent at some health care facilities. By contrast, other health care facilities support culturally competent health care by employing providers who are bilingual/bicultural and by providing interpreters. This dichotomy makes it imperative to address the crucial need for bilingual/bicultural competency in the systemic provision of high quality health care. The paucity of Latino health care professionals is evinced repeatedly by statistics that reflect that "Hispanics ... are only 4% of the US physician work force and 2% of nurses" (National Coalition of Hispanic Health and Human Services Organizations [COSSMHO], 1995, p. 307). The legitimation crisis created by the public and politicians ignoring or withholding promises to fulfill health care needs for this population cultivates schizophregenesis--the perpetuation of competing policies.

Background of the Problem

Access to health care for undocumented Latinas in the southwestern U.S. reverberates within the complex issues surrounding self-interest, a by-product of this nation's fundamental philosophy of individualism. Conflict understandably exists between those who promote autonomy, isolating the provider, the patient, and the insurer, and those who are concerned with the good of the whole (McCabe, 1993). America's traditional fee-for-service system of payment isolates persons and exemplifies the traditional practice of medicine, in which experts receive payment for isolating, diagnosing, treating and/or curing disease. Consequently, the needs of undocumented Latinas can easily go unexplored and unresolved because they lack the financial resources to seek and pay for these services (Weisbord et al., 1992). The emergent corporate model of health care further complicates the isolation and increases the complexity of this issue, as services that were formerly provided by "public institutions or by private, not-for-profit, community-based facilities ... have become part of an industry that supplies health care industries for profit" (McCabe, p. 37). For example, many hospitals, health insurance, and health maintenance companies "operate on behalf of the public [but] ... are run like for-profit businesses" (Bergquist, 1993, p. 211).

Some reports consider that the financial constraints of Latinos, "such as the cost of health care was the most frequently encountered" (Estrada, Trevino, & Ray, 1990, p. 28) utilization barrier for health care services. The fear of deportation, seasonal employment, lack of trust in culturally-alien institutions, inadequate transportation, and spiritual beliefs that illness is a test of God comprise other major reasons affecting Latinas' access to health care (Caudle, 1993; COSSMHO, 1995; Council on Scientific Affairs, 1991). Comprehensive understanding also demands the consideration of competing policies and health care conditions that exacerbate the effect of the foregoing threats by simultaneously making it both appropriate and difficult to provide health care for undocumented Latinas.

Realistically, constrained resources present significant obstacles to the provision of universal health care. Further, the ensuing legitimation crisis that has emerged due to societal conflict over these scarce financial resources "provides a more normatively acceptable justification of negative actions" against undocumented Latinas (Wetherell & Potter, 1992, p. 207). This crisis has accentuated an ugly global backlash from a "skeptical public ... who would prefer that Hispanics not be accepted as fully participating members of the society" (Chavez, 1991, p. 85). This political dilemma is the crux of a "schizophrenic" (Hoffmann, 1965, p. 189) policy "that would yield yet another deficit to be passed on to later generations, the deficit of uplifting those left behind" (Martin, 1994, p. 98).

Health care based on a central conceptualization of social justice, with its associative implications of fairness, is not only financially beneficial, but safer for all. This conceptualization is particularly worthwhile where public health and preventive health care services are concerned, and within a social network so gravely depending on the health and stamina of key participants such as the Latina. When health care is framed to emphasize the long-term cost of not providing these services against the short-term savings, the results are significant (Eisenstadt & Thorup, 1994). For example, research findings demonstrate that "each dollar spent on prenatal care saves some three dollars in later costs from treating birth complications and related health problems" (Eisenstadt & Thorup, p. 66). A study released in 1992 by Los Angeles County officials concluded that the region's legal and undocumented immigrants and their citizen children "pay more in taxes than they consume by using health care ... services" (Blankenau, 1993, p. 38).

Changes in our health care system should be based on a "sound ethical foundation, and not the divided goals of special interest groups" (McCabe, 1993, p. 39). In order to redevelop and shape health care policy, crucial issues posed by special interest groups such as the legitimation crisis must be addressed and resolved if we are to fulfill our promises concerning the health needs of Latinas.

This qualitative study seeks to promote knowledge and understanding about what policy revisions may be needed to rectify and expand access to health care for undocumented Latinas. This focus originates from my interest in women's health as a critical component in the advancement of knowledge regarding the nature of health problems, and the development of effective interventions for reducing women's health problems. I portray conditions generated by competing policies that might precipitate the legitimation crisis from participants' points of view.

Significance of the Study

While the findings of this research should not be generalized into assumptions regarding other research settings or other population groups, and since the methodology seeks to examine the impact of competing policies concerning access to health care for undocumented Latinas, the findings do represent viewpoints of health care providers and political activists in San Diego--one of the two largest cities in the southwestern U.S. Further, the process is replicable and the incidence and continuation of such study is valuable to professionals engaged in any field concerned with the advancement of knowledge.

Even though the methodology makes no attempt to suggest that the findings are generalizeable to other settings, these findings can invigorate discussions and add to organizational and policy change, and thus influence the public policy context. As a result, the theoretical implications this research suggests can move practice questions readily into the public policy arena. Moreover, this study illuminates several policies that promote or constrain access to health care for undocumented Latinas, and, as well, identifies specific revisions that are necessary to facilitate health care for this population.

Purpose of the Study

The purpose of this study comprises three main areas: research into health care professionals' and activists' experiences with health care policy; the process of health care implementation; and classification of aspects that constrain and facilitate access to health care. Three research questions addressed this line of inquiry:

1. What are the policies that impact or are related to undocumented Latinas' access to health care?
2. To what extent do competing policies constrain and facilitate access to health care?
3. What changes in health care policies for undocumented Latinas may facilitate access to health care?

The research questions in my study therefore address access to health care for undocumented Latinas in an effort to advance the knowledge of women's health problems, and to find effective interventions for reducing these health problems. I adopted a particular focus on Latinas throughout this study. As a result, the research questions were crafted based on my underlying assumptions about access to health care.

Specific Terminology

Future Search. This concept enables us to envision a world as we want it to be. The essence of future search is its focus on possibilities for change, not on problems. *Future Search* involves viewing problems from multiple perspectives, i.e. access to health care for all at the macrolevel, and for undocumented Latinas at the microlevel (Bergquist, 1993; Brokhaug, 1992).

Hispanic. This term is a governmental designation in the U.S. While people from Central/South America and Mexico are more receptive to the term *Latino* than *Hispanic*, these groups prefer to identify themselves according to their national origin i.e. Dominican or Colombian. The designation *Latinas/Latinos* will be used in this study, with an underlying recognition of the limitations of both terms.

Latinos refers both to the entire population of men and women, or to males alone. *Latinas* refers solely to women and thus the word stands by itself. For this study's purposes, then, *Latinas* represents a more specific and thus more useful term (Arredondo, 1991).

Legitimation. This term refers to the "ideological justification of exploitative social relations ... which sustains and maintains the pattern of power relations," (Wetherell & Potter, 1992, p. 217) as with undocumented Latinas.

Legitimation Crisis. This dilemma is a "crisis of representation" (Nencel & Pels, 1991, p. 14) that occurs when what is "promised" is ignored or withheld, as from undocumented Latinas.

Competing Policies. Competing policies refer to conflicting policy mandates extended from policy makers to policy implementers that either facilitate or impair access to health care services for undocumented Latinas (Rist, 1994).

Anglo. Anglo refers to a population or individual whose color is white, characterized by allegiance to the Protestant value system (Hayes-Bautista, 1992).

CHAPTER 2

Review of the Literature

Introduction

The review of the literature from a historical perspective provides the foundation for exploring how present immigration policy and health care affects health care access and how competing health care policies may influence future policies. In order to fully explore the historical perspectives, the works of Caudle (1993), Committee on Small Business (1994), COSSMHO (1995), Cornelius (1981a; 1981b), Council on Scientific Affairs (1991), Eisenstadt and Thorup (1994), Fix and Passel (1994), Juarbe (1995), Lillie-Blanton, Martinez, Taylor, and Robinson (1993), and the President's Commission for the Study of Ethical Problems (1983) form the nexus of the discussion.

For this dissertation, the remainder of the literature review serves as a vehicle for developing the argument in the dissertation for increasing knowledge and understanding about the measures necessary to change the conditions of Latinas' access to health care. The major sections relate to understanding access to health care and visions of health care and social justice (Locke, Spirduso, & Silverman, 1993).

Historical Context of U.S./California Immigration Policy

In most instances, the health status of both undocumented and documented immigrants improves with increased access to health care. Efforts to limit rising health care costs have shaped public policies in recent years that restrict access to health care. The passage of Proposition 187, and current revamping of U.S. immigration policy exemplify the increasing popularity of these policies due to perceptions by the public, politicians, and the media of staggering population growth. Problems associated with burgeoning population are, of course, nothing new.

As people gradually populated the earth, nomadic groups began bumping against one another. They "had to either continue a nomadic life-style and face ongoing conflict with other nomadic groups" (Bergquist, 1993, p. 40), or settle down in one spot and establish cooperative relationships with other small groups. The critical choice--between domination and partnership is still being reenacted between countries such as the U.S. and Mexico (Bergquist, 1993).

Many of the core elements of exclusionary policies, such as the exclusion of poverty stricken migrants likely to become public charges, were adopted from the colonial era (Fix & Passel, 1994). Comprehensive, congressionally enacted immigration policies did not emerge until the 19th century. For example, the Chinese Exclusion Act of 1882 suspended the legal immigration channels of Chinese laborers for 10 years. The National Origins Act of 1924 placed a ceiling of 150,000 per year on European immigration, and completely barred Japanese immigration.

Conversely, the labor shortage during World War II encouraged Mexican migration to the U.S. (Fix & Passel, 1994). The first *bracero* ("hired hand" from the Spanish word *braza* to embrace) program was initiated by the U.S. as a direct result of World War II. Since most of the predominately male worker population in America had gone to war, the country desperately needed farm and industrial workers to replace them. During that period, 250,000 *braceros* were hired to work seasonally in the U.S., numbers that varied in accordance to crop requirements (Chavez, 1991; Novas, 1994).

The second *bracero* program lasted from 1945 to 1964. During that time, more than 4.5 million Mexican nationals worked in the U.S. Most *braceros* worked in agriculture, but thousands drove trucks, delivered goods to civilian populations, and challenged opposition by U.S. labor to work on the Southern Pacific Railroad. This second program evolved in response to a request by the Mexican government to the U.S. for guarantees that would ensure the health and well-being of migrant workers, minimum wages, and legal recourse in case of noncompliance by U.S. employers.

Even with these laws, employers violated many tenets of the *bracero* program. Research statistics evince numerous incidents of poor food, deplorable housing, discrimination, exposure to pesticides, and physical mistreatment. The *bracero* agreement was terminated by 1964, a casualty of farm mechanization and organized labor's opposition to this program. The flow of Mexican "hired hands" continued by way of legal immigrants, *mojados* (wetbacks), day trippers, and other commuters (Novas, 1994).

The election of John F. Kennedy as President ushered in a new more inclusionary era in U.S. immigration policy. "Kennedy, of Irish descent, had written a book, *A Nation of Immigrants*, that denounced the national origins quota system" (Fix & Passel, 1994, p. 10). His death, the growing power of the civil rights movement, and the landslide election of Lyndon Johnson provoked a momentum to integrative policies that resulted in Congressional enactment of the Immigration and Nationality Act Amendments of 1965. This law limited the number of immigrants from the Eastern Hemisphere to 20,000 per year. In 1976, this limit of 20,000 was extended to the Western Hemisphere (chiefly affecting Mexico), and triggered a great expansion of undocumented immigration from this Hemisphere into the U.S. (Fix & Passel, 1994).

The Refugee Act of 1980 entitled refugees to federally reimbursable social and medical services, and included non-European countries in the immigration flow. By contrast, the Immigration Act of 1990 implies a compromise between exclusionary and inclusionary forces regarding legal immigration policy. However, this Act did symbolize a significant major liberalization of legal immigration policy. Total admissions grew to 40%, and represent a pivotal expansion of legal immigration (Fix & Passel, 1994). Overall, the Act raised "legal immigration ... to a fixed ceiling of 700,000 annually in 1992-1994 and 685,000 beginning in 1995"

(Calavita, 1994, p. 75). Refugees and asylees are not included in these annual levels.

In California, Governor Wilson responded to increased immigration by demanding a $1.5 billion reimbursement from the federal government to compensate the State for the estimated annual impacts of documented and undocumented immigrants (Passel, 1994). Wilson's letter to President Clinton urged the President to implement several changes in the laws concerning undocumented immigrants. Wilson's efforts most severely jeopardized immigrants' well-being when he called for a repeal of the federal law that guarantees emergency health care for undocumented residents. Wilson further emphasized that repeal of such care would accompany demands for deportation (Blankenau, 1993). This episode demonstrates how governmental policies both shape and are shaped by public attitudes toward immigrants. The current popularity of the scapegoat archetype in discussions of immigration policy further confounds attempts to convey accurate information on issues associated with access to health care for this population.

Levels of Policy

Policymaking has multiple points of access through which legislators, agency officials, constituents, interest groups, and media representatives may exert influence at the local, state, and federal levels. Public policies are created by local, state, and federal legislative bodies, and judicial rulings. All three governmental levels function interdependently, thus adding to the complexity for resolution of health policy issues concerning undocumented Latinos (Hanley, 1993). Policy decisions comprise "the choices that a society, segment of society, or organization makes regarding its goals and priorities and how it will allocate its resources" (Mason & Leavitt, 1993, p. 5).

Public policies "may be called policies, plans, programs, projects, decisions, actions, budgets, rules, or regulations" (Bryson & Crosby, 1992, p. 64). Organizational policies are the guidelines and positions constructed and adopted by organizations such as health maintenance organizations (HMOs). Institutional policies are those that pertain to the financial operations and goals of workplaces such as primary health care clinics (Bryson & Crosby, 1992; Hanley, 1993; Mason & Leavitt, 1993).

The Impact of Power Distribution

As health care costs absorb an increasingly greater share of the gross national product, "subsequent Republican administrations have tried to redefine the federal-state relationship and shift health and social program costs back to the state and local levels" (Hanley, 1993, p. 73). Consequently, intergovernmental tension develops when states pursue controversial means to increase federal contributions for programs such as Medicaid to balance their budgets; e.g. taxation of institutions obtaining Medicaid funds (Hanley, 1993). Hence, policy change is traditionally perceived as "the product of a power struggle among different resources and values/interest operating within ... a changing socioeconomic environment" (Sabatier, 1988, p. 157).

The uncertainty about funding for health care services from year to year is intensified with the election of the County Board of Supervisors in San Diego every 4 years (see page 66). Increased fragmentation and reduction in health care services produced by this centralization of power will continue until there is more equal participation in the decision-making process, afforded by a more equal distribution of power between the public, coalitions, and the government (Bryson & Crosby, 1992; Sabatier, 1988; Schattschneider, 1960).

Polemical Remnants of Political Yawing and Policy Tweaking

Restrictive policies adopted by the County Board of Supervisors in San Diego are the controversial remnants from its political shifting and policy adjustments. For example, the Ryan White Act provides federal funding to San Diego County for HIV services. However, acts to ensure HIV care compete with restrictive measures by the Board regarding the designation of priority risk groups. A critical situation exists in treatment distribution due to the Board's designation of high priority risk groups (which include homosexuals and intravenous (IV) drug users) over low priority risk groups, which include Latino families with AIDS.

Moreover, the actual number of women who are HIV positive, and the number of Latinos who are HIV positive, are significantly higher than the respective representations. This lack of awareness--due to the paucity of research on the severity and prevalence of the illness--parallels the dearth of research available on this population in general (see pages 59-60). When two consumer groups (the HIV Planning Council and the HIV Coalition) were established to make recommendations as part of this legislation, their proposals were discounted by the Board.

By contrast, a decision made by the Departments of Health for the State of California and the County of San Diego to address border health issues with Mexico seemed very worthwhile at its outset. However, the hollowness of this commitment unfolded about 3 years ago when the Office of Border Health was created to address preventive health measures and promote binational cooperation between Mexico and the U.S. For example, the State and County decided to staff the Office of Border Health with <u>one</u> person. Furthermore, the impotence of this effort is particularly damaging to the Latino community, because many health problems such as TB, measles, chicken pox, or polio could be prevented by a partnership between the two neighboring countries.

The County of San Diego also decided to authorize a restrictive policy for medically indigent adults that severely impacts undocumented Latinos. For example, since San Diego, does not operate a County hospital, "County Medical Services (CMS), Department of Health Services, contracts with both the public and private sectors to form a network of providers of health care to eligible medically indigent adults" (Regional Task Force, 1991, p. 24). However, the County's Indigent Contract with a local health care organization, cut the funding in half--twice--with an eye toward reducing or eliminating health care for undocumented Latinos.

Access to Health Care

Access to health care is a complicated issue, comprising numerous facets that are sometimes difficult to understand. When health care issues are discussed, basic language differences often serve as the spark for endless debate. Despite a common language, differences in background, race, culture, education, religion, and experience present barriers to communication between individuals and groups (President's Commission for the Study of Ethical Problems, 1983).

