POLITICS, STIGMA, AND THE MARKET:

ACCESS TO HEALTH CARE FOR THE POOR IN THE UNITED STATES, 1965-2020

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POLITICS, STIGMA, AND THE MARKET:

ACCESS TO HEALTH CARE FOR THE POOR IN THE UNITED STATES, 1965-2020

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Access to health care is both a cause and consequence of inequality in the United States. To address lack of access to care for the poor, the federal government initiated the Community Health Center (CHC) program in 1965 as part of the War on Poverty. The CHC program—unusual for its bipartisan support and mission to defy socioeconomic stratification by serving anyone regardless of ability to pay—provided care for nearly 30 million predominantly poor patients across 13,000 clinics in 2019. Given its substantial growth in recent years and direct contact with millions of socially and economically marginalized Americans, the CHC program is an important institution for understanding how structural conditions impact population health and inequality. This dissertation uses three complementary methodological approaches to examine the political, social, and spatial dynamics of the CHC program. The first empirical chapter draws upon nearly forty years of historical evidence and leverages a comparison with Medicaid—a highly-contentious policy sharing the same purpose, place, and period—to understand how CHCs avoided controversy. I argue that policymakers' initial articulation of frames aligning with both morals *and* markets allowed the CHC program to resonate across ideological divides, while Medicaid's lack of market alignment and pervasive framing as inequitable inhibited its political support. The next chapter relies upon a qualitative case study of a small-town health center to explore the interpersonal, organizational, and institutional mechanisms underlying how CHCs deliver care to low-income patients. Describing how shifts toward marketization have impacted the safety net

setting, the findings extend scholarship on stigma and poverty governance at the nexus of debates over health care as a right versus a commodity. The final empirical chapter uses a novel historical dataset to document geographic variation in Hispanic immigrants' proximity to CHCs since 1970, highlighting how access to CHCs may be a crucial yet underexplored factor in understanding the health of this disproportionately uninsured population. In the conclusion, I discuss the theoretical, substantive, and policy implications of the findings, as well as opportunities for future research addressing the longstanding disparities in access to health care for low-income Americans.

BIOGRAPHICAL SKETCH

Emily Anne Parker was born and raised in Montpelier, Vermont. She received a Bachelor of Arts in Sociology, magna cum laude, from American University in 2012. Following her undergraduate degree, she worked at the New York State Health Foundation where she focused on issues of access to health care for underserved populations. In 2015, she began her graduate studies in Policy Analysis and Management at Cornell University, with a concentration in Sociology and minor in Demography. In the Fall of 2021, she will begin an appointment as a Postdoctoral Fellow with the Population Studies Center at the University of Michigan.

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Though writing a dissertation at times felt like a solitary journey, especially amidst a global pandemic, I have been extremely fortunate to be surrounded by a wide array of supporters this year and for many years past. First and foremost, this dissertation would not have been possible without my committee, particularly my chair, Laura Tach, who has advocated for and believed in me every step of the way. Laura picked me up when I faced obstacles and provided the intellectual and practical support I needed to start and sustain this research; I will always strive to emulate her creative and thorough scholarship, as well as the care and thoughtfulness she brings to mentorship. I am also very grateful to Sharon Sassler for taking me in under her wing as a first-year graduate student and training me in qualitative methods; she has taught me the academic ropes, consistently provided insightful feedback, and brought a sense of humor and levity to all of our collaborations. Vida Maralani has inspired me in many ways; her curiosity about the social world is infectious, she has shown me how to approach research carefully and methodically, and has reliably been there for me when I needed advice or cheerleading. Since my early days of graduate school, Erin York Cornwell has also served as a supportive mentor offering advice on everything from classes to publishing to developing my research agenda; I have always been able to count on Erin to push me to think sociologically and incorporate social theory into policy-oriented research. Many thanks to all of my committee for helping me cross the finish line.

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I owe much gratitude to the love and support from my family. My dad instilled in me a lifelong love of learning and a genuine sense of curiosity about the world. He taught me to think outside the box, resist being predictable, and showed me how to be a thorough researcher. My sister, Becky, has been my lifelong best friend. She has inspired me to follow my passions and find both the good in people and joy in the beautiful things in life. I aspire to be as keen of an observer as she is, spotting and relishing the details. My mom has the biggest and warmest heart of anyone I have ever met and shares her love selflessly with all who cross her path. From starting not just one but two successful businesses, she has shown me since I was young what hard work and determination look like. My ambition, perseverance, and independence are all attributable to her. And thanks to my mom's tea shop, The North Branch Café, for continual supply of delicious tea for both caffeinating and calming me through graduate school! Beyond my immediate family, I am very grateful to Uncle Gerry who instilled an appreciation of writing and hockey, to Uncle Rod for keeping me well-fed and cared for as an undergraduate and checking in on me ever since, and Aunt Grace for imparting her love of yoga, hiking, and adventure.

Last but certainly not least, I thank my partner, Tom, for believing in me, loving me, and cheering me on for the past six years. This dissertation is a direct result of his encouragement; whenever I have had doubts or felt like an imposter trying to learn new theoretical or methodological approaches, he has stood there firmly, not let me give up, and reassured me that I can do whatever I set my mind to. We have spent countless hours talking about my research; he has pushed me to be more rigorous, provided thorough—albeit sometimes stinging—criticism, encouraged my now insatiable appetite for books, and has read and given feedback on almost everything I have written. He has grounded me through difficult times, been my adventure partner in and around Ithaca as well as across the country and all over Europe, and we have shared so

much joy together in loving our cats. Thanks to our feline companions, Terry, Gary, and Tabitha, for making us relax, play, and being a never-ending source of delight and adoration for us both.

Finally, I am grateful to the people, community, and natural beauty of Ithaca. Our waterfalls, gorges, lakes, creeks, hills, and parks have inspired much of this dissertation. I will always look back fondly upon the six years I have been lucky to live in this magical place.