To understand what the term "access to health care" means, it is first necessary to examine the relationship between health care, the quality of life, and societal responsibility. At its core, access to health care implies "freedom from barriers to health care" (President's Commission for the Study of Ethical Problems 1983, p. 82). Fear of deportation, poverty, racial/ethnic discrimination barriers, language barriers, lack of transportation, lack of financial resources and educational opportunities, and lack of Latino health care providers represent several such barriers that often constrain or prevent the utilization of health care services by immigrant populations (Caudle, 1993; COSSMHO, 1995; Eisenstadt & Thorup, 1994).

The process of understanding access to health care is further complicated because few researchers have studied undocumented Latinos' health needs, health status, health beliefs, health behavior, or family roles. Consequently, this population has been called the "silent or invisible minority" (Caudle, 1993; Del Portillo, 1988). Latinos are the second largest minority group in the country. During 1980-90, the Latino population grew 53%, with Central and South American natives representing the fastest growing sectors (Committee on Small Business, 1994).

In 1990, there were 22.4 million Latinos in the U.S., comprising approximately 9% of the total population. Women represent about 10,966,000 (49%) of this population. These figures exclude the approximately 3.5 million residents of Puerto Rico and undocumented workers, a group estimated at between 3 to 6 million. The unregistered status of undocumented persons decries any attempt to enumerate their presence in the U.S. today (Committee on Small Business, 1994; Juarbe, 1995; Lillie-Blanton et al., 1993).

The rapid increase among this population in the U.S. affords a variety of factors that contribute to poverty as a barrier to health care and warrant research study. Given the spatial limitations of this dissertation, My study focuses on those barriers I find most compelling; poverty, racial/ ethnic discrimination, and language. For example, poverty impacts the rise in morbidity and mortality among Latinos.

Poverty as a Barrier to Health Care

Despite the growing population and increasing numbers of Latinos living in poverty, "little is known about their health and nutritional status and their participation in public assistance programs" (Poverty and Hunger, 1988, p. 2). As late as 1988, only 30 states included a Latino ethnic classification on state-issued death certificates. Misclassification is a significant problem plaguing attempts to accurately enumerate infant mortality statistics. A recent study showed that 30% of infants assigned a specific Latino origin at birth were assigned a different origin of death (Lillie-Blanton et al., 1993).

In general, poor Latinos are at a higher risk for conditions of unrecognized and/or untreated hypertension, diabetes, and obesity than their more affluent counterparts or impoverished white counterparts. Hypertension is more prevalent among Latinos than whites. Compared with whites, Latinos have 3 times the risk of diabetes. Obesity and diet are largely correlated with diabetes in Latinos (Council on Scientific Affairs, 1991; Estrada, Trevino, & Ray, 1990).

The impact of Latinas' poverty upon this group's access to health care is a major factor in the lack of prenatal care and resulting infant mortality. Latinas are also 3 times less likely than non-Latinas to receive prenatal care, which contributes heavily to the morbidity rates of poor Latina mothers and infants (Council on Scientific Affairs, 1991).

For example, health risks are intensified by the incidence of tuberculosis (TB) that is 4.3 times greater for Latinos than whites. Researchers suggest this increase relates to latent TB infection, activated by the human immunodeficiency virus (HIV) among Latinos. In fact, Latinos account for 14% of reported acquired immunodeficiency syndrome (AIDS) cases; nearly 21% of AIDS cases among women; and 22% of all pediatric AIDS cases. AIDS has become the leading cause of death among women 25-34 years old (Council on Scientific Affairs, 1991). This conveys an ardent message--germs do not need to carry greencards! Germs defy minuscule measures to contain them by actuating morbidity and mortality --their proof of residence.

Utilization indicators suggest that racial/ethnic discrimination barriers to care persist, particularly among low-income women. According to this data, Latinas are less likely to visit a physician, make fewer visits per person, and obtain less hospital care than white women. For example, 23.3% of Latinas were without a physician visit in 1988, compared with 19% of African American women and 18.4% of white American women with incomes under $10,000. Despite a greater incidence in reporting poor health than white Americans, Latino Americans are less likely to receive hospital care (Lillie-Blanton et al., 1993). Moreover, data collected on medical care expenses among Mexican women in San Diego, California raised the specter of "second class" care, provoking a 1983 presidential commission to hypothesize that poor women receive correspondingly "poor" quality of care. Many of these women are in the country without proper documentation from the U.S. Immigration and Naturalization Service (INS), and so encounter constraints on access to government-sponsored health programs (e.g. Medicaid) (Chavez, Cornelius, & Jones, 1986; Lillie-Blanton et al., 1993).

In a similar fashion, the financial self-interest of physicians may transcend their obligation to collaborate with hospitals as public service providers. They instead prefer to remain autonomous and provide private, fee-for-service health care individually, in group practices, or through contract services with hospitals. Medicine's evolution as a private enterprise has historically been maintained as an autonomous process. This autonomy has been the foundation of the American Medical Association (AMA) throughout its existence. As a result, private physicians are not obligated to care for patients who cannot pay for services rendered. The first piece of information physicians usually obtain from patients is their medical insurance coverage for health care.

Numerous studies have designated language differences as one of the main barriers for Latinas requiring access to health care. For example, Solis, Marks, Garcia, and Shelton (1990) found that spoken language is a stronger predictor than written language in utilization of health care services for Mexican women, but not for Puerto Rican or Cuban women. The authors concluded that the ability to speak English is directly associated with increased access and utilization of health care services. Language differences between patients and health care workers accentuate restrictions on access for Latinas. For instance, Latinas who speak only Spanish are less likely to understand how to access preventive health care services than English-speaking Latinas (Council on Scientific Affairs, 1991; Juarbe, 1995).

Language barriers foster powerlessness by limiting the health choices of Latinas. This group's opportunities are limited by language barriers that prevent them from obtaining access to information and resources for medical treatment, prenatal care, contraception, sterilization, and abortion. Latinas are further excluded by virtue of language limitations from understanding the benefits and risks of health-related decisions (Juarbe, 1995), and from grappling with competing policies, etc., especially those bound up in immigration policy.

Effects of Competing Policies on Health Care

Immigration policy in the U.S. is a pivotal issue characterized by two polarized views. The first group advocates an inclusionary view in which the nation serves as a refuge for the world's dispossessed without exception. At the other end of the spectrum stand those who believe immigration policy should admit only those immigrants who add to the U.S. economy and society, and excludes those who might become a burden (Fix & Passel, 1994). This fundamental tension--evident throughout the evolution of immigration--is vividly reflected in the controversy over California's response to Proposition 187 in 1994. Governor Pete Wilson declared that the state will abolish prenatal care to illegal immigrants on December 1, 1996 under terms of the new federal welfare law, however, "immigrant advocates are seeking a federal court order to block the governor's plan as a violation of the injunction against Proposition 187" (McDonnell, 1996, p. A26). Accordingly, Proposition 187 is discussed in several sections of the dissertation.

Cornelius (1981a) attributes the continued immigration of Mexican workers seeking employment in the U.S. to their attempts to meet "basic human needs" (p. 10). The income these workers earn in the U.S. "may make the difference between adequate medical care or death from lack of it" (Cornelius, p. 11). Such essential human needs will continue to drive Mexican workers across the U.S.-Mexican border, no matter how severely U.S. immigration laws are enforced (Cornelius, 1981a).

Bergquist (1993) argues "we must honor the differences" (p. 41) rather than defeating and banishing people who we perceive are different from us, and who compete with us for space and resources on a densely populated planet. However, the gap between the goals of national immigration policies and the results of these policies is "wide and growing wider ... thus provoking greater public hostility toward immigrants in general and putting intense pressure on ... government officials to adopt more restrictive policies" (Cornelius, Martin, & Hollifield, 1994, p. 3).

This recent trend stands in sharp contrast to the governmental programs of the past 35 years, since 1960, which produced significant changes in access. For instance, Title 6 of the Civil Rights Act of 1964 increased the flow of federal dollars to health care for minority populations. The creation of the Office of Equal Health Opportunity within the Public Health Service contributed more to the advancement of increased access than any other single program. Hospitals were thereby forced to end discriminatory practices based on race to qualify for federal funds. Title 18 and Title 19 of the Social Security Amendments of 1965 increased access to those over 65 years of age, and the very poor through the creation of Medicare and Medicaid programs (McCabe, 1993; President's Commission for the Study of Ethical Problems, 1983). In addition, the federal government funds rural health centers in California, Oregon, Washington, and other states. Urban clinics receive funds through the Public Health Services Urban Health Initiative. Such health care centers provide primary care regardless of the immigration status of the patient receiving care.

The current cycle of austerity characterized by diminishing funds for health and social services, has provoked significant challenges to this nation's commitment to the above-mentioned measures (Eisenstadt & Thorup, 1994). This political dilemma is the crux of a "schizophrenic" (Hoffmann, 1965, p. 189) policy "that would yield yet another deficit to be passed on to later generations, the deficit of uplifting those left behind" (Martin, 1994, p. 98).

The direction of health care reform is further threatened by "compassion fatigue" in the U.S. This syndrome is shaped by the myriad images that come to mind "when stories of homelessness, violence, and suffering are falling on deaf ears that can no longer bear to listen" (Behar, 1993, p. xii). Moreover, efforts to surmount challenges to this nation's commitment for health care funding face intense opposition from a public and its politicians deluged by media presentations outlining the undocumented Latino "drain" on the economy. The media thus reinforces compassion fatigue which subsequently fuels competing policies. However, the willingness of government officials to transcend the status quo might forge the shaping of policies that eradicate "compassion fatigue" and austerity as barriers to reform (Cornelius et al., 1994; Eisenstadt & Thorup, 1994).

Visions of Health Care and Social Justice

Cornelius (1981b) envisions a U.S. policy concerning undocumented migrants from Mexico that could be expanded to include all undocumented immigrants. His hypothesis is based on a system comprised of temporary work visas and a newly created preference category for permanent legal immigration. The pivotal point of this approach transposes "the problem" of undocumented immigrants away from traditional associations (taking jobs, depressing wages, using social services, etc.) to the consequences that flow from their illegal status, such as fear of seeking health care, vulnerability to exploitation, fear of participating in union organizing activities, etc. This policy prescription does not eliminate undocumented immigrants, or attempt to exclude them by "barring the door," but rather concentrates on eliminating their illegal status (Cornelius, 1981b).

Literature suggests that the main objective of U.S. policy concerning undocumented immigrants ought to be directed toward reducing the size of the undocumented component within the immigrant population. A reduction in undocumented immigrants would decrease our tendency to depersonalize immigrants through group classification, and instead allow our vision to focus on the individual human being (Cornelius, 1981a; 1981b; Curry Rodriguez, 1988; Nagengast, Stavenhaven, & Kearney, 1992).

This proposal to reduce the undocumented flow of immigrants focuses on one component of a new U.S. policy concerning undocumented immigration, primarily that emanating from Mexico. At present, the system of U.S. immigration laws and policies is geared to permanent legal immigration. However, all available evidence from studies indicates that short-term undocumented migrants based in Mexico constitute the majority of Mexicans employed in the U.S. in any given year. This proposal maintains that those Mexican workers who wish or need to work in the U.S., but who need or want to maintain their permanent homes in Mexico, should do so legally whether or not they qualify for admission to the U.S. as permanent residents (Cornelius, 1981b).

The proposed system would involve issuing temporary worker visas of a predetermined number on a first-come, first-served basis, through U.S. consular offices in Mexico. Workers holding these visas would then be classified as free agents in the U.S. labor market, subject only to a time limitation (an annual 6 month limit on length of stay for up to 5 years and renewable for another 5 years). If the temporary visa holders applied for permanent resident status at the end of the initial 5 year period, this "sweat equity"--the time spent working in the U.S. and adhering to the terms of the temporary visas--would place the workers and their dependents in a newly-created preference category. Although this would not guarantee permanent resident status, this process would expedite the adjustment-of-status process. Each visa holder would be subject to computerized programs and border checkpoints that monitor compliance and record entry/exit data. Violators of the time restrictions would have their visas canceled (Cornelius, 1981b).

U.S. employers would have to compete for this legalized temporary labor on a free-market basis by offering competitive wages and working conditions. While employed in the U.S., workers would be permitted to bring their dependents with them. A range of benefits would extend to the worker's dependents. School-age children would have access to tuition-free public education. Workers and their dependents would also have access to emergency and nonemergency health care at public facilities, the cost of which would be covered by the worker, the employee, or labor union. Visa-holders would be encouraged to join workplace-based group health insurance plans. Since visa holders are entitled to join a labor union, they would be eligible for the full range of benefits offered by the labor union, including health insurance (Cornelius, 1981a; 1981b; Nagengast et al., 1992).

Cornelius (1981b) proposed a system based on the following principles:

1. To promote the quality of life for individuals;
2. To protect individuals' vulnerability to exploitation;
3. To meet individuals' needs for human services, especially health care and education;
4. To support individuals' freedom of choice regarding a permanent place of residence.

This system could be extended to other key source countries, such as in Central and South America, after a trial period of 3 to 5 years. The detrimental effects of the program would primarily affect those who profit from the existing system of U.S. immigration laws and policies. These profiteers include "coyotes" (professional smugglers of migrant labor), employers who pay below the legal minimum wage, exploitative landlords, merchants, and all others who take advantage of the vulnerability of undocumented migrants (Cornelius, 1981b).

Finally, it should be recognized that the current wave of Mexican migration to the U.S. is the outcome of "literally millions of uncoordinated decisions by individuals, kinship groups, and employers on both sides of the border" (Cornelius, 1981a, p. 10). By contrast, this proposed policy is based on the integration of decisions. Cornelius' hypothesis offers a dynamic vision for the future because its principles promote increased quality of individual life and that of the common good in the central areas of health care, education, and social justice (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1991).

Coming to Terms With Competing Policies

In order to come to terms with competing policies, it is essential to move toward "a better understanding of the factors affecting a specific policy over time" (Sabatier, 1988, p. 157). Moreover, this increased understanding does not guarantee the termination of policy conflict (Sabatier, 1988; Sochalski, 1993). For example, Medi-Cal eligibility requirements and scope of benefits have been significantly reduced from their original status, and are currently the center of controversy over increased restrictions. According to Sabatier, as long as actors with political resources determine that the costs of present policies are undesirable, "agreement on some aspects of the problem and on the probable consequences of some policy alternatives will not lead to a policy consensus" (p. 157).

Instead, an analytical debate among different coalitions moves toward a distillation of the principals' understanding of the problem, the importance of relationships, and the consequences of policy alternatives. The conflict will persist until all major interests find a combination of policies to be acceptable (Sabatier, 1988; Sochalski, 1993). One such consensus is exemplified by the integration of California's State Medi-Cal program with a managed care program, which includes cultural and linguistic competence standards advocated by community organizations. These groups worked to ensure that language rights of non-English speaking individuals were protected. Of course, unless these standards are implemented effectively in combination with managed care and Medi-Cal, clashes of interests will resurface. To forestall such conflict, coalitions such as the Latino Coalition are collaborating with the State of California to facilitate implementation of competence standards ("Task Force Delayed," 1996).

Further, the acceptance of common core values in a world of limited resources offers all parties powerful incentives to acquire knowledge about the dimensions of salient problems, the forces affecting them, and the ramifications of policy alternatives (Sabatier, 1988). This "common humanity" also offers hope for increased convergence on global and local issues such as air pollution and health care. With increased emphasis on the importance of communication and dialogue, competing professionals may more readily find themselves compelled to address each others' findings if they are to achieve a better understanding of the interrelation of complex policy and the populace over time (Sabatier, 1988; Sochalski, 1993).

Health Care Leadership Implications

A collaborative, multilevel health care leadership awareness, and accompanying commitment to enhance the quality of life and the good of society are fundamental prerequisites if we are to be successful in our attempt to forge consensus in health care policy. "Transformational leadership and the skilled exercise of the balance of power is essential" (Reason, 1994, p. 334), therefore, on the part of collaborators charged with this development.

Salient efforts in health care policy formulation require the selection of an appropriate tool or policy choice--"be it a grant, ... a new regulation, ... or the provision of direct" (Rist, 1994, p. 553) health care services to undocumented Latinas. Furthermore, enlightened leadership from participatory inquiry about health care policy promotes a deeper understanding of how health care policy tools are "used to achieve ... health care policy objectives" (p. 553). Hence, a crucial issue for leadership in health care policy is knowing "how to link those in the research and academic communities ... to those in the policy arena who can commission such work and who will make use of the findings" (Rist, p. 556).

Qualitative research aims that are consistent with enlightened leadership include interaction, conceptualization, and resolution with policies that compete with one another (Silverman, 1993; Sochalski, 1993). Enlightened leadership can deliver qualitative work directly into the policy arena (Abascal-Hildebrand, 1993).

Summary

The complexity of U.S. health care policy is embedded in those policies that serve to maintain rather than overcome the influence on limited access to health care. Some groups are trying to turn the issue into a national immigration issue. Even now, the advocates of Proposition 187 are intensifying their efforts through a movement to nullify the 14th Amendment. This action would deny citizenship to U.S. born children of undocumented mothers ("Prop. 187," 1995). Augmenting this drive, President Clinton has promoted an aggressive campaign to "triple the number of deportations from the current figure of about 40,000 per year" ("Clinton Assails," 1995, p. A5).

As a result of these initiatives, Elaine Elinson of the American Civil Liberties Union argues, "It is part of this overreaching mean-spirited xenophobia which is dictating a lot of proposals" ("Prop. 187," 1995, p. A3). Calavita (1994) points out however, that the nature of the immigration "problem" may have less to do with the ineptitude of Congress to find a solution than it does with reaching "a consensus on what is the problem" (p. 77). I explored several methodologies to facilitate knowledge and understanding about health policy for creative solutions to the immigration problem and health care access.

I selected a qualitative methodology as the most appropriate form of inquiry concerning this social issue for two reasons; first, to foster more understanding about health care policy formulation and implementation, and, at the same time, to expand my knowledge base concerning the effect of competing policies that limit health care access for Latinas.

CHAPTER 3

Methodology

Introduction

The heart of action theory and social inquiry methodologies is a worldview that emphasizes participation as its core strategy. To understand the way in which the methodology focuses on participation, I offer the following six sections; (a) methodological overview, (b) research design, (c) data collection, (d) data analysis, (e) summary, and (f) background of the researcher.

We fuel our participation for social transformation by holistic and systemic thinking. From this starting point, we create knowledge both in action and for action (Reason, 1994). Action science is concerned with the beliefs and agreements about the "development of effective action that may contribute to the transformation of organizations and communities towards greater effectiveness and greater justice" (Reason, p. 330). Therefore, I sought to engage the participation of health care providers so that they themselves could join me to suggest action through an examination of policies that promote or constrain access to health care, and so that together we might create a study to enlighten leaders to pursue democratic initiatives for a social transformation of health care (Reason, 1994).

Methodological Overview

A normative theory of action "that promotes a spirit of open inquiry" (Reason, 1994, p. 330) is identified by Argyris and Schon as Learning Model II. One rule presented in this model states that people should not "use power or hierarchical position to obstruct the cooperative process" (Stacey, 1996, p. 142). People ought to cooperate and participate in a quest for win-win solutions; analyze the information, produce the options, suspend them for public discussion and testing; and stand amenable to changing their mind in the light of that testing (Stacey, 1996).

This model incorporates features of the alternative world that action science seeks to create, a world that is premised on the principles of valid information, free and informed choice, and internal commitment. Action science focuses on the implicit cognitive models of practitioners and their actual verbal actions, while action inquiry addresses the questions of how to transform organizations into collaborative, self-reflective communities of inquiry (Reason, 1994; Stacey, 1996).

Dialogical retrospection embraces the aforementioned principles for transformation through the participants' recollection of events that impact health care policy such as the wave of volunteerism during the Vietnam War. This reciprocal process of exchange empowers the participants to "influence each other's points of view, ... discuss results and determine the course and outcome of the research"

(Schrijvers, 1991, pp. 169-170). Consequently, newly acquired insights emerge--currently known as the Ah, Ahs!" Moreover, the experience of sharing viewpoints as part of a future search facilitates closure by acknowledging participants' contributions to the study.

Criteria for data analysis in qualitative research are distinctive. Unlike quantitative research, in which rigor is evaluated by how well threats to internal validity have been managed and the validity of instruments assessed, qualitative research is more suitably assessed by credibility. Maxwell (1992) notes that "validity refers primarily to accounts; not to data or methods ... and is relative to purposes and circumstances" (p. 283). Credibility is therefore, strengthened when true to life descriptions of the experience "are recognized by the people who had the experience or by others who recognize the experience after having read about it" (Nyamathi & Schuler, 1990, p. 1284).

The reliability factor in quantitative research is based on the assumptions that replication of testing procedures is possible, and there is an observed regularity about human experiences. By contrast, qualitative research emphasizes the uniqueness of human experience that may not be accessible to validation through the senses (Maxwell, 1992; Nyamathi & Schuler, 1990). Auditability, rather than reliability, thereby serves as the criterion for rigor in this qualitative study. Auditability is the "condition in which another researcher can clearly follow the analysis pattern used by the researcher in the study" (Nyamathi & Schuler, p. 1284).

Future Search

The concept of future search incorporates the research questions from this study into this theory of action inquiry to develop "areas for action which ... reduce the gap between the desired and the passive pictures of the future" (Brokhaug, 1992, p. 98). Future searches create opportunities for knowledge and understanding about the connections between present reality and future potential, i.e. what health care ought to look like for undocumented Latinas, and what changes in public policy may be necessary for movement in this direction.

I first approached the research questions through a pilot future search. The future search of the focus group produced other ways to create change. These solutions addressed the issues of what an ideal health care system should comprise, and disclosed some policy revisions necessary to change existing conditions that obstruct access to health care. Furthermore, the virtue of focus groups derives from a central premise that the "explicit use of the group interaction [produces] data and insights that would be less accessible without the interaction found in a group" (Morgan, 1988, p. 12).

Pilot Study

Using a focus group comprised of five participants, I conducted a pilot study to explore how a future search might initially shape the study. Four of the five pilot participants were in the nursing profession; all have had experiences with undocumented immigrants. The fifth participant, a Chicano activist, was executive director of an agency involved in human and civil rights for undocumented immigrants.

Basic to the concept of future search, I brought the participants together to discuss their visions about what health care ought to look like for undocumented Latinas; these visions cluster in three themes: (a) the dismaying lack of understanding by the public, politicians, and undocumented immigrants about health care costs, (b) the uncertainty about the outcomes of pending legislation, such as Proposition 187, and (c) concerns about the current transition regarding health care reform, health care policy, immigration policy, and economic constraints. During the course of the discussion, the group produced a number of potential action plans to address the preceding themes: educating the public and politicians, letter writing campaigns to government officials, and grassroots activism. The data from this meeting illustrate a fundamental goal of action research, as this initial meeting served to generate rapport with participants and establish effective communication patterns (Carey, 1994; Denzin & Lincoln, 1994).

In addition, the future search offered a "concentrated insight into participants' thinking" (Morgan, 1988, p. 31) about health policy and health care access, especially beneficial at the beginning of the research study. Hence, the data from the pilot future search were used in the data analysis. The data analysis, implications, and recommendations addressed the linkage between health care reform and the direction of public policy and were reported in Chapter 4.

Research Design

Entry to the Population

My professional nursing background afforded me access to potential participants through nursing faculty referrals, political resources, preventive care management resources, U.S.-Mexican transborder organizations, and cultural workshops such as the Social Issues Committee Communities in Flux Workshop held at the University of San Diego (1995). I identified participants who serve Latinos on the basis of two criteria: their experiences with undocumented immigrants, and their willingness to share their viewpoints (Morgan, 1988).

Selection of Subjects

I recruited the participants by phone, as all were living or working in the San Diego area. This was a criterion for the selection of participants because San Diego is one of the largest cities in the southwestern U.S. facing health policy issues concerning undocumented immigrants. This group comprised selected health care providers, preventive health care managers, representatives from U.S.-Mexican transborder organizations, and political activists who have had experiences related to undocumented immigrants. All of the participants each had over 10 years of professional work experience with undocumented Latinos (see Appendix E). I invited them to participate in two individual field interviews, and a focus group interview. Contact visits to each followed the initial call. During these visits, we discussed the nature of the study, and the process of informed consent; I also used the meeting to ensure that each party met the selection criteria for the study. I presented an oral overview of the study, and delineated the requirements of the study for the participants (Seidman, 1991), and the means by which they would be protected as subjects.

Protection of Subjects

Prior to the interviews, I answered any questions about the nature and purpose of the study from participants. Interviews were audio-taped, and then transcribed by a privately-employed transcriber for the purpose of analyzing emerging themes (Morgan, 1988).

First, I provided an explanation of the study and secured participants' consent to engage in the study. I informed the participants that they were not obligated to participate in the study; that the study was not part of their job, so they would know there was no jeopardy if they declined to participate; that they could stop or leave the interview at any time; and that they could refuse to answer any questions.

I did not disclose the participants' identity in my report on the findings in Chapter 4 of this study. To facilitate accuracy and to ensure participants' anonymity (Seidman, 1991), I returned a transcript of the individual interview to each participant with a letter that stated that they should please feel free to make any corrections on the transcripts ... to assure accuracy and to be sure the data do not reveal your identity. I sent each a copy of the informed consent form (see Appendix A) which included a statement of their rights as subjects as well as the names and phone numbers of contact persons should they have questions (Morse & Field, 1995).

I identified video and audio tapes by an interview code number and a participant code number, and kept the tapes and codes in a locked file cabinet. I coded the transcripts to protect the identity of participants, and to report the outcome of the study. All identifying information was omitted from the tapes before the transcription process, and all tapes were destroyed upon completion of the transcripts. I maintained the informed consent forms in separate form from the data (Morse & Field, 1995), and will do so for a period of four years from the date of this dissertation.

Approval for this research was obtained by the Committee on the Protection of Human Subjects (CPHS) at USD in February, 1996 (see Appendix F). Data collection started in March, 1996.

Data Collection

Interviews

Denzin and Lincoln (1994) highlighted the interview as the preferred methodological technique for the qualitative researcher. I combined qualitative data collection methods to engage eight participants in two field interviews and a focus group for 60 to 90 minutes each.

I arranged a second interview with individual participants, which was aimed toward a distillation of preliminary assumptions from the data analysis. This process was facilitated by an examination of the individual interview transcripts and a summary sheet previously sent to each participant. The summary sheet included main ideas, themes, explanations, speculations, and summary statements (Miles & Huberman, 1994). Six participants made grammatical corrections and contextual comments on their transcripts. I also held phone conversations with selected participants to elucidate their ideas for the sake of clarity.

Subsequent to the second interview, I conducted a focus group interview with the same participants. The ideal composition of focus groups is seven to 10 participants, which promotes expression of experiences (Morgan, 1988; Nyamathi & Schuler, 1990). A focus group can clarify those areas clouded by the number of different viewpoints generated during individual interviews. The overriding goal was to conduct enough sessions to provide sufficient responses to the research questions (Morgan, 1988). Since "the common rule of thumb is to overrecruit by 20%" (Morgan, 1988, p. 44), I invited 10 individuals to participate in the focus group to compensate for no-shows. Participants were not sent a transcript of the focus group interview.

Their participation in the study was originally expected to conclude after the focus group interview. One of the participants, however, possessed such a reservoir of information concerning advocacy coalitions such as the Latino Coalition for A Healthy California that I decided an additional follow-up interview with this participant would be valuable. This inquiry provided knowledge about the ways in which "coalitions seek to translate their beliefs into public policy" (Sabatier, 1988, p. 142).

In an attempt to seek greater knowledge and understanding about methods of resource mobilization for health care programs, two of the participants and I searched beyond the boundaries of San Diego by attending the Latino Coalition for a Healthy California on May 17-18, 1996, in Los Angeles. This trip also afforded the opportunity to understand how intergroup power relations mold policymaking (Bryson & Crosby, 1992) and how dialogue and discussion foster exploration of health policy ideas from groups of health activists.

This coalition experience validated my use of guiding interview questions in all sessions to support the exploration of participants' viewpoints (see Appendix B). As expected within this methodology, the discussions generated additional questions. All of my questions were open-ended and included suggested prompts. At the end of the interview process, I provided participants with an opportunity to ask any questions themselves and, further, to identify what questions they should have been asked that were not. The interviews lasted approximately 45 to 60 minutes. The interview process sparked a free flow of ideas, and fostered further exploration of participants' experiences. The interviews varied in scope, length, and complexity in accordance with the range of participants' experiences with health care for undocumented Latinas (Morse & Field, 1995; Seidman, 1991).

I sent a follow-up letter to the participants to confirm the date, time, place, and location of the interviews and focus group (see Appendixes C and D). The Media Center at USD served as the site of the focus group interview. One audio tape recorder and one video tape recorder were used to record this session.

Individual field interviews ensued at a mutually arranged place convenient to the participants and me. If further participant data were desired, I conducted follow-up phone conversations and/or follow-up interviews (Kleffel, 1994). However, these phone conversations were limited to specific topics in an effort to fill in data gaps.

Focus Group

The focus group was a collective endeavor to comprehensively address the spectrum of research questions. The session was conducted from 9:20 a.m. to 11:15 a.m. on May 13, 1996 in the Media Center. Eight out of 10 participants attended the focus group. One of the two alternates replaced a participant who was unable to attend. The remaining alternate participant did not attend.

Most of the participants had previously met. They were also familiar with each other's work in the community. In addition, they were spontaneous and energetic in expressing their viewpoints. As one participant commented at the end of the focus group, "[The discussion] was very empowering--very, very empowering.... You can make changes. It may take a lot, but you can do it."

Data Analysis

The approach to data analysis was designed to determine whether existing access to health care for undocumented Latinas "has improved, worsened, remained static; ... whether the condition has spread or contracted; and whether the aims of the program ... still match the assumptions and previous understandings of the condition" (Rist, 1994, pp. 550-551). Data analysis was the ultimate stage "of listening to hear the meaning of what is said" (Rubin & Rubin, 1995, p. 226).

There were five parts to facilitate this process. First, I reviewed data from the individual field interviews and focus group for potential trends and patterns. Second, I conducted content analysis by identifying understandable and meaningful examples, themes, and patterns in the data (Patton, 1987). Third, I used the "scissor and sort" approach to mark, copy, cut apart, and sort relevant passages in the transcripts (Morgan, 1988). Fourth, I discussed data across the themes to enhance readers' understanding of a broader view of data and speculations for data analysis. Fifth, I developed a categorization in a matrix display that included three levels of policy--public, organizational, and institutional--to classify data on policies that facilitate and constrain access to health care (Aroian, 1990; Mason & Leavitt, 1993; Sandelowski, 1995).

I analyzed the data to formulate a collective narrative detailing those policies that create barriers to health care, and delineating those policy revisions that may be required to improve access to health care for undocumented Latinas. Analysis continued until saturation occurred; saturation refers to that state at which no new data or categories can be identified (Richardson, 1990; Strauss & Corbin, 1990). Analysis is complete when "you have developed your overarching themes" (Rubin & Rubin, 1995, p. 255) from the relevant data, and possess sufficient responses to implications such as "Who cares?" and "So what?" The process ends when "you feel you can share with others what the interpretations mean for policymaking, for theory, and for understanding the social and political world" (Rubin & Rubin, p. 227).

Summary

The fundamental components of this methodology underscored an approach aimed toward promoting the spirit of social inquiry. This process facilitated the accumulation of information and perspectives, held different viewpoints up for discussion and testing, fostered openness to changing views in the light of that testing, and generated options. As part of this process, I presented the necessary steps to address the research questions; conveyed the importance of credibility and auditability; identified interview techniques for data collection; and articulated the stages in the data analysis (Creswell, 1994; Stacey, 1996).

These qualitative findings developed from interactions with and among those participants whose viewpoints supplied meaning to the research questions. The unfolding and analysis of public policies therefore occurred more naturally, because I, too engaged in the cooperative, social inquiry process with the participants. The findings represented the singular viewpoints of these health care providers and political activists who live in the southwestern U.S. The viewpoints and the interview themes that emerged are, of course, not necessarily the views of the general public, other health care providers, political activists, or individuals involved in other disciplines, though the process may be undertaken elsewhere.

All of the participants requested a summary of the study to support their quest for increased knowledge and understanding about this issue. I offered the following information about my background to enable this group and subsequent readers to understand my choice of topic, methodology, and analysis.

Background of the Researcher

I have identified the following biases in order to articulate the conceptual framework for this study. As a nurse, I am a health care provider who advocates improved health care for undocumented Latinas. As a woman, I feel compelled to deepen the level of understanding about the barriers Latinas encounter in their attempts to access health care. Furthermore, my education evinces a feminist perspective, that developed significantly during graduate school. I attended Boston University School of Nursing and graduated with a B.S. degree. I attended Boston College, 3 years later and received a M.S. degree in a Psychiatric Clinical Nurse Specialist program in 1977. My clients during these years were primarily female. Through this exposure, I became increasingly aware of the need to make women's health issues more visible, especially those of Latinas.

Finally, I am committed to heightening individual and group awareness of inherent biases through an ongoing endeavor to create policy with health care providers and researchers, "as we try to make sense of our social world and give meaning to what we do as researchers" (Janesick, 1994, p. 212). Therefore, I used this research to uncover the leadership implications for "commitment in the face of attractive temptations" (Reason, 1994, p. 334) to counter tendencies to maintain the status quo, and to cultivate more socially just health care policies that affect particularly vulnerable populations.

CHAPTER 4

Presentation and Analysis of the Data

Introduction to Data Themes

This chapter offers a data analysis for enhancing knowledge and understanding about several policy revisions required to change the contradictory conditions affecting health care access for undocumented Latinas. The data are complex, and interrelated, because their categories all concern the way in which health care policies compete with one another. For the sake of clarity, the data are presented in four interwoven categories.

The first category refers to multiple sectors of differing interpretations. These interpretations are evident in the hostility and resentment emanating from the public and politicians over the provision of health care for this population, even that care designed to prevent contagion and mortality. This ignorance is produced by cultural beliefs and a lack of information concerning the nature of illnesses, such as AIDS. On their part, state and federal governments show little consensus on what constitutes emergency care, and related issues such as the impact of permanent residence requirements. This ignorance is further exemplified by erroneous notions about the Latino population from participants in the study and the public regarding the actual population figures of this group and its utilization of health care services. Lastly, the interpretation gap is illustrated by politicians and the public ignoring the call for holistic health care from providers and patients for migrant outreach programs.

The second category refers to uncertainty about funding for health care services. Uncertainty in all groups thus mentioned is caused by policy roulette over legislation such as Proposition 187, and is perpetuated by such issues as Medi-Cal fraud investigations, and the INS's present interference policy. Finally, it is reflected by the problematical impact of legislation to limit funding on health care.