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LIST OF ABBREVIATIONS

Affordable Care Act (ACA)

American Medical Association (AMA)

Aid to Families with Dependent Children (AFDC)

Children's Health Insurance Program (CHIP)

Community Health Center (CHC)

Congressional Budget Office (CBO)

Department of Health and Human Services (HHS)

Department of Health, Education, and Welfare (DHEW)

Department of Social Services (DSS)

Earned Income Tax Credit (EITC)

Federally Qualified Health Center (FQHC)

Health Maintenance Organization (HMO)

Health Resources and Services Administration (HRSA)

Health Security Act (HSA)

Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA)

Medically Underserved Areas (MUAs)

National Association of Community Health Centers (NACHC)

National Health Insurance (NHI)

National Health Service Corps (NHSC)

National Welfare Rights Organization (NWRO)

Neighborhood Health Center (NHC)

Office of Economic Opportunity (OEO)

Office of Management and Budget (OMB)

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)

Primary Care Block Grant (PCBG)

Rural Health Initiative (RHI)

Supplemental Nutrition Assistance Program (SNAP)

Temporary Assistance for Needy Families (TANF)

CHAPTER 1

INTRODUCTION

Access to health care is both a cause and consequence of social inequality. In the United States, this association has been intensified by the historic stratification of our health care system that rations care based on socioeconomic resources, leaving marginalized Americans few opportunities to receive medical services (Hoffman 2012). Since 1965, the U.S. government has attempted to remedy this problem by providing health care to the poor through two major policy interventions: Medicaid, a federal-state health insurance program for low-income families, and the Community Health Center (CHC) program, a federally funded network of clinics targeting low-income and medically underserved places. While an abundance of social scientific research has examined the role of Medicaid in attenuating or exacerbating inequalities in access to health care as well as health outcomes, social scientists have tended to overlook the institutional setting where the state delivers health care to the poor: Community Health Centers. This dissertation aims to remedy this oversight by examining the *political, social,* and *spatial* dynamics of the CHC program. Specifically, I assess how this institution has avoided political controversy, the qualitative experience of the poor in this safety net setting, and spatial inequities in access to CHCs for historically underserved populations. Below I first provide a general overview of the program before outlining the three empirical chapters of the dissertation.

Emerging from President Johnson's War on Poverty, the CHC program began as a small demonstration project developed by the Office of Economic Opportunity (OEO) that funded clinics in poor urban and rural communities (Sardell 1988). Motivated by a social justice mission

and the philosophy of health care as a human right, the CHC program established clinics with free or low-cost services in highly impoverished places where private medicine would not voluntarily practice (ibid). Though modest in its origins, the program expanded slowly and steadily over time, establishing a nationwide, multi-level advocacy network with strong ties to Congressmembers (ibid). It narrowly avoided multiple attempts at retrenchment as the political landscape shifted in the 1980s from welfare state expansion to one of austerity in the name of the free market.

The CHC program has grown tremendously in recent years due to its accomplishment of widespread bipartisan support (Lefkowitz 2007). President George W. Bush nearly doubled the number of delivery sites, and President Barack Obama *more* than doubled its size (author's own calculations), such that as of 2019 there were nearly 13,000 clinics nationwide (NACHC 2021). In turn, the number of patients served as well as the overall federal grant funding have also nearly tripled since 2000 (Figure 1). On an annual basis, the CHC program received nearly $5 billion in grant funding in 2019, and an additional $16.6 billion from public insurance (Medicare, Medicaid, and CHIP) reimbursement.[1] Now touching almost all corners of the country and receiving a substantial portion of federal funding, the CHC program is a critical institution for understanding how the state intervenes in health care for underserved populations.

This massive growth, which shows no signs of subsiding, means that many people now encounter this federal program. As of 2019, CHCs served nearly 30 million people, which equates to one in eleven Americans. CHC patients are primarily low-income, with fully 91% of health center patients in or near poverty (below 200% of the federal poverty level) (NACHC 2021). Health centers care for a disproportionate share of racial and ethnic minorities: as of 2019, 62% of patients were minorities compared to 40% of the U.S. population, translating to 1 in 7 minority

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[1] https://data.hrsa.gov/tools/data-reporting/program-data/national

Americans attending a health center (ibid). CHCs have also historically targeted services toward certain disadvantaged populations, including 5.2 million public housing residents, 1.5 million homeless, over 1 million agricultural workers, 7.4 million non-native English speakers, and nearly 400,000 veterans annually (ibid). With a longstanding focus on serving vulnerable groups with complex medical conditions, it is important to understand how CHCs shape the health and well-being of disadvantaged communities.

Figure 1. Community Health Center Patients and Grant Funding, 1970-2019
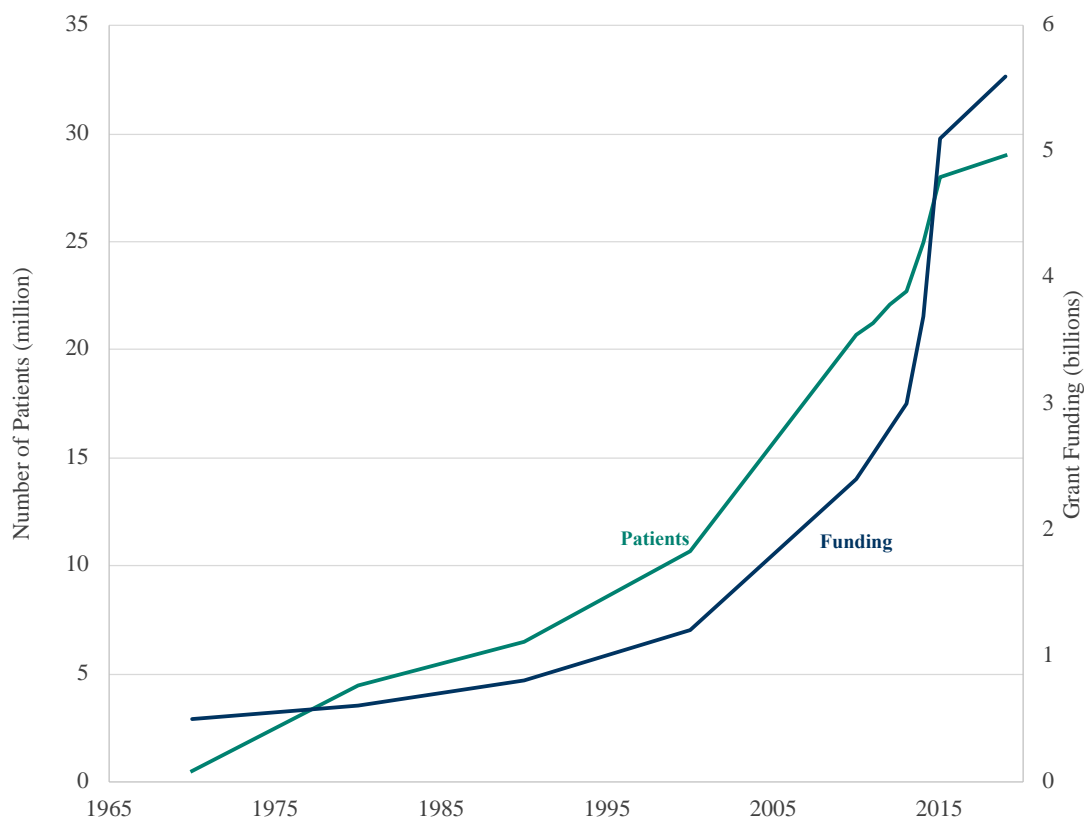
Sources: National Association of Community Health Centers (2021) and Bailey and Goodman-Bacon (2015)