The third category refers to tokenism offered by superficial programming for health services. This lack of serious commitment is a product of the wave of reduction in health care services based on the erroneous belief that undocumented Latinos are draining the health care system. This theme is intensified by the media, and works to reinforce distortions about health care costs for inflated numbers of undocumented Latinos. Tokenism unveils itself through the federal government's proposal to block grant Medi-Cal funds in the guise of cost-containment efforts by physicians and hospitals to uphold for-profit services. Finally, tokenism symbolizes polemical remnants of political yawing and policy tweaking. These remnants are usually transformed into restrictive policies, such as the Zero Tolerance policy adopted by the County of San Diego that eliminates public services for undocumented Latinos ("Q & A: Doris Meissner," 1995).

The fourth category concerns power shifting and policy shaping in health care policy. The concept involves the shift of power from federal to local jurisdictions. This process illustrates the difficulty in creating change, adding to the frustration of participants over their lack of influence regarding federal and local legislation. This process also conveys how the contrary use of data as a "double-edged sword" can be and is used to harm this population, and inspires this search for solutions to create change. Data associated with this category highlight the negative power of inaction from organizations such as the California Hispanic-American Medical Association (CHAMA), and accordingly, call for empowering Latinos through collective action.

In order to prepare the reader for understanding a broader view of data and making speculations for data analysis, I discuss data across the categories. The advantage of presenting data in this pattern is that it facilitates the fulfillment of the ultimate purpose of the study. The differing interpretations about the structure and function of the health care system convey the first of the interrelated themes that pose barriers to the creation of socially just health care policies.

Differing Interpretations

Hostility and Resentment

Interpreting the obstacles to health care within the structure and function of the health care system is a very difficult and complex process, especially for undocumented Latinos. Obstruction occurs on all three policy levels--public, organizational, and institutional. According to a participant who is a health care activist, this difficulty is further intensified when some health care workers display a superior "attitude of greatness and power" toward this group, making it extremely unpleasant for them to obtain health care services.

The situation is further complicated when health care workers demand that those undocumented Latinos who do not understand English are required to bring interpreters to fill out mounds of paperwork. This demand is usually voiced after the patient has spent hours waiting to receive assistance. This power syndrome exemplifies the attitude that shapes restrictiveness, and that typifies the U.S. health care system, wherein only those people with language skills, or with strong support systems, possess the means for the basic understanding required to access health care.

When undocumented Latinos are faced with sizeable resistance and voluminous application forms from public servants on the other side of the counter, the confrontation can be a devastating experience. The aforementioned health care activist refers to this situation as the "Behind-the-

Counter" syndrome. He characterizes the typical experience, " ... like climbing Mt. Everest for these people. They have to walk away and say, I'm not able to do it.... So it tends to discourage them." Differing interpretations are fueled by some politicians' interwoven perceptions that undocumented Latinos are undeserving of health care, and further, are draining the system. This apathy syndrome, in which the public and politicians neglect their responsibility to prevent contagion and mortality, and promote the public good, seriously violates the health and well-being of this relatively powerless group.

The public's stance toward institutional public service for undocumented Latinos mirrors these differing interpretations. It is extremely difficult for hospitals to provide public services, such as primary health care, while simultaneously experiencing and responding to public outrage over the provision of these services. The display of public outrage extends from beyond verbal expressions to use of formal channels such as sending angry letters that target hospital administrators. Public resentment flows from the same vessel from which some officials drink--the belief that undocumented Latinos are not entitled to receive health care services, and, as well, are draining the system. A former health care administrator shares what she experienced from the general public, "I got hate mail that people said, I don't know what your problem is and why you can't just deny the care. Just say no. I can't get an operation for my husband, but these people can get care."

Clinics experience similar public outrage at the institutional level, although for different reasons. For example, a clinic with a large Mexican population decided to promote access to health care for this population by providing translators or interpreters who speak Spanish. However, this action escalated the tension and conflict both within the community and at the clinic; racist comments by some Anglos toward Mexicans flourished in tandem with assumptions that the latter group were receiving preferential treatment.

One element that sharpens this controversy is the fact that when some Anglos listen to Spanish being spoken between patients, interpreters, and/or health care providers, they may feel alienated from knowing what is taking place during those discussions. As a health care administrator comments, "They hear Spanish being spoken and they don't really know what is going on around them. They may see patients going in before they do and so they just assume that we are favoring these people." The stage is thereby set that fosters an environment of hostility and misunderstanding; Anglos feel their needs are not being met, especially when they see Mexicans receiving care before they do.

Cultural Beliefs and Educational Needs

The combined effects of this anti-immigrant sentiment and Latino cultural beliefs that illness is a test of God contribute to the concomitant interpretations by undocumented

Latinos about the need for preventive health care, such as HIV education and TB testing. Consequently, many in this group seek access to health care usually only at the point where they are very sick. Undocumented Latinos usually enter the health care system through the emergency room, often comprising a life-threatening situation for themselves and a more costly situation for the public. One participant, who is a health care administrator, notes, "It is usually through the emergency room when they are very sick--[a preventable situation] if we detected them 6 months earlier to provide care." In addition, many undocumented Latinos do not understand the poor prognosis associated with HIV or AIDS, or the concept of viruses and related transmission process. An understandable product of differing interpretations is the fact that contagion and mortality of illnesses such as AIDS are not typically limited to one member of a Latino family.

In many instances, a mother or father diagnosed with AIDS unwittingly transmits the virus to others in the family through subsequent births. A health professional reveals such an instance when a Latino, accompanied by his family, sought health care in the emergency room and was diagnosed with AIDS, "They didn't get health care until he landed in the emergency room and by then it was too late; by then they had four kids, and when they tested the children, two came up positive." This casualty syndrome points to the imperative need to provide preventive health education to not only the affected family member, but the whole family as well.

Emergency Care and Permanent Residence

The differing interpretations between legislative intent on the federal level and implementation on the state level concerning emergency care, complicate the provision of this care on the local level. For example, if emphasis at the state level is placed on time constraints (such as duration of treatment to reduce costs), it competes with a broader parameter on the federal level, i.e. the provision of whatever is necessary to complete treatment of an emergency condition. A former health care administrator gives an example of how this applies to an example about the treatment for removal of a pin in a patient's leg, "You've got that emergency episode of service including surgery, and whatever it takes to complete that treatment.... You have a state structure attempting to define it in the narrowest terms--an emergency is complete within 3 days." Undocumented Latinos thus are caught in a gray and murky area. For example, they may be ineligible for continued follow-up care because of the tension between the respective state's efforts to contain health care costs, and the mandated adherence to broader parameters of care intended by the federal government.

In a similar example, preventive health services were provided by the joint-federal-state program known as the California Medical Assistance (Medi-Cal) Program for an 18-year-old married Latina who was also applying for permanent residence in the U.S. This program was established "to provide health care services to public assistance recipients and other qualified individuals who cannot afford to pay for these services" (Legal Analyst's Office, 1996, p. C27). However, her differing interpretations about eligibility qualifications for permanent residency, which is based on self-sufficiency, led her to reject Medi-Cal coverage. This Latina, and a participant who knew her, operated under the assumption that rules of immigration preclude persons applying for permanent residence from using any kind of public assistance. Medi-Cal, however, does not fall within the parameters of those public assistance programs as noted in the definition above. This mistaken assumption caused the Latina to forego prenatal care, even though she was 7 months pregnant. Situations such as these predispose pregnant Latinas to unnecessary risks, including premature births and/or birth defects. The associated long-term consequences of inadequate health care moved a health care activist to add, "What our primary concern should be is on the future of that baby.... This costs society a lot of money afterwards and a lot of suffering and aggravation to that family."

Most of the participants during the focus group reacted with disbelief upon hearing this story. The incident prompted a former health care administrator experienced in state legislation to comment, "That is absolutely illegal." Moreover, reflecting on Latinas' fear of having their applications rejected for permanent residence led a health care professional to add, "That is why those women went without prenatal care." Confusion subsequently emerged from the participants regarding the demarcation lines between public assistance and Medi-Cal, since funding for these programs comes from the same source--the state and federal government. However, Governor Wilson's budget proposal terminates prenatal care services (Legislative Analyst's Office, 1996).

The confusion evinced by the research participants themselves--all of whom speak English and are health care professionals--reveals how arduous it is to understand these health care programs. This realization is a pivotal movement toward understanding the difficulty experienced by undocumented Latinas, who may not speak English and are not health care professionals. Moreover, these episodes generate speculation that this population is not a central drain upon the health care system. A health care activist posits, "How can you convince me that these people come here, and overnight become experts in how to manipulate the system, when those of us who are here with the language can't figure it out?"

Notions About the Latino Population

Notions gleaned from these participants about the public's attitude regarding the Latino population reflect specific confusion about how many people comprise this population, and its use of health care services. Unfortunately, this confusion may be partially attributed to the lack of effort from past researchers to differentiate subgroups and generations among Latinos. Consequently, this neglect has fueled the public's scorn. A health care administrator describes how she believes the public views this population, "People tend to lump all immigrants together. They lump the undocumented along with the documented and blame everyone for everything."

Furthermore, adjunct health care professionals such as social workers can increase this confusion when they conduct needs' assessments to determine whether or not Spanish-speaking people are eligible for financial support. Their level of anxiety may be so overwhelming about contracting diseases such as TB that they may report an inaccurate identification. One health care administrator describes what may occur:

> The social worker that you sent into that isolation room ... is so frightened about this TB that in her Spanish-speaking discussion with this person in bed, she can't figure out that they are Puerto Rican. They are not undocumented Mexican and that often happens.

Consequently, such Spanish-speaking people may actually be inaccurately reported, for example, as Puerto Rican natives, rather than counted as undocumented Latinos. This health care administrator points out, "If a social worker who is trying to get financial support for these people cannot distinguish the residency status ... or if the social security card is legitimate, ... Spanish-speaking people ... are put into an area of undocumented."

Beyond methods of evaluation for determining whether

Spanish-speaking people in the U.S. qualify for public services, confusion also exists over eligibility determinations for emergency phone calls along the border. According to this health care administrator, "There are more 911 calls along the San Diego-Tijuana border that anywhere else in San Diego County." At present, we have no way of determining who these people are, resulting in immense confusion concerning those seeking health care along the border. This group can include Latino Americans living in Mexico as easily as it does undocumented or documented Latinos.

Ignoring the Call for Holistic Health Care

In response to this confusion, a call for action from grassroots activists "paved the way" for public support of various institutional programs, such as migrant outreach services. For example, the migrant outreach program based out of North San Diego County Health Services was established to provide health care for migrant workers and their families. A lack of awareness about the importance of establishing clinic hours to accommodate the employment schedules and needs of migrant workers and their families initially resulted in an outreach clinic without any patients. This vacuum was attributed to the fact that migrant workers do not accrue sick leave, nor are they able to take a leave of absence from work to seek health care. To resolve this situation, these clinics have implemented extended hours on weekends and in the evening. A health care professional who works with this population comments, "This outreach program will go to the actual field after hours.... I think they go out after 4:00 p.m. to as late as 8:00 p.m. at night, and ... on weekends."

A former health care administrator voices a similar view concerning the constraints on the effectiveness of migrant outreach programs. She views program services as "patchwork", averring that inadequate or absent follow-up programs prevent the provision of holistic health care. This mirrors the situation as outlined previously on pages 57-58, whereby follow-up care can be terminated due to inconsistencies between intent and implementation on the federal and state levels of government. Therefore, these competing policies have severely jeopardized the quality of life for undocumented Latinas. Furthermore, they support the speculation that preventive health care without any commitment for follow-up care will not only be a road to mortality, but will cause a significant increase in the mortality rates of undocumented Latinas. For example, this former health care administrator reveals how tragic it is to diagnose an undocumented Latina with breast cancer. She then describes what usually occurs when a Latina in a similar situation accesses the emergency room:

> There is no coverage for cancer for undocumented persons.... The first time you find a woman with breast cancer is in the E.R. and by then we've got a very sick person and there is little hope. What do they do with the patient if they don't have any coverage? All they

> have is emergency coverage. In some ways, it's really awful to diagnose something.

Cultural factors further compound the lack of holistic health care for this group. For instance, undocumented Latinas may be unaware of free or low-cost breast screening programs open to them, such as those that offer mammograms, or how to access these services; their unawareness may be due to illiteracy and/or the cultural expectation that decisions to obtain health care require the consent of their husbands and/or family members. A health care professional describes the limitations of being illiterate or having little access to information otherwise for Latinas living in migrant camps, "People need to understand the mentality of being illiterate and not having a TV set.... You just don't get wind of some of the more common concerns or educational programs out there that the general population gets," or to legislative issues, such as the uncertainty over Proposition 187.

Uncertainty

Policy Roulette: Proposition 187's Wheel of Uncertainty

Even though Proposition 187 is in judicial abeyance (Lota, 1995), some participants indicate that many of the undocumented population are not privy to its status. For example, clients in the community continue to question nurses and doctors about the possibility of deportation if they obtain health care. This fear of deportation may compel them to avoid seeking any health care, regardless of need.

As one health care professional emphasizes, "You know, that really brings up an issue of trust. That is one thing they don't want to do, is to get deported." This uncertainty reflects the participants' views about Proposition 187 displayed during the pilot study (see pages 38-39). Moreover, they believe that mixed messages about health care availability were conveyed to Latinos from legal rights' groups such as the American Civil Liberties Union. A nurse practitioner explains, "They're saying that [Proposition] 187 is on hold, continue with your health care, your visits, ... but at the same time, these [competing] policies are coming through fast and furious."

A Climate of License: Medi-Cal Fraud Investigations

The fear of deportation has been escalated further by extreme measures used by Medi-Cal fraud investigators who involve the INS. A climate of license has propelled Medi-Cal fraud investigations to determine Medi-Cal eligibility by accessing data banks, and then leaking that information to INS officials--who implement the deportation process. A health care administrator emphasizes, "That should never have happened because these data systems should never talk to each other, but things fall through the cracks and they do."

The present interference policy of the INS may change, pending sweeping revisions in health care legislation. For instance, the INS has a policy to stay away from clinics and hospitals, a measure that has enabled some Latinos to feel safer and so continue to access health care without fear of deportation. By contrast, evince the experience of another health care administrator, "In the past, we've had some new INS officers who have swept our parking lot." If undocumented Latinas are denied access to health care, especially if they are pregnant with "elevated blood pressure or gestational diabetes," this leads to speculation that a life-threatening crisis will follow. In addition, speculation over a show of force by the INS, suggests there is considerable potential for violence and fatalities resulting from violent confrontations between the INS and undocumented workers.

The Core of Uncertainty

Three factors lie at the core of uncertainty over the availability of health care services in the future; funding limitations, increased eligibility requirements, and activities of the INS. This uncertainty affects both public and private health care organizations. Outreach services are particularly vulnerable because of the uncertainty over their political popularity from one year to the next, and variations in financial priorities by the leadership of these organizations. As a result, a health care administrator decided to put outreach at the end of her department title. She explains why, "I put outreach at the end, so that if it fell out of political popularity, I could drop it."

This cloud of uncertainty casts a dark shadow over strategic financial planning to offset expenses. It is extremely difficult for health care organizations to survive entirely on Medi-Cal payments and a sliding-fee scale. In order to provide health care for undocumented Latinos, some organizations are striving for a balance--a mixture of people that can pay the full fee and/or have insurance, and noninsured individuals that can make incremental payments. If these attempts coupled with radio advertising are unsuccessful, there will be perforce an increase in fees as well as limitations on the number of patients being served, a combination that would severely impact undocumented Latinos. A health care administrator involved in strategic planning comments, "I would probably have to limit a number of patients that I would serve--basically limit a number of slots that I have for the cash-paying, low-cost program."

The uncertainty over funding from one year to the next sends a chilling message about what could happen to health care services. The temporary nature of funding for various programs adds to the fragmentation of services available to undocumented Latinos. Further, the inconsistency of care--one year available, the next year, terminated--creates a lack of trust in the health care system as previously discussed on pages 63-64. Uncertainty over funding has been compounded due to proof of residency requirements. Moreover, it was due to differing interpretations about eligibility for medical care and permanent residence that prevented this aforementioned Latina from obtaining prenatal care even though she was 7 months pregnant (see pages 57-58).

San Diego County's expectation that funding for the Primary Care Grant is contingent upon proof of residency places primary care services in jeopardy of being abandoned or severely limited. This funding is crucial because it serves as a supplement to help clinics underwrite sliding-fee-scale patients. However, if people have to prove legal residency status before they are eligible for services, this activates speculation that they may cease to access health care altogether. A health care administrator comments, "You don't want to ask them, Are you legal? If they are not legal, that frightens them. They are not going to come back and they are coming in for services with ailments that may be contagious or infectious."

The participants in the pilot study voice similar concerns accentuated by their own ethical dilemma associated with this situation. Health care providers may have to make a choice between reporting undocumented immigrants seeking health care to the INS, or jeopardizing funding and health care for the entire community. Further, a participant notes the County's approach to alleviate financial strain "from an economic and political perspective," rather than a health care perspective, impairs the well-being of many people beyond the undocumented immigrant group.