I now review key features of the CHC program that will be necessary to understand the relevance, arguments, and contributions of the dissertation. The first point to clarify is that CHCs offer primary care services, including a comprehensive array of services for generalized medical concerns, mental health, dental care, reproductive health services and family planning, enabling

services, and care coordination. CHCs do not offer the specialist services of secondary care providers, nor the tertiary care services found at hospitals, such as surgery and emergency procedures. Therefore, CHCs are not a panacea for the un- or under-insured population, as specialist care and hospital visits often remain out of reach for these individuals, even if they have access to CHCs. The second matter that requires explanation is terminology: the modern-day CHC program is an umbrella term that includes Federally Qualified Health Centers (FQHCs) and look-alike centers. The technical difference is that FQHCs receive annual federal grant funding and additional benefits like higher public insurance reimbursement, while look-alikes do not meet the criteria necessary to receive federal grant funding but do qualify for similar reimbursement benefits. There are also special population centers, most but not all of which are also FQHCs, including Migrant Health Centers (MHCs), Public Housing Primary Care (PHPCs), and Health Care for the Homeless. The focus of this dissertation is entirely on FQHCs, or those clinics that receive annual federal grant funding, which is a highly competitive process and results in a distinctive institutional setting from look-alike clinics due to its direct involvement and regulation from the federal government. Throughout the dissertation, though, I refer to the CHC program because its terminology encapsulates the broader program and more closely corresponds to its historical political development.

The third important characteristic of CHCs is what distinguished these clinics from the broader health care system: according to their legislative statute, CHCs are required to serve any patient, *regardless of ability to pay*.[2] Although CHCs originally offered free services to entire communities, they subsequently adapted to a sliding scale fee model (Sardell 1988). Each CHC is

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[2] Section 330 of the Public Health Service Act (Title 42 of United States Code (U.S.C.) Section 254b) provides funding for CHCs and as a condition for receipt of this funding, CHCs must ensure that "services shall be available to all residents…without regard to method of payment or health status" (42 C.F.R. § 51c.303 (v)(3)).

allowed to establish its own sliding scale fee policies, most relying upon a standard means-test that calculates the fee based on patient's income. The fourth feature to clarify is how the program is designed: to be eligible for funding, the federal government requires that CHCs are located in what are called medically underserved areas (MUAs). MUAs are calculated with a weighted scale of four characteristics: share of population living under the federal poverty line, percent above age 65, the infant mortality rate, and the ratio of primary care physicians to population. Therefore, CHCs are in theory targeted toward underserved places that need them most.[3] Finally, all CHCs are legally mandated to have patients comprise at least 51% of their governing board. This is one of the principal carryovers from the Great Society's emphasis on "maximum feasible participation" of the poor in governance of local institutions.

From a historical perspective, the CHC program has been used by the federal government to address current and pressing public health issues, such as the HIV/AIDS epidemic under President Clinton as well as the opioid epidemic during President Obama's term. Most recently, the CHC program has been strategically deployed by President Biden's administration in response to COVID-19. Given their location in underserved areas and longstanding ties with the marginalized communities who have been hardest hit by the pandemic, the widespread network of CHCs have been used as a tool to promote both coronavirus testing and vaccine equity. Between January and May of 2021, CHCs administered nearly 5.5 million vaccinations, 76% of whom were given to racial and ethnic minorities.[4] CHCs were allocated $7 billion in the 2021 American Recovery Plan[5] and have been at the front and center of the Biden administration's press statements

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[3] There are some exceptions: for instance, once receiving FQHC status, grantees can expand delivery sites into places that do not qualify as MUAs, a trend that has become more common in recent years. Another exception is that Governors can request MUA status for places that would not otherwise qualify, though this is fairly uncommon.
[4] www.nachc.org/coronavirus
[5] https://www.usatoday.com/story/news/politics/2021/04/27/community-health-centers-getting-1-billion-federal-funding/4853374001/

and speeches addressing racial disparities in health that COVID-19 has glaringly exposed.[6] For instance, in the opening minutes of President Biden's first address to Congress on April 29, 2021, he referenced prioritizing the distribution of vaccines to CHCs where "the poorest of poor can be reached."[7] Even Republican Congressmembers who voted en masse against the American Rescue Plan have touted the funding that has now been awarded to their district's health centers.[8] In these ways, I argue that scholars should consider CHCs as an arm of the state: they are used by policymakers as tools to achieve political ends, they are politically consequential entities—particularly for Congressional, state, and local politicians' rapport with their constituencies—and they directly intervene in the health of our society's most disadvantaged communities. Together, this federal institution should be of great interest to social scientists who care about how structural conditions and policies impact population health and social inequality.

I now discuss the outline for the remainder of the dissertation, describing the research question, data, methodology, and key findings for each of the three empirical chapters. In Chapter 2, I conduct a comparative historical analysis to explain the CHC program's unusual political popularity. Seeing as policies targeting the poor have historically attracted intense partisan conflict in the U.S., it is puzzling that the CHC program has been able to achieve bipartisanship. Because Medicaid shares the same purpose, national context, and historical period as the CHC program but diverged in the degree of political contention, I leverage the *presence* of political contention within Medicaid to understand its *absence* in the CHC program. This comparison provides further insight into the broader theoretical puzzle of why some public policies encounter more controversy than

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[6] https://buildbackbetter.gov/uncategorized/fact-sheet-president-elect-biden-outlines-covid-19-vaccination-plan/
[7] https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/04/29/remarks-by-president-biden-in-address-to-a-joint-session-of-congress/
[8] https://apnews.com/article/personal-taxes-health-coronavirus-pandemic-business-government-and-politics-d0b1f48aa32baf6b47880faf15d5dea3

others. Drawing upon nearly forty years of primary documents collected from seven presidential archives (1965-2001) as well as other historical sources, I find that initial policy designs led to the divergence of both discursive opportunity structures and the acquisition of elite support. Specifically, policymakers' articulation of frames aligning with both morals *and* markets allowed the CHC program to resonate across ideological divides, whereas Medicaid's lack of market alignment and pervasive framing as inequitable inhibited its political support. I develop a concept of the *market failure paradox*, which holds that blaming the market for failing to serve the poor, rather than casting doubt on the efficacy of the market, instead bolsters market-oriented policymaking in two related ways: through reinforcin*g* policymakers' devotion to market principles and circumventing debates over deservingness, race, and morality that are often at the epicenter of political conflict in the U.S. I conclude with how the theoretical argument extends to other antipoverty policy areas, which shows the usefulness of transposing the morals and markets framework developed by economic sociology to research on the politics of the U.S. welfare state. Through a detailed examination of historical processes, this study also provides practical insights into improving the political viability of public policy focused on disadvantaged communities.

As highlighted earlier in this chapter, CHCs now have regular and direct contact with millions of socially and economically marginalized Americans but little is known about this federal institution's role in alleviating or perpetuating inequalities. In Chapter 3, I present a qualitative case study of a small-town health center, Crownsville, located in a post-industrial community in the northeast, to understand how CHCs provide care to low-income communities. Using in-depth, semi-structured interviews with patients and staff, this case study explores the underlying *interpersonal*, *organizational*, and *institutional* mechanisms in how care is delivered and experienced by the poor, focusing particularly on the emergence of stigma in this setting. Despite

its historical roots as a policy targeting low-income communities, I found that Crownsville's status as a federal program for the poor was *not* widely perceived among patients and even some staff. Poor patients generally did not view Crownsville as a "second-tier" institution and few were aware of the government's involvement, resulting in a pronounced lack of stigma. In connection with Chapter 2, I argue that the absence of political contention in the evolution of the CHC program at the macro institutional level is closely tied with the lack of stigma in the organizational practices and micro-level interactions of the health center. But this was not without drawbacks. I found that the contradiction between health care as a human right versus a commodity ran like a fault line through Crownsville, as the organization strove to be inclusive of the poor while presenting like a for-profit entity. This had mixed consequences. On the one hand, appearing business-like contributed to the perception by poor patients that they were receiving mainstream care no different from those with greater economic resources. On the other hand, patients were largely unaware of their rights to be treated regardless of ability to pay and instead reported strict and paternalistic enforcement of rules related to overdue bills. I conclude that although Crownsville claimed to be a highly inclusive institution that would serve anyone, it did not escape pressures to conform to trends of marketization in health care, which has complex implications for the experience of poor patients in the safety net. The findings from this chapter advance research on stigma, poverty governance, and the persistence of health inequalities in the safety net as it wrestles with the pressures of marketization in the U.S. welfare state.

In Chapter 4, I focus on geographic variation in access to CHCs for a highly uninsured and underserved population: Hispanic immigrants. Hispanic immigrants have long faced barriers to accessing health care in the U.S., as they are largely excluded from federal programs like Medicaid and tend to work in occupations that do not provide employer-sponsored health insurance. This

means that CHCs are often the only source of care for Hispanic immigrants, including those who are undocumented, because CHCs are legally mandated to serve anyone regardless of citizenship status. To what extent has this widespread, immigrant-inclusive institution been accessible to Hispanic immigrants? This study documents spatial variation in population-level proximity to CHCs in relation to changing Hispanic migration patterns using novel administrative data on the historical location of CHCs joined with Census and American Community Survey data from 1970 to 2017. I find that health centers, both historically and contemporarily, have been far more spatially proximate to poor and foreign-born Hispanics than to poor whites. In 2017, 56% of poor and foreign- born Hispanics in the U.S. lived within two miles of a CHC compared to 30% of poor whites. While access to CHCs has been consistently greater in established gateways, regardless of urbanicity, growth in new destination safety net infrastructure has increased at a faster rate. The CHC program has been substantially more accessible to the foreign-born than U.S.-born Hispanic and uninsured populations, showing the geographic potential for CHCs to provide care to underserved immigrant communities. This study provides the first descriptive evidence of the programmatic reach of this safety net institution across time and space, highlighting a crucial yet underexplored factor in understanding the health of Hispanic immigrants.

In the concluding chapter of the dissertation, I reflect upon the substantive and theoretical contributions and the policy implications of the findings, as well as opportunities for future social scientific research on this understudied institution.