All of the participants save one believe California Governor Pete Wilson's political shift to eliminate emergency Medi-Cal for undocumented Latinas adds to the uncertainty over health care services. Wilson's budget proposal limits prenatal care services for undocumented Latinas, yet advocates reproductive health care on a broad basis: for example, "the budget proposes a $20 million General Fund augmentation to establish a "state-only" Medi-Cal family planning program effective January 1, 1997.... Family planning services do not include abortions or prenatal care services" (Legislative Analyst's Office, 1996, pp. C48-C49). Thus, the prevention or elimination of new lives takes precedence over the preservation of lives. This general belief among the participants is a self-serving political position that scapegoats nearby prey--pregnant Latinas and their children.

In the contrasting view, one health care administrator believes that Governor Wilson is "trying to identify the most economic, efficient way to deliver services to people who live in California." From this perspective, an advantage of the family planning program is that it is not contingent upon proof of residency. Furthermore, the program is highly valuable in its efforts to enable undocumented Latinas in family planning. The program, however, does not eliminate this group's need for prenatal care, provoking a concern over the future of prenatal or pregnancy-only Medi-Cal. As a health care administrator cautions, "We are pretty sure at some point it is going to be eliminated and that is going to be a big barrier to health care." However, immigrant advocates sought a federal court order to block Governor Wilson's plan to eliminate prenatal care to illegal immigrants on December 1, 1996 as previously mentioned on page 24.

Tokenism

The Downside Wave of Tokenism

Medi-Cal is becoming hollow in its health care commitment because of restrictive eligibility requirements and reduction in services. A participant in the pilot study referred to this dilemma as "a wave of reduction" in health care services during the '90's. This reduction emanated from public and political sentiment that undocumented Latinos are draining the health care system. In response, the State and County have placed restrictions on application rules for eligibility, which are linked to categorical specifications including age, income, disability, and the process is time-consuming. However, undocumented immigrants who reside in the U.S. and have no present intent to leave are eligible for Medi-Cal emergency services. According to one participant, "Not so they can get access to care, but so the providers who are treating them can get paid something."

Further, these constraints have been enforced by Medi-Cal fraud investigators due to a climate of license that prevails previously noted on pages 64-65. The snare of tokenism has resulted in intimidating measures by Medi-cal investigation units designed to induce fear of reprisal and withdrawal of Medi-Cal applications. Moreover, these actions perpetuate differing interpretations in the public's view toward hospitals' public service duty and its outrage over out-patient care at clinics as previously discussed on pages 54-55.

The Media: Tokenism's Reinforcer

According to the participants in both studies, part of the perfunctory shift to stringent enforcement and restrictive requirements originates in media publicity over the extent of Medi-Cal fraud in San Diego. A participant in the pilot study recommends a book about counterstudies by Fix and Passel (1994) to "clarify distortions" about the number of immigrants and their utilization of health care services. Furthermore, the participants in both this study and the pilot study agree that skewed distortions of costs have increased the public's lack of understanding, hostility, and resentment (see pages 54-55). Consequently, this elicits speculation that such exaggeration overrides the contributions undocumented Latinos have made to society.

Moreover, they believe people must be educated about the distribution of real costs versus exaggerated costs for health care which overlook that undocumented Latinos do, in fact, pay for their care in many cases. A health care administrator had more to say, "Seldom do I hear from my staff that they encounter a patient who says, I don't want to sign the contract for the low-cash program because I deserve free care and I'm not going to pay for it."

Passing the Policy Buck Through Tokenism

Tokenism assumes another form through the federal government's threat to block grant Medi-Cal funds. The impact of this threat is significant, because as soon as block grants get delegated to the State, less money is likely to be distributed to the local levels of government. This momentum creates a chain-reaction, as a health care administrator notes, whereby "less people will be eligible for Medi-Cal" coverage. This process may be a huge setback for the population as a whole. While fewer people will be eligible for Medi-Cal--a reduction that saves money--this reduction also applies to the scope of benefits.

If the block grant goes through, the health care services for those who are covered will be limited. Further, as the administrator points out, "It may wash away the current eligibility for the undocumented that is pregnancy-related." Governor Pete Wilson's budget proposal limiting prenatal care services (see pages 67-68) has intensified the uncertainty and concern over health care services.

One outlier participant's attempt to forge a holistic conceptualization concerning the flow of money through various governmental sectors led her to assert that the federal government does this "through passing the buck where legislation and visible policy would not be politically expedient." She further adds, "It resonates within the hearts and pocketbooks of citizens who think that is why their taxes are so high." Health care programs in existence are in jeopardy of being overburdened. A health care professional comments, "It seems like no one wants to take responsibility for this population because the funding is not there for them."

The Cost-Containment Masquerade

Both hospitals and physicians contribute to this perfunctory spirit of limited health services because of the desire and need to contain costs. The current priority to provide for-profit services demonstrates a lack of commitment to the community on the part of both institution and individual. For example, hospitals have competing mandates--an overt one, as a public service agency, and the second, as a covert for-profit business. This for-profit focus may contribute to the lack of awareness about how they could do more for the community without necessarily spending huge sums of money. One participant, a health care administrator for a private health care organization points out, "We are ... aware of both the public view and of maintaining our public image as a service agency, and also from a strictly financial and business viable way, regardless if nobody knows about it strong and collaborative business relationships." If source of payment is an issue, they can simply refuse to see the patient; thus, according to this participant, "It's source of payment that is the issue, not documented or undocumented." All of the participants report that this fee-for-service mentality is one of the largest barriers to accessing health care for undocumented Latinos.

In addition, the County's Indigent Contract with a local health care organization, previously mentioned on page 18 is another barrier to health care. A participant, a former health care administrator, comments, "They cut the funding in half, and said that they would no longer count the undocumented person who receives emergency services as eligible for payment adjustment calculations.... The next year the funding was cut in half again."

This action resulted from the adoption of the Zero-Tolerance policy by the County of San Diego. The extreme nature of this policy fuels uncertainty about the future of health care, which will feel the effects of the actions of the County Board of Supervisors' and Governor Wilson's budget proposal as previously noted on pages 67-68. Moreover, these actions reveal the firm interpretations of the Board and Governor Wilson that undocumented Latinos are undeserving of public services (see pages 54-55). Under this policy, funds cannot be used to support health care for undocumented Latinos. More changes are anticipated, given the County's responsibility for determining Medi-Cal eligibility and distributing Medi-Cal benefits for California, according to Governor Wilson's assertion that "the state simply cannot afford" (McDonnell, 1996, p. A26) Medi-Cal expenditures. One participant notes, San Diego County contracts currently specify that "none of these funds will be used to support undocumented people." As this former health care administrator points out, "Even though there are not County dollars involved, that policy impacts access to the state and federal dollars that come through the Medi-Caid program.... Zero Tolerance is what made them cut the contract for indigent care."

Power Shifting and Policy Shaping

The Shift From Federal to Local Jurisdiction

Impending shifts in health care policy from lesser to greater local control exacerbate the already fragmented views that surround access to health care. For example, the federal movement to block grant Medi-Cal funds as previously noted on pages 70-71, represents the snare of tokenism through a shift in jurisdiction. Furthermore, the participants view this proposal as threatening the continuity of health care services. Moreover, the exercise of political influence by the County Board of Supervisors in San Diego regarding funding distribution for restrictive, nominal policies as previously discussed on page 73, severely threatens the provision and scope of health care services.

The participants view the current federal-to-state shift in jurisdiction as a certain prompt to increase the fragmentation of health care services for undocumented Latinos. Moreover, the shift increases the likelihood of tragic situations, i.e. such as those that transpire when undocumented Latinas are diagnosed with breast cancer, yet are unable to obtain follow-up care due to restrictive health policies (see page 62).

The participants, therefore, hold education to be a crucial tool for health care providers, the public, and politicians to increase their level of awareness, particularly about the impacts of fragmented health care services and how their attitudes act to increase this fragmentation. One health care administrator adamantly iterates a major obstacle to this expansion of knowledge on the part of politicians, "They don't want to be educated. They only want to think about cutting dollars because all they are focused on is their deficits."

The other participants' beliefs mirror those held by the participants in the pilot study vis-a-vis the importance of education. The latter group further believes the need for education will only intensify due to the incredible growth rate of Latinos within the next 10 years. The participants in the pilot study also feel that while people may not respond to "altruistic reasons for health care, [they] would respond to education about the financial end of things." As a participant notes, "It is better to pay $1.00 for preventive care than $4.00, 6 months down the road, for complications." Consequently, both groups share their frustration over the continuing barriers in the effort to ensure continuation of financial support despite parallel efforts to educate the public about health care. Moreover, this dialogue conveys the struggle agencies and health care administrators experience in order for their agencies to remain viable.

Difficulty in Creating Change

Most of the participants during the focus group voice their frustration over how difficult it has been to formulate changes for a socially just health care system. This frustration permeates their views concerning the health care system's inadequate social and political infrastructure, a central obstacle in the effort to facilitate access to health care. By contrast, one participant who is an activist for women's health, disclosed research findings that convey just the opposite--that adequate infrastructures are available (see page 80). Despite these differences in outlook, all participants believe their relationships with nonprofit organizations that provide donations for health care services (such as the United Way) are very fragile. This consensus mirrors the uncertainty associated with funding distribution from the federal government and the County as previously discussed on pages 63-64. A health care administrator of a community clinic currently experiencing the threat of major funding cuts voices her frustration:

> I get real tired ... of depending on what the favorite victim is seeing AIDS become less favorable because we are into domestic violence.... You just can't keep a consistent form of care.... You are always chasing whatever is popular at the time.

Hence, the data produced by this study lead to speculation over whether or not we even have a "health policy" in the U.S. The participants' view is that this confusion is partially due to the major emphasis placed on the economic and political aspects of health care, to the exclusion of quality of life issues previously discussed on page 62. A former health care administrator further adds, "I think we have financial policy, to a certain extent. We have political expediency, but we don't have health policy. And it is not just for undocumented persons, it's for the poor in this country in general." Health policy therefore continues, for these participants, to be a highly controversial and frustrating issue, and will remain so as we approach the year 2000.

Further, the data outlined thus far in the study suggest that the only form of political address for these issues is by punitive actions. The severity of politicians' methods, coupled with a lack of understanding about this population, conveys an attitude of extreme hostility and resentment as previously noted on page 53. From Governor Pete Wilson's budget proposal to eliminate emergency Medi-Cal for undocumented Latinas (see pages 67-68), to the County Board of Supervisors' restrictive, nominal policies (see page 73), to the wave of reduction mentioned by the participant in the pilot study (see page 69), the State of California has become saturated with policies intended to castigate undocumented Latinos.

The outlier participant comments about how difficult it is to create change as she argues, "I've never seen any politician do any thing unless there was a constituency behind it--unless we shame them." In her view, it is necessary "to humiliate and belittle the other side so they would join in" (Gerzon, 1996, p. 242). However, these actions generate speculation about the risks associated with shaming politicians, i.e. that bringing politicians to their knees may undermine the resolution process concerning access to health care. Furthermore, this method would almost certainly escalate tension and conflict between all parties making even dialogue extremely difficult. The mayhem ensuing from political influence is not limited to California, but has purled from the federal government in President Clinton's promulgated immigration policy tagged, "Operation Gatekeeper." The program's purpose is the curtailment of the flow of undocumented immigrants who cross the San Diego-Tijuana border to seek a better life. A health care activist presents his views regarding these political actions:

> They are inhumane, and they are contradictory to the ethical traditions of this nation.... We found the money to send a man to the moon.... We find solutions for the problems that we really want to resolve, if we're willing to pay the price for it. This is really a minute problem.... These people are coming for self-preservation and I would do the same thing.

To reverse these political actions, a participant who is a health care administrator calls for changes in data collection methods to improve the quality and accuracy of information concerning those groups accessing health care in the hospital setting.

The Contrary Use of Data

Some of the participants promote the need for governmental collaboration with social service agencies to develop demographic profiles that would accurately verify details on individuals and groups utilizing health care services. This health care administrator adds, "I think there could also be better efforts towards hospital-based information." The focus of this effort ought to be on obtaining accurate emergency room data, i.e. who is accessing care in the emergency room and for what purpose--a cold, or a life-threatening condition such as a cerebral hemorrhage.

Although most of the participants during the focus group consider data collection to be generally beneficial, some participants underscore the ramifications associated with data utilization by all three levels of government. One participant, who is a health care professional, articulates her skepticism regarding the Janus-faced nature of data, "Data like that is a double-edged sword.... They have used it in a negative way towards this population ... not just the undocumented people seeking health care dollars, but also [for] research into the fertility rates of undocumented women." A health care activist adds that "There has not been one concentrated, centralized grant from ... some institution to really make a full counterstudy."

The impact of the ways in which data can be used to create uncertainty and fear of deportation among undocumented Latinos has already been detailed in the incidents whereby Medi-Cal fraud investigators were accessing data banks for deportation purposes (see pages 64-65). Furthermore, the availability of data on the fertility rates of undocumented women perpetuates this fear and uncertainty. Moreover, the data may conceivably have been used to set the stage for

Governor Wilson's budget proposal to augment funds for family planning services, and his accompanying political shift to eliminate emergency Medi-Cal for undocumented Latinas as previously discussed on page 67. By contrast, data can be used in a positive manner, such as through community needs' assessments by local hospitals that provide recommendations for community health care programs. A health care administrator who is actively involved in this study indicates that she is working on "reviewing data on maternal-child statistics, fertility rates, the number of deliveries in the County and the rate of adolescent pregnancies." Other hospital groups are currently reviewing issues such as domestic violence, educational programs, and children's issues. Surveys are also being distributed to hundreds of organizations in the County of San Diego to obtain data from the grassroots level.

The challenges facing health policy research involve a reexamination of factors causing limited or poor access to health care, such as lack of transportation or language barriers (see pages 22-23). Moreover, according to the same participant, some findings thus far have indicated that barriers are a result of access, not availability, because "the facilities, the providers, and the infrastructures for health care for the underserved are there. People need to learn how to get to them and access them."

These discoveries lead to speculation that unless undocumented Latinos acquire more knowledge and understanding about how to access and utilize the health care system to meet their needs, morbidity and mortality rates will rise in this population. Further, although data are an important means for the promotion of access to health care for this population, the future search of the focus group produced other ways to create change. These solutions address the issues of what an ideal health care system should comprise, and disclosed some policy revisions necessary to change existing conditions that obstruct access to health care.

Searching for Solutions to Create Change

The participants feel it is important to be united in the voice and messages they are sending to the public and politicians. As a participant expresses, "I frankly see some of the best hope as a group. All of us are in positions of consequence and connection to some extent ... with populations that have some ability to influence policy."

One catalyst for change is outlined in the recollection of a participant, as she detailed her experiences in the Vietnam War era. She believes health care providers ought to revisit the spirit of social consciousness that occurred during the Vietnam War over two decades ago. Her experiences in health care during that time reflect the wave of volunteerism that characterized the age. She reminisced about her experiences as a 16-year-old health care volunteer with the United Farmworkers. The rise in social consciousness is perhaps most sharply exemplified at that time by the influx of volunteers in community clinics.

The participants agree that it is necessary, and perhaps urgent, for health care professionals to serve this population through volunteerism. This health care administrator comments about the need for volunteerism, "The day will come where you will not even be able ... to charge the minimum amount because you will not be able to collect it once you bill it." All participants agree that governmental funding will continue to decline as a consequence of pending legislation and a climate of self-interest.

Further, the participants believe that hospitals could play a significant role in providing health care for those who are unable to afford payment for services, or have limited funding. For example, a participant notes that some physicians are willing to provide gynecological (gyn) surgery, free of charge, if the hospital and anesthesiologist are equally willing to volunteer their services. Some of the participants believe that hospitals could promote even greater access to health care by offering their services at Medi-Cal rates for this population. The group also examines and promotes the expansion of their own roles as health care advocates to include collaboration with hospitals, with an eye toward increasing institutional knowledge concerning the feasibility and necessity for promoting the quality of life. Moreover, the participants agree that it is necessary to create a system that facilitates the assumption of responsibility for payment of services.

The outlier participant notes the potential for negative reaction on the part of public institutions and the community, "You also end up, if you're a public institution, with the community asking, What the hell are you doing?... You won't do that for me. And why are you doing that for them?" This observation underscores the possibility that such efforts might generate hostility and resentment due to the public's differing interpretations as previously noted on pages 53-54. However, one participant surmounted public opposition to health care for undocumented Latinos by initiating a crusade for a privately-funded clinic.

A participant voices how he was able to obtain a staff of volunteer health care professionals and private donations for a community clinic in spite of the public controversy over access to health care. His facility serves as a "one-stop" place for health care needs with a minimum of paperwork, and was established to serve those who are unable to pay for health care services. This collaborative effort decreased fragmentation of care, fostered a sense of community, and provided a leadership model for subsequent endeavors. Funding was obtained from private sources such as friends of this participant.

This same health care activist shares his vision for engaging in a cooperative endeavor with doctors, nurses, physician's assistants, nurse practitioners, and social workers who embrace the spirit of social consciousness and volunteerism. The glue that binds people together forms from the beliefs they share toward promoting access to health care for undocumented Latinos. People receive health care with a minimum of paperwork, and a great deal of love and respect. The fragmentation of services is reduced by the provision of interpreters, referrals for domestic violence, transportation, food, clothing, and hospitalization on an "as-needed" basis. This same health care activist notes, "If you are successful in doing something like this, others will join." In fact, the community clinic subsequently attracted private institutions to the volunteer effort including a private company that performs lab services.