CHAPTER 2

POLITICAL CONTROVERSY, PARTISANSHIP, AND HEALTH CARE FOR THE POOR: A COMPARATIVE ANALYSIS OF U.S. POLICIES, 1965-2001

> The right to health care for every citizen is probably the least controversial of any of the rights men have sought through the ages. Controversy does arise, however, over how best to secure the right to every individual. –Edna Tate, Economic Opportunity of Atlanta (1968)[9]

INTRODUCTION

Debate over social welfare policy is perhaps the clearest and most consistent hallmark of partisanship in the contemporary United States. Liberals and conservatives have been sharply divided over the expansion and retrenchment of the welfare state, such that partisan conflict in social policymaking has largely been treated as a foregone conclusion. Indeed, most antipoverty policies do encounter political backlash, leading scholars to conclude that policies targeting the poor are politically vulnerable (Quadagno 1994a; Skocpol 1995; Weir, Orloff, and Skocpol 1988). Yet, political conflict over social policies is *not* inevitable (Howard 2007), and some policies targeting the poor are able to achieve bipartisan support. I argue that focusing on the absence of political contention is equally important as its presence (Tilly and Tarrow 2015) for understanding both the historical evolution and future of the American welfare state.

Despite a wealth of literature on the emergence, variation, and impact of welfare states (Brady and Bostic 2015; Esping-Andersen 1990; Fox 2012; Korpi and Palme 1998; Pierson 2000; Prasad 2006; Skocpol 1992), insufficient attention has been paid to explaining the emergence of political conflict over social welfare policies beyond traditional cash assistance (some exceptions

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[9] LBJ Library, Papers of Wilbur Cohen, Box 1, "DHEW Medicaid Public Hearing: Atlanta" p. 64 (1968).

include Pierson 2000 and Hacker 2002).[10] This is a significant oversight for several theoretical reasons. Partisan conflict influences all stages of policymaking (Kingdon 1984), but it is particularly important in the initial adoption of policies and the ability of policies to survive and adapt to changes in power (Amenta 2003). Political conflict also impacts the people who rely upon safety net programs, as contested policies can engender stigmatization in public program participation and galvanize antipathy toward the "undeserving" poor (Gilens 1999; Piven and Cloward 1993; Soss, Fording, Schram, et al. 2011). Finally, as political processes generate unequal access to public benefits that affect people's life chances, emergence of political contention has broader implications for how the welfare state intervenes in or reinforces systems of stratification (Esping-Andersen 1990; Michener 2018; Montez et al. 2020). Assessing the conditions that stimulate or suppress political conflict over social welfare policy is, thus, both necessary and timely in the intensely partisan climate of the United States.

To identify why some policies for the poor are more controversial than others, I leverage an unusual case in which two policies that shared the same purpose, national context, and historical time period diverged from each other in the degree of political contention. Since 1965, the U.S. government has attempted to provide health care to the poor through two major policy interventions: Medicaid, a federal-state health insurance program for low-income families, and the Community Health Center (CHC) program, a federally funded network of clinics targeting low-income places. Unlike Medicaid, which has become a highly contentious policy in recent decades, the CHC program boasts "almost unprecedented bipartisan favor" (Iglehart 2010). Republicans have wholeheartedly embraced the CHC program as a necessary component of the nation's safety

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[10] A number of scholars have addressed this topic peripherally in explaining the development, expansion, retrenchment, or structure of the U.S. welfare state, but exploring why some policies become controversial has not been the central focus of inquiry.

net infrastructure (Mickey 2012). Whereas President George W. Bush attempted to slash Medicaid funding (Olson 2010), he was one of the CHC program's foremost proponents (Lefkowitz 2007). As President Obama faced intense opposition from Republicans in expanding Medicaid through the Affordable Care Act (ACA), he was met with little resistance as he simultaneously proposed expansion of the CHC program, more than doubling the number of delivery sites. Examining how two comparable policies have departed so drastically in partisanship provides purchase on broader questions regarding what explains political contention in modern American policymaking.

While controversy over Medicaid follows the expectation in the literature that policies targeting the poor are politically vulnerable (Korpi and Palme 1998; Skocpol 1995), bipartisan support for the CHC program is puzzling. There are ample ways in which health centers could have been—or were—politicized. Beginning under President Johnson's War on Poverty, the CHC program was strongly associated with the Democratic party and its leaders, which could have made it ripe for partisan conflict. The CHC program was also connected with both the Civil Rights Movement and the Black Panther Party (Nelson 2011), such that the earliest clinics almost exclusively targeted urban Black neighborhoods and Hispanic migrant communities (Sardell 1988) and thus could have attracted racial conflict, like other War on Poverty programs (Quadagno 1994). Furthermore, CHCs represent the federal government's direct involvement in the provision of health care, which could have been tarnished by conservatives or the medical establishment as "socialized medicine." To varying degrees, I will show that these conflicts did occur, yet somehow did not induce partisanship. Instead, a groundswell of bipartisan support has led to tremendous growth in the CHC program, such that we now have a nationalized system of clinics, which served nearly 30 million predominantly low-income Americans in almost 13,000 delivery sites as of 2019 (NACHC 2021). The CHC program now far surpasses other more well-known and controversial

health programs like Title X Clinics (which served around 4 million patients annually at 4,000 sites in 2019[11]) or the Veteran's Health Administration (which served about 9 million patients in roughly 1,300 facilities in 2019[12]), but has been able to maintain its political support.

With a historically entrenched two-party system, the dearth of empirical research examining why partisan conflict does or does not emerge in the policymaking process leaves a significant gap in our understanding of how safety net institutions have developed in the U.S. To develop a theoretical framework, I draw upon several possible interrelated explanations from literature on the U.S. welfare state. Policies for the poor may become contentious when they confront debates over deservingness (Cook and Barrett 1992; Katz 1989, 2001; Steensland 2006) and are racialized (Fox 2012; Gilens 1999; Katznelson 2005; Neubeck and Cazanave 2001; Quadagno 1994b; Soss, Fording, Schram, et al. 2011); because the poor lack political power to attract elite support or influence (Howard 2007; Nathanson 2010; Piven and Cloward 1993; Weir et al. 1988); depending on how the policies are designed (Prasad 2006; Skocpol 1995; Weir et al. 1988; Wilson 1987); and due to conflicting ideas or philosophies on how the government should address poverty (Campbell 1998, 2002; Jencks 1992; Schön and Rein 1994). While these explanations provide important components and some of the necessary conditions to understanding the phenomenon, I find they are insufficient on their own to account for the divergence of political contention between Medicaid and the CHC program.

Rather, I argue that frames in alignment with market principles were central to the divergence of political contention. Building from Somers and Block's scholarship on the ideational embeddedness of market fundamentalism (2005), I develop a concept that I call the *market failure paradox* to explain these results. It holds that blaming the market for failing to serve the poor,

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[11] https://www.kff.org/womens-health-policy/issue-brief/current-status-of-the-title-x-network-and-the-path-forward/
[12] https://www.va.gov/health/aboutvha.asp

rather than casting doubt on market principles, instead strengthened its epistemological power over time. Because market failures in health care were perceived as "natural" or inevitable following principles of competition, employing a market failure logic paradoxically did not challenge the effectiveness of market-oriented policies and instead reinforced policymakers' devotion to the market. Because the market was understood as failing naturally—through no fault of its own—market failure frames had two consequences: first, it prevented individuals from being blamed for poverty, thereby circumventing debates over morality, race, and deservingness; and second, it allowed for bipartisan political support to coalesce around state interventions in addressing poverty. A main conclusion of this study is that the deployment of market failure framing has the potential to suppress political conflict over public policies in neoliberal welfare state regimes like the United States.

Methodologically, I use a "parallel case-oriented strategy" (Ragin 1987) by leveraging the presence of political controversy within Medicaid, the positive case, to examine the absence of these features in the CHC program, or the negative case. I draw upon primary documents collected from seven presidential archives, spanning from both programs' legislative origins in 1965 under President Johnson through President Clinton's administration ending in 2001. The confidential materials from within the executive branch reveal explicit details on political strategizing, rationales for policy decisions, framing techniques, and disagreements among elite actors, providing rich insights into the policymaking process. Systematically analyzing more than 15,000 pages of archival materials, supplemented with secondary sources and media coverage, I employ techniques of pattern matching and process tracing to assess cross-case associations and identify mechanisms that explain variation in the policy outcomes (Mahoney 2003). In the following, I first review possible explanations for what drives political conflict over social welfare policy, outline

how I conceptualize political contention, detail the case selection and methodological approach, and then trace nearly forty years of evidence of policy developments within each time period.

BACKGROUND

EXISTING PERSPECTIVES ON THE POLITICS OF ANTIPOVERTY POLICY

Due to the widely held conclusion that policies for the poor are bound to encounter backlash (Skocpol 1995; Weir et al. 1988), there has been limited empirical research outlining the conditions under which political contention over these policies emerges. The foremost program to be studied, Aid to Families with Dependent Children (AFDC), has generated the lion's share of evidence that policies for the poor are stigmatizing and politically vulnerable, and this assumption remains largely undisputed in the literature on the U.S. welfare state (for an exception, see Howard 2007). Yet, narrow attention on AFDC has also constrained the field's consideration of antipoverty policies that have avoided political controversy. As such, we lack a clear understanding of the conditions under which policies do or do not become contentious. To build a theoretical framework, I draw from literature on the politics of social policy, the policymaking processes, political mobilization, and the sociology of ideas, which suggest five interrelated factors that influence political controversy in the U.S. context.

First, policies for the poor have historically had to navigate contestations over who is deserving of help from the state (Katz 1989). The issues that have long dominated poverty discourse—how to categorize the poor, the impact of welfare on work and family, and the limits of societal obligation to the poor—all present opportunities for the emergence of contention surrounding morality and deservingness. Though the boundary-making process continually evolves, individuals are generally viewed as "deserving" if they are perceived as truly in need, due

to no fault of their own, have no other resources to meet that need, possess the will to be independent, and use benefits wisely (Cook and Barrett 1992). Brian Steensland argues that these "cultural categories of worthiness" have shaped the evolution of social policymaking in the U.S. via constitutive, linguistic, and institutional channels (2006, 2008). The existing literature, thus, leads to the expectation that debates over deservingness and morality are a central element of political contention in policymaking for the poor.

Second, race and racial discrimination have also been fundamental to the formation of the American welfare state (Fox 2012; Katznelson 2005; Neubeck and Cazanave 2001; Quadagno 1994b; Soss, Fording, Schram, et al. 2011). Social policies in the U.S. have historically discriminated against racial and ethnic minorities through exclusion from receipt of state assistance while channeling the majority of benefits toward white citizens (Katznelson 2005). President Johnson's War on Poverty attempted to equalize opportunity by centralizing authority within the federal government and targeting aid toward minorities, but this resulted in political backlash and the racialization of both poverty and welfare (Quadagno 1994), leading some scholars to conclude that racially targeted policies are more apt to incite political conflict than those that are race neutral (Wilson 1987). Subsequently, the Nixon administration's attempt to redistribute federal aid toward white and Republican constituencies deepened racial divisions in the welfare state, making race the centerpiece of political conflict in social policy (Brown 1999). The "welfare queen" myth, popularized during the Reagan administration, became a potent symbol for the racist stereotype that welfare recipients lacked work ethic and took advantage of cash assistance (Soss et al. 2011). Often tied explicitly or implicitly with discourse over deservingness, the deployment of racial frames has influenced both political opportunities and mobilization around social welfare policies (Brown 2013a), with racial stereotypes strongly conditioning anti-welfare attitudes (Gilens 1999;

Soss, Fording, Schram, et al. 2011). Racialized political conflicts are also exploited by elites to make race more or less salient in policy debates via interrelated attitudinal, cultural, and political channels (Brown 2013). Thus, the extent to which race, racism, and prevailing cultural stereotypes of racial groups are salient in each policy's development is also expected to shape the degree of political contention.

A third explanation is that antipoverty policies struggle to gain political support because the poor lack power to influence policy elites (Hays 2001). Scholars have argued that the poor are a "nonexistent political constituency in an institutional system designed to reflect constituency pressures" (Heclo 1986: 337), and that the lack of political mobilization by the poor renders them unable to exert their policy preferences (Nathanson 2010). Therefore, policies targeting the poor are less likely to be passed (Heclo 1986) and, when they are enacted, unlikely to become popular programs as they do not advance the self-interest of the general public or Congress (Cook and Barrett 1992). However, seeing as health care is one of the largest and more profitable industries in the U.S., political support from elite actors and interest groups plays an important role. For instance, Medicaid has been widely supported by medical providers and hospitals who want to receive compensation for caring for the poor (Engel 2006; Howard 2007; Olson 2010). Despite an unambiguous absence of political power among the poor to mobilize and advocate for their health care needs, powerful advocacy and lobbying groups have a vested interest in seeking profits for providing health care to the poor, and politicians also have an incentive to please their constituents. Whether mobilization takes place by the poor or groups who act on behalf of the poor, the achievement of elite support is likely instrumental in determining the degree of political conflict.