This same health care activist also seeks creative ways to provide access to health care by comparing how other states such as Texas offer provisions for prenatal and postnatal care. He had more to say, "In other states, midwives deliver babies and have their own facilities. In Texas, ... for $700 a woman can come and have prenatal care, deliver the baby, and have postnatal care for 2 or 3 months." The participants believe that the expanded role of midwives in Texas is a major factor in providing health care services for this population.

By contrast, a health care administrator states that some hospitals in San Diego have physician committees that deny an expanded role to midwives. She comments on the situation at her health care organization, "The doctors have voted it down every single time due to quality issues." Speculation about physicians' concerns over quality of care issues stems from licensing requirements, responsibility for care, and malpractice issues, coupled with the competitive threat such a policy poses for their own practices. All of the participants believe that an ideal situation would consist of birthplace centers in individual hospitals that are licensed and staffed separately. This action would enable birth costs to be reduced, and as well, facilitate access to health care for undocumented Latinas. By contrast, the inaction of some Latino organizations has limited creative solutions for change in health care policy.

The Power of Inaction

The participants believe that CHAMA could serve as a pressure group to influence the AMA by providing more visible leadership. In their view, CHAMA, as an organization comprised of Latino physicians, has been both nonsupportive and complacent regarding health care access for this population. However, the report by COSSMHO (1995) recognizes the contributions Latino physicians make by practicing in Latino communities and calls for "community advisory boards" (p. 310) among other resources to increase the number of Latino health care providers.

The discussion moved a health care administrator to speculate that this CHAMA complacency can be attributed to the members' backgrounds. She comments, "They probably come from middle-upper class families ... and have forgotten." In her view, such individuals possess little identification with the health care issues facing this population, or choose to avoid the issues altogether.

Similarly, the CHAMA's commitment to promote access to health care for undocumented Latinos mirrors the tokenism of the Office of Border Health previously discussed on page 17. Further, CHAMA's beliefs ironically parallel differing interpretations conveyed by some Anglos toward Mexicans outlined earlier on page 55. For example, according to the participants, there is a significant portion of the membership in this organization who feel undocumented Latinos are undeserving of health care and are draining the health care system. However, one health care administrator points out, "There are some very good people in CHAMA who have never led before." Her comment portrays a more balanced perspective, which enabled the group to consider other reasons contributing to this leadership vacuum. The participants agree that the lack of commitment by members of CHAMA can be partially attributed to the lack of experience in leadership roles. A related issue was raised by a health care administrator, who argues that the leadership in Latino organizations historically directs their priorities toward time-consuming projects such as the Mercado Apartment Project (a mini-village of low-income apartments for indigent families in National City), rather than mobilizing resources to promote macrolevel access to health care. The admittedly well-intentioned efforts of these groups may have unwittingly contributed toward the sense of rejection experienced by undocumented Latinos concerning their health care needs. This participant adds, "It has taken them 20 years to finish the project. It has taken them 20 years ... to get some real true social justice and progress for their community."

The unintentional effects of housing priorities prompted speculation among these participants that the health care needs of this population will continue to be neglected unless particular Latino organizations such as CHAMA are able to balance their priorities for the public good and address the most urgent social issues affecting their community. By expanding their priorities to include health care, for example, Latino organizations could have a significant impact on the well-being of undocumented Latinos. Moreover, this current imbalance fuels competition rather than cooperation in policy formulation; it also mirrors the tokenism of the County Board of Supervisors toward health care for Latino families with members who have AIDS (see page 16).

Efforts to mobilize the Latino community are not only directed toward CHAMA and Latino organizations who participated in the Mercado Project, but extend to a range of community efforts, such as the yearly Caesar Chavez march in San Diego. According to this participant, the indifference from the Latino community at the most recent march was demonstrated by the small handful of people that showed up for the event. She further notes that "Everybody has their own fears that immobilize them." Moreover, a Latino health care activist believes that the lack of leadership necessary to support this population could be the result of self-interest and lack of commitment. He comments that

"Unfortunately, Hispanics are not known for their social consciousness." This lack of commitment was conveyed on the Anglo side by the State and County when they provided nominal representation for the Office of Border Health previously discussed on page 17.

However, efforts to raise the social consciousness of the Latino community concerning health care access are a high priority of the Latino Coalition for a Healthy California (see pages 118-119). Latinos are empowered and inspired due to the collaboration of the Latino Coalition with federal, state, and local representatives for health policy reform.

Empowering Latinos Through Collective Action

The Latino Coalition is a statewide policy and advocacy organization that strives to create healthy Latino communities throughout California. The topic of this year's conference was "Defining Latino Health Policy for the 21st Century: Achieving a Broader Vision."

With several workshops to choose from, the participants attended those concerning managed care, which highlighted such topics as "Forming Effective Partnerships With Mainstream Health Care Providers." I attended the workshop on "Research and Policy Priorities for Implementation of a Latina Health Policy Agenda." During the workshops, ideas about policy priorities that concern Latino health care are discussed and presented at the plenary meeting with state and federal policymakers. These priorities include a statewide cultural competency initiative; collaboration with other advocacy organizations working on immigrant issues; increased funding; voter registration drives; increased research on Latina health issues; and ways for the community and the County of Los Angeles to form real partnerships by supporting each other in their efforts to redefine themselves. The Coalition's collective action in pursuit of the common good is exemplified in its processes--by working together, mobilizing resources such as sponsors, and fostering a sense of cooperation (Bryson & Crosby, 1992; Sabatier, 1988).

Moreover, the data analysis validates how vital shared power is to create change. In order to promote access to health care for undocumented Latinas, it is imperative to make the transition between "power over others (read control), ... and engage in leadership activities that empower others--that is power with others, or shared power" (Astin, 1989, p. 9). Accordingly, Chapter V will address recommendations on how to attain this power, coupled with implications for leadership necessary to maintain it.

As an example of this transition, the importance of empowerment in shaping health care policy was promoted by one participant's involvement in city council meetings and school board meetings. She believes that the future is optimistic for improved health policy for undocumented Latinos, and that the pendulum's movement will be the result of increasing numbers of Latinos (including migrant workers) in San Diego within the next 10 years. She has been working with council board members and school officials in an effort to reduce their fears of the unknown and differing interpretations through education as previously noted on pages 53-54. She offers an example, "I explain to them that migrant workers are not the bogeymen. They just didn't pull into town. A lot of these migrant workers have been here longer than you and I, so this is their home."

In addition to coalitions and education for the public and politicians, one participant believes it imperative that radio stations empower Latinos through the airwaves. She feels that stations ought to provide programs that educate their audiences about the contributions and rights of undocumented Latinos. She points to the ability of radio stations to reach out to those who listen to the airwaves at places such as laundromats and grocery stores. This effort, she believes, may enhance Latinos' desire to take control over their futures and rights by becoming more assertive. She comments, "So they are a very viable part of our economy and this needs to be brought home to them, as well as to the rest of the population and to the politicians."

The right to vote represents a primary vehicle for empowerment. The participants in this study and the pilot study believe the right to vote ensures a voice politically. A nurse practitioner in the pilot study points out, "There's approximately 10 million Latinos in California, but only 10% are registered to vote." However, his assumption concerning the percentage of Latinos registered to vote is premature. According to Lindquist (1996), "Nearly every town and city in the state's rural region ... have become more than 90 percent Latino, up from less than 50 percent 10 years ago" (p. A18). Further, the Chicano Federation estimates that approximately 20% of Latinos are registered to vote in the state of California. Therefore, empowering Latinos through collective action is an essential avenue for promoting access to health care and "moving toward a more equitable society" (Scherr, 1995, p. 12).

Summary

The themes' relevance for change in health care policy is significant throughout the data analysis. In particular, the differing interpretations about what constitutes emergency care and permanent residence are a pivotal issue of concern for undocumented Latinos, the participants, health care providers, the public, and policy implementers. Notions about the Latino population and the grave consequences regarding the inability of migrant outreach services to provide holistic health care have life-threatening implications. Moreover, the uncertainty sparked by the policy roulette with Proposition 187, and the climate of license enabling Medi-Cal fraud investigators to collaborate with the INS through access to data banks, continues to generate fear, devastation, and mistrust.

Likewise, the data enlightened me about the ways the snare of tokenism may manifest itself in its seductive facade through block grants, the media's reinforcement of distortions, the cost-containment masquerade from physicians and hospitals, the Office of Border Health, and restrictive policies adopted by the County Board of Supervisors. These displays, ironically, have been fueled by the inaction of part of the Latino community itself according to one participant who works solely in a private, physician group clinic. At its core, the data point to the dangers of ignorance that looms from similar views held by a portion of the Latino community and Latino organizations such as CHAMA.

All of the themes then, represent poignant reflections of ideas, beliefs, and values conveyed through the lens of participants engaged in a dialogue on health care policy. The complex effect of competing policies upon access to health care is intensified by power shifting and policy shaping on the part of federal, state, and local jurisdictions. However, the study demonstrates that, in spite of competing polices that underscore cultural differences and barriers, there is hope for a better life. For instance, the reemergent spirit of social consciousness offers great potential to create and implement policy revisions that improve access to health care for undocumented Latinas at the microlevel, and for all human beings at the macrolevel.

Moreover, part of this transformation to a more socially just health care system necessitates coming to terms with competing policies that facilitate or constrain access. To be successful, this reconciliation process calls for a reexamination of relationships and communication models, the central vehicles to mobilize resources in the Latino community and produce equity in the distribution of power and participation in health care policy.

It is therefore crucial that leaders in both political and social sectors embrace shared power through relationships, collective action, collaboration, and mutuality to move beyond the "inevitable differences of opinion" (Hayes-Bautista, 1992, p. 198) toward consensus and cooperation. Accordingly, the forthcoming chapter cultivates a reconciliation of differences through a summary of the study, its implications, and emergent recommendations necessary to ease the "struggle over the realization of ideas" (Majone & Wildavsky, 1979, p. 194).

Access to health care for undocumented Latinos faces extraordinary challenges as we approach the year 2000. The arduousness that characterizes the change process for this population may be due in part to a natural cultural tendency. As voiced by a Latina participant, "We tend to be a little quieter about how we do things and it takes us a little longer to get out from under the chains." On all our parts, leadership in all sectors must embrace the call to amplify the discussion for coming to terms with competing policies, and facilitate the dissolution of the links that prevent this population's access to quality health care.

CHAPTER 5

Summary, Implications, and Recommendations

Introduction

This qualitative interview study seeks to promote knowledge and understanding about the problems of competing policies among myself, a selected group of health care administrators, and providers. The study further promotes the realization of their perceptions concerning proposed policy revisions that are needed to change the conditions of access to health care for undocumented Latinas. The illumination of specific policies that promote or constrain access to health care is essential if agents of change are to redress the health and well-being of this population. Finally, the implications of the study target the dangers of ignorance regarding health care issues within this population that reflect similar views held by a significant portion of the Latino community and Latino organizations such as CHAMA.

Implications of the study are organized into five sections; (a) the dangers of ignorance, (b) struggles behind the veil of uncertainty, (c) the snare of tokenism, (d) impotence: a product of power shifting and policy shaping, and (e) ethical perspectives. I feel compelled to include ethical perspectives, since moral implications regarding access to health care are tantamount to understanding how vital the quality of life is for all human beings. Moreover, the implications underscore significant reasons that provoke ethical concerns such as the lack of commitment generated by organizations such as the AMA, CHAMA, HMO's, and County Board of Supervisors concerning human welfare and as well, cautious optimism regarding health care in the present and future.

Recommendations are highlighted in four sections; (a) education, (b) research, (c) fundamental premises: pillars of the right to health care, and (d) leadership through empowerment. The participants' recommendations point out that social justice perspectives are integral to redefining, restructuring, and remedizing health care policy. In sum, these recommendations seek to empower a chronically disenfranchised, highly vulnerable, and underserved population, through avenues of action that enable the population to utilize its assets to articulate ideas for a better quality of life, and socially just health care access.

Summary of the Study

This study focuses on the problems of health care access experienced by undocumented Latinas: women from Mexico, Central and South America, and the Caribbean. For example, undocumented Latinas are likely to find family planning services easier to obtain than prenatal care under terms of the new federal welfare law that eliminates prenatal care for undocumented immigrants. This qualitative interview study illustrates that it is possible to promote knowledge and understanding about the problems of competing policies among myself, a selected group of health care administrators, and providers. The data analysis portrays their new awareness for which policy revisions are needed to rectify and expand undocumented Latinas' access to health care services.

The findings of this research should not be generalized into assumptions regarding other settings or other population groups. However, since the methodology seeks to examine the impact of competing policies vis-a-vis undocumented Latinas' access to health care services, the findings do represent viewpoints of health care providers and political activists in San Diego--one of the two largest cities in the southwestern U.S. and one that comprises one of the largest assembly of undocumented immigrants in the country. Elements of the study data, thus, may illuminate discussions and research conducted by educators and health care professionals in regions characterized by similar socioeconomic strata. Moreover, the process is replicable and the incidence and continuation of such study is valuable to professionals engaged in any field concerned with the advancement of knowledge.

This study utilizes a qualitative method known as action theory to address research questions. The heart of social inquiry methodologies is a worldview that emphasizes participation as its core strategy. Action science is concerned with the beliefs and agreements about the "development of effective action that may contribute to the transformation of organizations and communities towards greater effectiveness and greater justice" (Reason, 1994, p.

330). I first approached the research questions through a pilot future search. Using a focus group comprised of five participants who have had experiences with undocumented immigrants, I explored how a future search might initially shape the study. The future search offered a "concentrated insight into participants' thinking" (Morgan, 1988, p. 31) about health policy and health care access, especially beneficial at the beginning of the research study. This study, thus, seeks to suggest action through an examination of policies that promote or constrain access to health care, so that enlightened leaders may pursue democratic initiatives for a social transformation of health care (Reason, 1994).

I combined qualitative data collection methods to engage eight participants in two field interviews and a focus group. Following the initial interview sessions, I arranged a second interview with individual participants, a process designed to distill preliminary assumptions from the initial data analysis. I conducted an examination of the individual interview transcripts and a summary sheet previously sent to each participant.

Subsequent to the second interview, I conducted a focus group with the same participants. I invited 10 individuals to participate in the focus group to compensate for "no shows." Eight out of 10 participants attended the focus group. Most of the participants had previously met and/or were familiar with each other's work in the community.

First, I reviewed data from the individual field interviews and focus group to identify potential trends and patterns. Second, I conducted content analysis, identifying understandable and meaningful examples, themes, and patterns in the data (Patton, 1987). Third, I used the "scissor and sort" approach wherein I marked, copied, cut apart, and sorted relevant passages in the transcripts (Morgan, 1988). Fourth, I discussed data across the themes to enhance readers' broader view of the data and speculations for data analysis.

Fifth, I developed a categorization through a matrix display that included three levels of policy--public, organizational, and institutional. This matrix comprised an organizational structure that clearly classified data between those policies that facilitate, and those which constrain access to health care for undocumented Latinos (Aroian, 1990; Mason & Leavitt, 1993; Sandelowski, 1995).

Findings and Implications of the Study

Four interwoven categories emerged from the data analysis. These include: (a) differing interpretations, (b) uncertainty, (c) tokenism, and (d) power shifting and policy shaping. Differing interpretations that comprise the first category permeate nearly every social strata. This ignorance is evinced by the hostile and resentful response that consistently emanates from both community and governmental circles regarding the provision of health care for this population, even that care designed to prevent contagion and mortality. On their part, state and federal governments show little consensus on what constitutes emergency care, and related issues such as the impact of permanent residence criteria. This ignorance is further exemplified by erroneous notions held by participants in the study and the public regarding the actual population figures of undocumented Latinos and this group's use of health services. Lastly, the interpretation gap is illustrated by politicians and the public ignoring the call for holistic health care from providers and patients for migrant outreach programs.

The second category, uncertainty, is explained by policy roulette over legislation such as Proposition 187. Uncertainty is perpetuated by such issues as Medi-Cal fraud investigations and the INS's present interference policy. Finally, this uncertainty is reflected by the problematical impact of legislation to limit funding on health care.

Tokenism, based on the erroneous and widespread belief that inflated numbers of undocumented Latinos are draining the health care system, is a product of the wave of reduction in health care services and media hyperbole. Tokenism unveils itself in the federal government's proposal to block grant Medi-Cal funds, an effort that cloaks cost-containment efforts by physicians and hospitals to uphold for-profit services. Tokenism symbolizes polemical remnants of political yawing and policy tweaking. These remnants are usually transformed into restrictive policies, such as the Zero Tolerance policy adopted by the County of San Diego that eliminates public services for undocumented Latinos.

The fourth category concerns power shifting and policy shaping in health care policy. The concept involves the shift of power from federal to local jurisdictions. This shift illustrates the difficulty in creating change, a complexity that adds to the frustration of participants in the study concerning their lack of influence regarding federal and local legislation. This process also conveys how the contrary use of data as a "double-edged sword" can be and is used to harm this population. The manipulation of data inspires the search for solutions to create responsible change. Finally, data associated with this category highlight the power of inaction from organizations such as CHAMA, and, as a result, call for empowering Latinos through collective action.

General Implications

The Dangers of Ignorance

Policy analysis is warranted as a means to expose transgressions concerning the quality of life, and to reshape policy ideas regarding inadequate health education, follow-up care, lack of finances, preventive health care, and utilization of emergency services. This analysis is vital for everybody, but it is especially vital for individuals suffering from AIDS, TB, cancer, or other life-threatening illnesses. Early access to health care and health education not only saves money by reducing the need for emergency services, but promotes a quality of life for all human beings (Lindblom & Woodhouse, 1993).