A fourth and multifaceted reason why programs for the poor become controversial is due to policy design, particularly the longstanding debate over whether policies should be universally

available to all citizens or targeted toward the most disadvantaged. Policies targeting the poor—

the so-called "lower tier" of the welfare state—are thought to produce animosity, divide social

class groups, and engender stigma through degrading means-tests and difficult application

procedures (Brady and Bostic 2015; Skocpol 1995). Many argue that separating the U.S. welfare

state into two tiers has had deleterious consequences for the formation of broad political coalitions

and policy outcomes, as this system has politically isolated the poor, especially the Black poor,

from the working and middle classes (Prasad 2006; Skocpol 1995; Weir et al. 1988). Monica

Prasad argues that targeted programs in the U.S. contributed to the creation of "adversarial

policies" that weakened autonomous state structures (2006). For these reasons, many scholars

conclude that universalism maximizes the range of potential beneficiaries and is better able to

build political consensus around social policies (Weir et al. 1988). Yet, others push back on the

notion that the U.S. has a clearly defined two-tier system or that this translates to political

popularity, arguing that some policies in the "lower tier" of the welfare state have more political

viability than others (Howard 2007). Through analyzing the EITC and Medicaid, Christopher

Howard concludes that policies targeting the poor can gain political support by attempting

incremental changes, avoiding the spotlight, and drawing distinctions from welfare (2007).

In addition to the two-tier system, federalist policy design and the role of states is highly

consequential, especially in the U.S. context. Some contend that federalism protects against the

centralization of power by increasing political participation and providing opportunities for

innovation at the state level, while others criticize the inequities of federalism and the cumbersome

burden of policy implementation (Nathan 2005). There is strong evidence that federalist policies,

like Medicaid, generate disparate political engagement among marginalized populations across

geographic contexts (Michener 2018). For political contention in the policymaking process,

though, the consensus is clear: "federalism has been a principal weapon of partisan […] conflict in American history" (Robertson 2014: 345). Federalism has long been used as a tool to achieve political goals—such as the prominent states' rights rhetoric deployed in conflicts over slavery to the block grant revolution under President Reagan—for the simple reason that "fights over federalism are fights about power" (Robertson 2014: 350). In the policymaking process, federalist policy designs increase the number of "veto points." Incorporating multiple levels of government actors introduces additional obstacles, whereas centralized policy designs can more easily pass legislation without as many veto points to overcome (Prasad 2006). Therefore, policy design in relation to federalism, centralization, and what entity holds power over policies is likely an important factor in the emergence and degree of political contention.

Finally, political contention over policies for the poor is affected by conflicting ideological approaches to government and beliefs about the state's responsibility in addressing poverty (Jencks 1992). Political ideologies are formulated in relation to values and principles, and are comprised of both "descriptive" aspects in understanding the social world as well as "prescriptive" features that propose ways to address social problems (Taylor 2007). In general, U.S. liberals of the social democratic ideology support more government intervention and aid to the poor than modern-day American conservatives, who tend to prefer a laissez-faire approach that relies more upon the private market than the government to address issues related to poverty (ibid). Policies motivated by a particular ideological position are more apt to encounter contention when changes in political power occur like, for example, when the social democratic ideology of President Johnson's Great Society programs faced the New Federalist conservative ideology of President Nixon.

Ideas about policies are a powerful mode of exchange and influence, with some contending that "all political conflict revolves around ideas" (Stone 1988: 13). At the cognitive level, ideas

influence the field of policy actions as well as the range of solutions available (Campbell 1998).

At a normative level, policymakers' taken-for-granted values and beliefs influence decisions on

the logic of appropriateness of policies (Campbell 2002; March and Olsen 1989). Contention can

emerge when these normative ideas clash among policymakers (Schön and Rein 1994), or among

more widespread public sentiments which also shape the actions that elites perceive as being

acceptable to the public (Campbell 1998). In contrast, contention can be avoided when normative

and cognitive ideas of policymakers align with prevailing public sentiments and are framed in a

"culturally resonant," socially appropriate manner (Campbell 1998; Snow and Benford 1988). The

cognitive and normative aspects of ideas shape framing of policies, and thus the presence or

absence of culturally resonant frames has the potential to impact political support for policies

(Skocpol 1996, 2000). This study leverages a single policy debate—health care for the poor—to

determine how different frames influence policy support among elite actors and, in turn, political

institutions (March and Olsen 1989).

MARKET FUNDAMENTALISM AND THE AMERICAN WELFARE STATE

A well-known trend in the modern American welfare state is the shift away from social democratic

policies of the New Deal and Great Society toward market-oriented, neoliberal policymaking in

the latter part of the twentieth century (Harvey 2007; Jones 2012; Skocpol 1988; Soss, Fording,

Schram, et al. 2011). In the 1980s, conservatives united around efforts to delegitimate

governmental interventions by accusing the state of interfering with the free market. Devolution,

retrenchment, and privatization became common tactics to take authority away from the federal

government, with rhetoric criticizing "big government." Instead, conservative policymakers

celebrated the efficiency and rationality of markets—complemented by the charity of private non-

profits or religious organizations—resulting in what some have dubbed a "neoliberal paternalist" approach to poverty governance (Soss, Fording, Schram, et al. 2011).