However, contention exists over how relevant education is in improving the quality of life since it "is often confused with schooling" (Marshall, 1992, p. 48). Education, not just the duration of schooling, does enhance the thinking and decision-making skills necessary for the survival of undocumented Latinos (Marshall, 1992). Part of this educational process ought to include policy analysis regarding the parameters of emergency care services, preventive health care, and follow-up care.

For instance, differing interpretations pose an enigma about the extent of and the need for emergency care services. These differences are exemplified by the interpretation gap between legislative intent at the federal level, and policy implementation at the state level, a product of misinformation concerning the constituent elements that comprise an "emergency." The illustration previously cited on pages 62-63, in which an undocumented Latina is deemed ineligible for health care even though she presented to the emergency room with a diagnosis of breast cancer, gives credence to this dilemma. The quality of life, therefore, is severely jeopardized when preventive programs such as breast cancer screening and AIDS education simultaneously exclude provisions for follow-up care.

Furthermore, predetermined categorical programs such as Medi-Cal are unable to meet the needs of those they serve because "too many people fall between the cracks" (Marshall, 1992, p. 53). The significance of this plight unfolded when an 18-year-old married Latina was faced with the dilemma of having to choose between financial assistance for prenatal health care, or permanent residency based on perceived requirements for self-sufficiency. She chose the latter, which represents less an option than it does a predicament.

There are other factors that inhibit undocumented Latinos' full access to available health care services. For example, outreach clinics in North San Diego County initially had no patients despite preventive health services that targeted migrant camps (see pages 61-62). These "no-shows" were produced by differing interpretations on the clinical side, primarily regarding the importance of scheduling clinic hours to accommodate the needs of migrant workers and their families. This ignorance reinforces the inadequacy of health policies based on traditional Anglo-Protestant values. As Hayes-Bautista (1992) asserts, "policy needs cannot be formulated as mere variations on a traditional theme" (p. 148), such as the 8-hour-a-day, 40-hour work week instituted by the Anglo-Protestant value system.

Struggles Behind the Veil of Uncertainty

Public policy decisions particularly about complex issues such as access to health care "are virtually always made behind a thick veil of uncertainty. They invariably require judgments about alternatives the outcomes of which are highly uncertain" (Dahl, 1989, p. 337).

Marshall (1992) portrays this veil as an implicit, pathological struggle between prevention and remediation attitudes by illustrating the "schizophrenic" core embedded in categorical health policies. He envisions someone saying:

> You are not a drug addict yet, so we cannot help you. Or, If you had robbed a bank, there would be something we could do. If you're just thinking about robbing a bank, there's not a whole lot we can do. (p. 53)

For example, Governor Wilson's 1996-1997 budget proposal perpetuates a pathological struggle for prenatal care and preventive health services because the budget channels a $20 million augmentation fund to the family planning program (Legislative Analyst's Office, 1996). This budget conveys a mindset in which the prevention or elimination of new lives outweighs the preservation of lives. The veil of uncertainty is further sustained by fear-inducing actions that may constrain health care for undocumented Latinas.

Hence, the County's health care policy under the Primary Care Grant places an overwhelming moral and professional burden on health care providers by requiring that they determine the legal status of patients in order to obtain funding for health care. Additionally, inconsistencies in applying the interference policy by INS officers who have "swept the parking lots" of clinics and hospitals, further escalate the fear and uncertainty of undocumented Latinos seeking access health care services.

By contrast, changes in the demographic growth of undocumented Latinos including "women and children [as] the newest addition to California's immigration pattern" (Lindquist, 1996, p. A19), might alleviate their struggles in

San Diego. These patterns may "induce public and private investments in data collection and analysis" (Furino & Sumaya, 1992, p. 204) for health policy formulation. However, some participants cautioned that data may be used as the "double-edged sword" previously discussed on page 79. For example, data might be used to accentuate the fertility rates of undocumented Latinas. Health care professionals, therefore, ought to scrutinize the appropriate utilization and accuracy of data concerning this population.

Thus, the mindset to eliminate preventive health services, the County's funding restrictions, the interference policy of the INS, and the contrary use of data may severely jeopardize a quality of life for undocumented Latinos. Moreover, this lack of commitment from the public, politicians, and health care professionals has inhibited an expansion of preventive health measures on a broader level between the U.S. and Mexico.

The Snare of Tokenism

When the Office of Border Health was staffed with one person to address preventive health measures for binational cooperation between Mexico and the U.S., it signaled a lack of commitment that indicated "our profound ambivalence" about improving the quality of life for undocumented Latinos (Bellah et al., 1985, p. 285). This decision further demonstrates the lack of "courage to face our deepening political and economic difficulties" (Bellah et al., p. 287). On the other hand, "we might find there is more basic agreement than we had imagined" (p. 287) by addressing border health issues between Mexico and the U.S. with more than nominal representation.

The federal government's threat to block grant Medi-Cal monies, which means less money will be distributed from the State, again discloses the snare of tokenism. As one participant emphasized, block grants may shrink the scope of benefits (see pages 70-71). The elimination of pregnancy-related coverage for undocumented Latinas will undoubtedly result in potentially life-threatening situations that impact the population across its parameters. This situation is compounded because of the "orphan status" of access to health care, which has become a domain or "a problem that nobody owns" (Haugen, 1992, p. 85). Health care professionals, therefore, ought to reclaim theory-building and policy-making for health policy changes so that undocumented Latinas can overcome "myriad barriers to get taken care of properly" (Stevens, 1993, p. 67).

Moreover, the importance of theory-building and policy-making is essential to counterbalance extreme limitations produced by a Zero Tolerance policy directed at undocumented Latinos. This policy sends a disheartening message about what might occur if access to health care is no longer a high priority; "It forces the consideration of the greatest extent of value issues: the morality of contagion, social worth, sexuality, costs of care, and near-certain death" (Hayes-Bautista, 1992, p. 147).

Value issues are embedded in policy formulation and implementation. These ethical attitudes are reflected in part by the tokenism generated from organizations and the government such as the AMA, CHAMA, HMOs, and County Board of Supervisors regarding human welfare. For example, the lack of commitment from medical organizations is partially attributable to their extreme level of independence, which acts to de-emphasize accountability. According to one participant, "the evolution of medicine as a private enterprise ... has incredible autonomy." Morgan (1986) referred to such autonomy "as the "ugly face" of organizational life" (p. 274). He further argued, "Human health is adversely affected by corporate practices that place profits before human welfare" (p. 274).

Likewise, economic interests impacted the County Board of Supervisors' AIDS policy, which ignored recommendations from two advisory groups--the HIV Planning Council and the HIV Coalition. The Board decided to implement a potentially fatal policy that ranked Latino families with AIDS as low priority risk groups. As one participant contemplated, "So, can you see the selfishness, the meanness of such ... legislation to a group of people--of innocent people?"

Impotence: A Product of Power Shifting and Policy Shaping

The present disequilibrium in health care policy indicates that changes in health care cannot remain cosmetic. Furthermore, an "American society will be poorly served in the 21st century ... if the broader and more complex health needs of this decade and the next millennium" (Furino & Sumaya, 1992, p. 201) do not provide an expansion of services and more efficacious health policies concerning undocumented Latinos. For example, the frustration currently voiced among some of the participants over severe budgetary constraints from Medi-Cal bloc grants, is due to the shift to more restrictive polices.

The shift in policy implementation activity from the federal to local levels is likely to cause inconsistencies in those health care programs that prioritize "popular" issues such as domestic violence, at the expense of life-threatening illnesses, such as AIDS. "True improvements will be difficult to attain without visionary leadership from the health professions and some empowerment of the presently disenfranchised, underserved groups to better articulate their needs and mold policy" (Furino & Sumaya, p. 201). Ironically, the lack of leadership within Latino organizations including CHAMA has actually worsened the level and quality of health care access for the Latino population. Latino organizations unwittingly neglected the health care needs of this population by channeling leadership efforts and material resources to improve Latinos' living conditions, such as the Mercado Apartment Project (see page 86).

Changes in health care policy may increase the fragmentation of health care services, a deconstructive process intensified by the oversight of Latino organizations mentioned above, and negative attitudes of the public, politicians, and health care providers. There is a tremendous need for education to promote understanding concerning the socioeconomic impact of fragmented services, and, as well, how negative attitudes regarding health care for undocumented Latinos maintain the status quo.

Changing present attitudes is dependent upon health care professionals' willingness to revisit altruistic messages from the past and the present, which emphasize social consciousness and the spirit of volunteerism. However, one health care administrator suggested that a reborn volunteerism effort may be unsuccessful, a casualty of the imbalance between public and private funding for health care services. The analogy of such negligence mirrors what often occurs between health policy formulation and implementation; "[Policymakers] want to have a thousand points of light" (Marshall, 1992, p. 53), but they don't enable us to create the lamp that would illuminate those other points of light.

Ethical Perspectives

All professions can serve the common good in the spirit of compassion by supporting values essential to create health policy change for access to health care (Jennings, Callahan, & Wolf, 1987). Ethical values include social solidarity, personal responsibility, and social advocacy. Social solidarity moves the system away from the "extreme of individualism and self-interest toward interdependence and fair access" (McCabe, 1993, p. 41). Personal responsibility incorporates "accountability, educational goals, and the shared obligation of everyone for health care access, health promotion, and prudent utilization of services (p. 41). The notion of social advocacy includes a broader perspective than patient advocacy, because the former process incorporates the needs of all members of society (McCabe, 1993).

Accordingly, the professions should "play a pivotal role in the creation of public frameworks for addressing and resolving public problems" (Jennings et al., 1987, p. 10). This effort requires the professions to overcome individual identification with special interest groups and rediscover the vision of their public duties. As a first step toward a richer vision for the future, which requires listening to the reflections of many voices (Jennings et al., 1987), professionals must discuss their public duties with each other. For example, the public duty of social work serves as a voice to understand the special problems of the poor, who are often hidden from public view. This effort "embodies a tradition of altruism, mutual aid, and social justice" (p. 9). Furthermore, these values must be consistently be reaffirmed if professionals are to meet the challenge of access to health care for undocumented Latinas.

The focus ought to center upon justice in its broadest conceptualization--"that is giving what is due to both persons and the natural environment" (Bellah et al., 1991, p. 143). The ultimate aim of health care reform should embrace a holistic approach, which respects ethical perspectives in a shared search for the common good. We need to change our hearts and broaden our sympathy for health care "goods" that are accessible, primary, affordable, and value-oriented (Bellah, et al., 1985; 1991; McCabe, 1993). This formulation is not an issue of charity, wherein the rich give to the poor, but of "solidarity and hope for the whole human species in relation to the whole natural world" (p. 143).

Leadership Issues

Recommendations reflect the cautious optimism and solidarity portrayed by the viewpoints of participants in both studies. Caution is an underlying trait in these viewpoints, a product of uncertainty regarding pending health care legislation. Hence, effective leadership for changes in health policy "should be viewed as a single sweeping gesture pointing from important ... [health issues] to desirable solutions, to adopted changes, to implementation of those changes, and to outcomes that indicate the problems have been overcome" (Bryson & Crosby, 1993, p. 319). Therefore, a more balanced perspective, one that moves away from the extreme of zero tolerance toward greater knowledge and understanding about what changes are needed in health care policies ought to be adopted if we are to facilitate access to health care for undocumented Latinas at the microlevel and all human beings at the macrolevel.

Education

The participants in both studies thus strongly endorse increased education for health care providers, politicians, and the County Board of Supervisors. They view education as a paramount weapon in the struggle to overcome the potentially devastating impact policies such as Zero Tolerance and Proposition 187 have upon a quality of life and skyrocketing health care costs. Participants recommend educating politicians and the public to clarify nebulous federal laws that are often misinterpreted, such as Medi-Cal eligibility and permanent residency requirements. They further recommend education efforts to promote community and public sector awareness of how ignorance and negative attitudes may escalate the fragmentation of health care for undocumented Latinos.

The participants endorse expansion of preventive health education programs aimed at decreasing life-threatening illnesses such as AIDS. They assert that health policies should encompass a holistic perspective. Their assertion is based on the premise that "[undocumented Latinas] are full human beings" requiring holistic, quality health care (Hayes-Bautista 1992, p. 149). The participants propose preventive care as a counterpart to follow-up care--especially with undocumented Latinas who have breast cancer or are pregnant.

However, adjunct health care professionals, such as social workers who promote preventive health care also need to utilize preventive health measures while performing their duties. These measures include the utilization of face masks in all activities that may expose the worker to contagious diseases from patient contact. Preventive health education for these professionals should act to reduce the fear and spread of contagious diseases such as TB. Further, this education may decrease their potential to overestimate the number of undocumented people seeking eligibility for health care, as previously noted on pages 60-61.

Research

The participants, therefore, endorse collaboration between hospitals and the government to increase research and data collection efforts to produce more accurate demographic profiles concerning health care access. The participants in both studies caution, however, that data can be used "as a double-edged sword," an issue previously discussed on page 79. Data may serve to exaggerate delicate issues such as fertility rates of undocumented Latinas and, as well, provide the INS with information resulting in deportation. The participants thus strongly recommend the confidentiality of data profiles be stringently enforced.

By contrast, data can be used in a positive manner. This usage is exemplified in research projects such as the "Resource Rolodex," described in Latino Health News (1996):

> The [Latino] Coalition has been collecting information and creating a database of health experts and programs serving Latino communities.... Over 200 Resource Rolodex (health expert) and Health Program records have been collected.... The statewide database will be available by the end of 1996 to health and human service providers, community-based organizations and government entities. (p. 4)

Fundamental Premises: Pillars of the Right to Health Care

In addition to education and research projects, the participants display overwhelming solidarity in supporting the fundamental right to health care for all human beings. The participants recommend that health care should be codified as a right, similar to the status of education in the U.S. One participant comments:

> ... the health of women and children especially, and everybody should be treated not as a privilege, but really as a right ... like education and any other kind of pursuit of happiness which our Constitution says we are entitled to [possess]. How can you pursue happiness without health?

Expansion of Health Care Services. The participants in this study recommend looking outside California to other states, such as Texas, for solutions to reduce costs and expand health care services. For example, they propose expanding the role of midwives; charging reduced fees such as a $700 delivery fee, which includes prenatal and postnatal care; and operating birth centers in hospitals (see page 84).

Some participants endorse case management as a methodology that acts to reduce the health care fragmentation. For instance, "one stop" clinics, similar to the clinic started by a participant, require a minimum of paperwork and offer case managers on their staffs (see page 83). Fragmentation can be alleviated, therefore, through the coordination of a broad range of services, including health care, food, interpreters, transportation, housing, legal assistance, and counseling for domestic violence.

Some participants in both studies propose an increase in health care programs, such as migrant outreach. A health care professional illustrates the efficacy of these programs through the actions of nurses and health care workers:

> ... they go out to the actual camps, ... provide transportation, provide bilingual staff, and are sensitive to their needs.... They offer health education to a population in its language because people are illiterate. They give them oral presentations and visual presentations--not necessarily a pamphlet or leaflet that they would get in a doctor's office ...

One nurse practitioner in the pilot study cites an outreach program through San Diego State University called *Por La Vida*, "where women go into the community to discuss health care." These women are *consejeras*--esteemed, upstanding Latinas in the community--whose agenda centers upon discussing health and safety issues such as heart disease, drugs, violence, and gangs (Caudle, 1993). The same participant also recommends setting up clinics such as the Logan Heights Family Health Center, which is situated within a school in urban Logan Heights.

To promote these efforts, outreach visits and clinic hours should be scheduled to accommodate employment hours and needs of migrant workers and their families. This accommodation is a pivotal point if we are to ensure that these programs serve as successful effective vehicles for health care access.

Universal Access. The participants in both studies recommend universal access and/or universal health insurance for all human beings, regardless of "what color they were, or how much money they made, or where they worked." The advantage of this approach is "that it allows for complete portability of benefits across states.... This approach would virtually eliminate rationing of health care on the basis of income and would end the two-tiered, private-public reimbursement scheme currently in place" (Torre & Rochin, 1992, p. 180).

Funding could be obtained through a general payroll tax, or the implementation of the funding model utilized by Social Security. This plan would, however, nullify the private-sector's health insurance business. Moreover, additional regulations might diminish the freedom of choice currently experienced in treatment planning between physicians and patients (Torre & Rochin, 1992). However, the negative effects of these regulatory actions are offset by the long-term consequences of inaction regarding health care access. Additionally, the negative effects of these changes can be alleviated by measures aimed at reducing funding deficits. For instance, the federal government could act to ease the funding gap by assuming more responsibility for reimbursement of health care services.

Federalized Reimbursement for Health Care. Reimbursement for undocumented immigrant health care ought to be treated as a separate budget issue apart from Medicaid. "[Reimbursement] should not be any part of block grants to states for Medicaid or other programs. It should not come from Medicaid funding at all, not even indirectly" ("Health Care," 1995, p. B8). House Speaker Newt Gingrich, a supporter of the separate health care budget, estimates that this "reimbursement would cost about $4.4 billion nationwide, with about half of it going to California" (p. B8).

This financial reimbursement is crucial for the University of California, San Diego (UCSD) Medical Center in Hillcrest, if it is to prevent a possible shut-down or corporate takeover in the near future due to enormous health care costs. For example, the Medical Center spends "$30 million to $35 million a year for treatment" ("Health Care," p. B8) of undocumented immigrants. In 1995, hospitals spent "an estimated $382 million" (p. B8) throughout the state of California on health care for undocumented immigrants. However, with a separate health care budget, the Speaker suggested that hospitals could send the bills for treating undocumented immigrants directly to Washington, D.C. ("Health Care," 1995). Even though there is a sense of crisis over health care for undocumented immigrants, the participants' suggestions for empowerment offer reasons for hope.

Leadership Through Empowerment

The participants in this study emphasize the activist role Latino physicians must occupy at the local level in the fostering of preventive health measures and access to health care. "At the local level, the role of practicing physicians is crucial" (Furino & Sumaya, 1992, p. 208). They further offer suggestions to assist Latino physicians in surmounting obstacles to participation, such as negative attitudes toward undocumented Latinos, avoidance, and lack of experience in leadership roles (see pages 88-89). For instance, participants recommend focusing leadership efforts on health policy issues, rather than time-consuming projects such as the Mercado Apartment Project. The participants propose that Latino physicians belonging to CHAMA partake in forums and coalitions that focus upon empowerment, knowledge, and understanding to promote access to health care. CHAMA leadership is critical in facilitating a shared endeavor, one that moves away from the current polarization toward increased collaboration in the resolution of differences regarding health care for undocumented Latinos (Gerzon, 1996). Moreover, the influence relationships formed between Latino physicians and members of the Latino community are vital for "the empowerment of local communities and their participation in policy-making" (Furino & Sumaya, p. 208).

Participation in Forums and Coalitions. The participants strongly recommend that Latino health care professionals participate in forums and coalitions such as the Latino Coalition to promote health policy issues (see page 88). This action both empowers Latinos and offers valuable resources to create change. In addition, the educative efforts of radio stations, previously noted on page 90, may inspire involvement of people within and outside the Latino community. Participants recommend increasing coalition membership to promote a more rapid response to emergent Latino health policy issues, and to identify policy priorities for the implementation of a health policy agenda.

For example, the Latino Coalition's agenda calls for; (a)increased research on Latina health issues, (b) the collection of Latina health data by subpopulation, immigrant status, age, and acculturation levels, (c) the inclusion of Latinas on teams that review research project proposals and awards, (d) the need to utilize ethnicity formulas in research to determine need, (e) a statewide cultural competency initiative, (f) support for the creation of a federal clearinghouse, such as the Resource Rolodex, (g) the advocation of increased funding for government health programs serving Latinas, (h) the allocation of responsibility for Latina health issues to the Office of Minority Health and the Office of Women's Health, (i) the establishment of community hub centers by phone companies, who would volunteer their computers for Internet access, and (j) support for voter registration drives ("Highlights of Conference," 1996).

On May 18, 1996, this agenda was delineated by a plenary meeting held to discuss the development of working group agendas. Policymakers attending the meeting included:

Congressman Xavier Becerra, a leading advocate in the area of health care access, State Senator Hilda Solis, and Illeana Herrell, from the Health Resources and Services Administration (HRSA) in Washington, D.C. Several health care activists promoted the resurgence of collaborative partnerships and volunteerism as creative solutions to health care access barriers.

Volunteerism and Partnerships. The participants recommend volunteerism to facilitate health care services and supplement severe economic constraints. Creative solutions focus on partnerships between physicians and hospitals to integrate volunteer services for health care. For instance, one participant's idea concerned the integration of obstetrical (ob)-gyn services by the hospital, physicians, and anesthesiologist. By affording reduced rates from volunteer efforts, this collaboration might significantly decrease the number of premature births and neonatal intensive care admissions.

Some participants feel that hospitals could increase their resource contributions to the community without spending huge sums of money. One participant articulates some very specific recommendations: "Hospitals can provide meeting places for organizations, free educational lectures, speakers for schools, job placement for adolescents, and sponsor sporting events such as soccer." Hospitals ought to expand their leadership beyond the public/government and private/business sectors, and assume their role as social-sector institutions. This redirection in focus combines the traditional aims of promoting well-being and human health with the promotion of civic consciousness based on responsible participation (Drucker, 1994).

Sharing Knowledge. Lastly, one participant strongly recommends hospitals require more of their physicians, specialists, and departments to transcend economic interests and share their knowledge. She argues, "They can do more with some of the knowledge that they have about management and give direction to some of the smaller centers ... and community organizations." For instance, she suggests that shared knowledge would be particularly helpful in assisting groups of people "with good ideas," such as coalitions, through the incorporation process. According to this health care administrator, incorporation would prove highly beneficial to these groups, as it enables funding for worthy causes.

Furthermore, sharing knowledge for the common good ideally would act to diffuse preoccupation with economic interests, a focus that may ignore health care issues such as holistic health care (see pages 61-62). Drucker (1994) contends knowledge has become "the new resource for economic performance" (p. 78). However, knowledge as an asset "has no price" (p. 78).

The importance of sharing knowledge is predicated upon the realization that "economic interests can therefore no longer integrate all other [health care] concerns and interests" (Drucker, 1994, p. 78), although they can be compromised. Hence, "half a loaf is still bread" (p. 78). On the other hand, when it comes to the value of human life, "half a baby, in the biblical story of the judgment of Solomon, is not half a child. No compromise is possible" (p. 78).

Conclusions

According to the Judeo-Christian ethic that serves to fundamentally order U.S. society, human worth is an inveterate moral issue that cannot be compromised. The integral and intransigent quality of human worth reflects the bedrock of our social consciousness. This common ground, therefore, compels us to restrain the "we versus them" mentality that characterized Nazi Germany and other such tyrannical regimes, and a mentality that threatens to reoccur if access to health care for undocumented Latinas and all human beings is not a top priority in our national consciousness. "The question for the responsible citizen today is, Are we responsible only for our own good or also for the common good? Even a benevolent tyranny can permit us the former; only a genuine democracy can make possible the latter" (Bellah et al., 1991, p. 81).

The content of this study urges that economic interests can no longer be showcased to camouflage the underlying catalyst responsible for serious violations and severe limitations upon effaceable, socially just health policy. The review of the literature and data analysis suggest that ignorance across societal sectors is the most critical barrier preventing necessary health care access for undocumented Latinas. Consequently, education for the community is generally promoted as the essential remedy to alleviate this and any population's pain, despair, and increased morbidity related to health care exclusion. Moreover, the participants believe education represents the crucial tool for subjugating this wrath of ignorance among the political elite.

This study contributes to refocusing the analytic lens that envisions Latinos "as faceless, anonymous, unthinking, [and] uncreative entities" (Hayes-Bautista, 1992, p. 148), and so represents the first step in ignorance abatement. This transformation may generate a more passionate role and a more compassionate welcome for Latinos as cultural activists, and promote "an understanding of the process by which Latinos continue to create meaningful actions" (Hayes-Bautista, p. 149), because we often view people who champion their own rights as proponents of moral choices that promote the common good. This decision-making process may include basic questions such as, "What shall I eat for lunch?" to [those] as complex as, "What is my individual and professional responsibility to a Latino person with AIDS?" (p. 149)

Health care professionals and health educators, therefore, can utilize this study as a tool in the ongoing effort to overcome the dangers of oppression toward undocumented Latinos. Professionals can utilize this study as a knowledge vehicle to communicate its ardent message among the public and policymakers--that Latinos' contagion and mortality may actuate the contagion and mortality of the general population and the general well-being of any population. In addition, this study serves as an excellent tool for reconciling myths, i.e. by providing first-hand knowledge from health care administrators that undocumented Latinos are not draining the health care system. The crux of the study points to education to promote acceptance and understanding of this moral dilemma from the public, politicians, and the media, and in so doing argues the development of health care policy that is equitable, holistic, affordable, financially-endowed, and consistently implemented from federal to local levels.

Our ultimate social responsibility, however, is to be educated in the broadest sense to dissociate the fallacies that generate among the aforementioned precursors of ignorance. This dissertation, thus, emanates a Platonistic spirit that professes "the object of education is to teach us to love what is beautiful" (Plato, 1955, p. 165) because all life is beautiful. In this light, dialogue and advocacy supersede ignorance and hatred to embrace everyone; health care activists, employers, employees, and, as well, general citizens who are not working closely with undocumented Latinas. Hence, knowledge and understanding call for participation and activism among the populace about the value of human life to promote health care access for undocumented

Latinas and all human beings.

For instance, a universal learning process is presently unfolding by means of a television series called "The Bold and the Beautiful". This series highlights the difficulties and hardships undocumented Latinas experience, such as fear of deportation while working in a clothing manufacturing company. Additionally, the series serves as a powerful educational voice because it reaches viewers both locally and globally. Viewers are presented with a realistic portrayal of compassion and consciousness-raising images about undocumented Latinos throughout the program. For example, the program underscores undocumented Latinas' vulnerability including health and safety risks, poor living conditions, and laborious working environments. Moreover, it provides a compelling picture of Latinos' desire for a better quality of life including health care access for themselves and all human beings. Accordingly, this program also dispels the notion that undocumented Latinos are a drain on the economy and the health care system.

Likewise, this qualitative interview study cultivates enlightenment by advocating a comparative review of California's health care system to those states that exemplify successful health care models for undocumented Latinos, such as Texas. Moreover, the study delineates models of coalitions that can mobilize individual Latinos, Latino communities, and organizations such as CHAMA to engage in educative efforts aimed at changing health policy. The study also reinforces the manner in which the shared power and "silent leadership" of Latinos can serve as catalysts for change via voting polls and letter-writing campaigns to federal, state, and local officials including House Speakers, Governors, and members of County Boards of Supervisors, respectively.

Transformation through a cultural activism model reaffirms hope that undocumented Latinas and all human beings can achieve a better life than mere survival. This study reinvigorates the call for common humanity, to realize the significance of the quest for triumph over tribulation (Estes, 1993). From the moment we decide to act on this call for humanity, "we become beings with purposes larger than material gain, finding meaning more inclusive than work and feeling rewards greater than profit" (DeForest, 1986, p. 231).

Hence, education for transformation necessitates the resurrection of our hearts and souls for human well-being primarily through love, respect, common humanity, and social responsibility. As one participant in this study argues, "if we are able to attain incredible feats such as [space travel] to the moon, imagine what we might accomplish by redirecting our efforts to health care access on earth" (see page 78). Moreover, such negligence has sociopolitical consequences, especially since the U.S. and South Africa are still the only developed countries of the world without a nationalized health care program for everyone.

Accordingly, if we are to surmount the severity of negligence concerning health care, Americans must redefine individual and jointly held notions of the value of human life, and “take responsibility for the [schizophrenic] courses that they have set for themselves” (Morrow, 1994, p. 77).

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Appendix A

University of San Diego
CONSENT TO ACT AS A RESEARCH SUBJECT

Toni Spadaro, a doctoral student at USD, School of Education is conducting a research study on access to health care for undocumented Latinas. Since I have been selected to participate in this study, I understand that I will be asked questions about access to health care.

This data collection will take about 60 to 90 minutes of my time for 3 meetings. Participation in this study should not involve any added risks or discomforts to me. My participation in this study is entirely voluntary. I understand I may refuse to participate or withdraw at any time without jeopardy.

I understand that the interviews will be audiotaped and later transcribed and coded so as to maintain anonymity. I understand my research records will be kept completely confidential. Audio and video tapes will be destroyed upon completion of the transcripts.

My identity will not be disclosed when findings are reported. I further understand that findings from this study will be reported in such a way as to maintain my anonymity.

Toni Spadaro has explained this study to me and answered my questions. If I have other questions or research-related problems, I can reach Toni Spadaro at 457-3245, or Dr. Mary Abascal-Hildebrand, Dissertation Director at 260-4270.

There are no other agreements, written or verbal, related to this study beyond that expressed on this consent form. I have received a copy of this consent document.

I, the undersigned, understand the above explanations and, on that basis, I give consent to my voluntary participation in this research.

______________________________ ______________________________
Signature of Subject Date

____
Location

______________________________ ______________________________
Signature of Researcher Date

______________________________ ______________________________
Signature of Witness Date

Appendix B

Guiding Interview Questions

Individual Field Interview

1. Tell me about your experience in health care with Latinas.
2. In your position, how does health care policy (plans, programs, projects, decisions, actions, budgets, rules, or regulations) facilitate or hinder access to care for undocumented Latinas?
3. Can you tell me how outreach programs or grassroots activism in San Diego have influenced access to health care?
4. To what extent do the restrictions imposed by Proposition 187 affect access to health care for undocumented Latinas?
5. Close your eyes and imagine what the future would be like for access to health care and complete the following sentence, "Wouldn't it be nice if ..."
6. Other questions as appropriate.
7. Is there anything you would like to ask me?
8. Is there anything else I should have asked you?

Focus Group Interview

1. What is your experience in health care with Latinas?
2. What do you imagine would be a more useful health care policy?
3. What things do we need to do to develop health care policies (plans, programs, projects, decisions, actions, budgets, rules, or regulations)?
4. Other questions as appropriate.
5. Is there anything you would like to ask?

Appendix C

Letter to Participants

Date:

Name:

Address:

Dear ________________:

Thank you for your willingness to serve as a participant for the individual field interview. The second interview is aimed towards a distillation of preliminary assumptions from the data analysis. It will be facilitated by an examination of the interview transcript and a summary sheet comprised of themes, explanations, and speculations, previously sent to you. Please bring these items to the interview.

The site of the_____________________interview, as mutually agreed upon, is at the________________________. I look forward to seeing you on _______ at________. As discussed, the interview may last for about 60 to 90 minutes. If you have questions or need to contact me, my phone number is ______________. You may also contact Dr. Mary Abascal-Hildebrand, Dissertation Director at 260-4270.

Thank you again for your participation.

Sincerely,

Toni J. Spadaro

Appendix D

Letter to Participants

Date:

Name:

Address:

Dear ________________:

As a small token of my appreciation for your efforts, I invite you to share in a conversation about competing polices in access to health care for undocumented Latinas for the final phase of our journey.

The site for the focus group will be at____________________ ___________________________ on ______________from _______to _________. A continental breakfast will be served 20 minutes prior to the meeting. Directions are enclosed.

If you have questions or need to contact me, my phone number is ________________. You may also contact Dr. Mary Abascal-Hildebrand, Dissertation Director at 260-4270.

Again, I would like to thank you for your participation and contributions toward the future search for knowledge and understanding about access to health care for Latinas and for all human beings.

Sincerely,

Toni J. Spadaro

Appendix E

Demographic Profile of Participants

Participant # 1
Age: 39 **Gender:** Female
Education: B.S.N., 1980; M.S. in Cross-Cultural Community Health Nursing, 1990, San Diego State University (S.D.S.U.).
Professional Background: San Diego Department of Public Health, general public health nursing for 7 years; Office of AIDS, senior case-manager for 5 years; Currently health administrator specializing in transborder issues.

Participant # 2
Age: 43 **Gender:** Female
Education: B.S. in Behavioral Health, 1976; M.S. in Public Health, 1993, S.D.S.U.
Professional Background: Volunteer at local community clinics for 20 years; Worked in nursing at federally funded health centers in San Diego County for 15 years; Presently hospital administrator for private medical center.

Participant # 3
Age: 72 **Gender:** Male
Education: B.S. in Letters, 1944, Havanna Provincial Institute; M.A. in Hispanic Language Literature, 1955, University of Chicago; Ph.D. in Romance Languages, 1962, Northwestern University.
Professional Background: Professor, Hispanic Literature, Roosevelt University, 1956-1964; Professor, Spanish Language, and Administrator at Franklin and Marshall College from 1964-1980; Retirement; Independent social worker and health care activist, 1984 to present.

Participant # 4
Age: 59 **Gender:** Female
Education: B.S.N., 1963, University of Colorado; M.S.N. in Nursing Services Administration, 1968, Catholic University.
Professional Background: Instructor in R.N. Diploma Programs and Associate Degree (A.D.N.) Programs from 1963-1978; Retirement; Volunteer work, 1990-1995; Primary Care Nursing, 1994-1995; Hospital administrator and education coordinator at local primary care clinic, 1995-1996; Presently working in Home Care.

Participant # 5
Age: 45 **Gender:** Female
Education: B.A. in Management, 1974; M.S. in Counseling, 1976, Memphis State University; M.B.A., 1992, S.D.S.U.
Professional Background: Assistant Director, mental health

center, 1975-1979; Regional Director of local birth control facility, 1979-1983; Currently health administrator of local community health clinic for 13 years; Holds membership in local community health care organizations.

Participant # 6
Age: 50 **Gender:** Female
Education: B.S.N., 1979; M.S.N., 1981, Arizona State University; Currently doctoral student at local university.
Professional Background: Primary program development: health promotion and disease prevention; Held supervisory and administrative positions in Southern California for 15 years; Presently community health administrator for local health care organization.

Participant # 7
Age: 35 **Gender:** Female
Education: B.S.N., 1985; M.P.H., 1992, S.D.S.U.
Professional Background: Nursing experience in health education, pediatric intensive care, public health, and discharge planning for 11 years; Currently administrator for local health maintenance organization.

Participant # 8
Age: 33 **Gender:** Female.
Education: A.D.N., 1985, San Diego City College; B.S.N., Ph.N., 1995, University of San Diego.
Professional Background: Community health nursing and home health nursing for the past 10 years.

Participant # 9
Age: 45 **Gender:** Female.
Education: Attended Cal-Western University, 1969-1971; Majored in Creative Writing.
Professional Background: Manager and administrator at local medical center for 20 years; Presently health care consultant.