This shift depicts what is known as market fundamentalism, or the "religious-like certitude of those who believe in the moral superiority of organizing all dimensions of social life according to market principles" (Somers and Block 2005: 260-261). In concert, the emergence of the perversity thesis—or the powerful idea that policies for the poor perversely incentivize dependence on the state—has emboldened market fundamentalism as a solution to enduring issues of poverty. That the perversity thesis and market fundamentalism are impervious to disconfirming evidence (Somers and Block 2005) reveals the socially constructed nature of policy frames. Furthermore, there is compelling cross-national evidence that neoliberal policies arose in the U.S. due to political-economic structures that incited adversarial policies pitting the interests of the poor against the middle class, which conservatives exploited to garner resentment against welfare policies (Prasad 2006). With evidence of both the ideational and institutional basis for the rise of market fundamentalism, the historical transition of the U.S. welfare state to align with principles of the free market is consequential for the policies that persisted through this time period.

Due to the dominance of market fundamentalism in policymaking, one undertheorized but fruitful component to explaining political contention—or its absence—is the relationship of social policies with market principles (Esping-Andersen 1990). Indeed, Monica Prasad contends that "progressive policies are achieved in concert with, and not in opposition to, business interests," arguing that the European welfare state was able to grow and expand because of its emphasis on market complementarity (2018: 233). Though most Social Democratic oriented policies of the 1960s relied heavily on moralistic frames related to social justice and human rights and were not centrally focused on aligning with market principles, I will show that the CHC program also

justified its purpose based on the perceived natural failure of the health care market to provide care in poor areas. Though Medicaid also was crafted in response to market failures in the private health insurance industry, it was not initially framed in relation to market principles and instead was accused of going against the market by disincentivizing work and inflating health care costs. While the extant literature has focused primarily on the moral foundations of social policy (Mohr 1994; Skocpol 1992; Steensland 2006), this study connects how market principles shape the political viability of social welfare policy in the contemporary U.S. polity.

POLITICAL CONTENTION AND FRAME CONFLICT

The dynamics of contentious politics have been studied in cross-national comparison of episodes like social movements, revolutions, strikes, nationalization, and democratization (McAdam, Tarrow, and Tilly 2001; Tilly and Tarrow 2015). But what about its continuous, non-episodic occurrence? This study brings to the forefront the long-term undercurrent of political contention that ebbs and flows in the policymaking process. While some of this contention takes place in public settings, much of it courses among political elites and out of the purview of the public. As I will show, political contention among policymakers is an ever-evolving, dynamic process, with the potential to change radically given a shift in political climate. I focus here on elite actors, as they hold the power to shape legislation and public opinion (Zaller 1992). This is especially warranted in the domain of health care, as all major health policies in the U.S. have been spearheaded by elite actors—primarily Presidents—rather than grassroots social movements (Hoffman 2003, 2010; Levitsky and Banaszak-Holl 2010).[13] I draw specific attention to the

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[13] Of course, public opinion has a demonstrable impact on policymaking (Brooks and Manza 2007), and indeed I found a plethora of public opinion data in the archives that policymakers relied upon in their decision-making and framing of policies, which I will discuss when relevant. However, public opinion has not played a major role in Medicaid policy (Howard 2007), and this is even more the case for the CHC program.

internal processes of policymaking by documenting the evolution of debates among elites in advancing their policy goals, overcoming opposition, and adapting to changes in power.

Framing is central to policymaking, as frames organize and define issues, construct meanings, and justify or explain the rationale for government intervention (Benford and Snow 2000; Snow and Benford 1988). A critical component to political contention is *conflict* over framing. In their seminal work on frame conflict in policymaking, Schön and Rein argue that "frames determine what counts as a fact and how one makes the normative leap from facts to prescriptions for action" (1994: xviii). Policy controversies emerge when opposing parties hold conflicting frames and can lead to institutionalized political contention when they are "enduring and invulnerable to evidence" (ibid: 4). "Cultural resonance," or the extent to which frames align with society's values and principles, is also a key component in determining the effectiveness of frames (Snow and Benford 1988). Cultural resonance yields an advantage to frames situated in larger "interpretive packages," which are part of a dynamic process of interaction and contestation over ideas, identities, and ideologies (Gamson and Modigliani 1989).

Institutions further condition the political acceptability of ideas, or what is known as "discursive opportunity structures" (Ferree 2003), which constrains what discourse resonates in the given political climate. While previous research has compared discursive opportunity structures for the same policy debate across national or state contexts (Brown 2013a, 2013b; Ferree 2003), the design of this study allows me to further isolate the divergence of discourse over two similar policies within the same national context. Building from these insights, the forthcoming analysis examines the degree of frame conflict among elite policy actors and the evolution of interpretive packages in discourse over policies that conditioned the degree of political contention.

DATA AND METHODS

There are three theoretical reasons supporting the case selection in this study: Medicaid and the CHC program have the same purpose (access to health care for the poor), share the same national context (the United States), and began in the same year (1965). I am therefore able to rule out the possibility that differences in temporal, national, or political contexts caused the variation in outcomes. "Controlling" for these characteristics is particularly useful because both policies faced similar structural conditions, such as the economy and changes in social mores, as well as encountered similar power dynamics of various political and interest groups. In approaching the comparison, it is important to emphasize my analytic logic: the primary goal is to use the positive case, Medicaid, in order to identify explanations of the absence of contention in the negative case, the CHC program. I do not aim to build an argument around how Medicaid could have avoided political contention, which would require a different theoretical approach, but rather to uncover its contrasting features with the CHC program to explain the lack of partisanship. In other words, Medicaid's political controversy is the rule, while the CHC program is the exception— understanding the exception is what motivates the logic of analysis.

There are two remaining considerations on the case selection. The first is whether, given their shared context, one policy may have impacted the development of the other. In the early years of the programs, I found surprisingly infrequent crossover in the policymaking discussions. They operated in entirely separate arms of the government, with Medicaid in the long-standing welfare administration and the CHC program in the Johnson administration's new Office of Economic Opportunity (OEO). Although the idea was for these programs to work in tandem, in reality, this did not happen in the early years. As the Office of Management and Budget stated in a memo to President Carter in 1979, Medicaid and the CHC program were "not logically integrated" and

"each has developed as if the other did not exist."[14] Two-thirds of state Medicaid programs chose not to fully reimburse for CHC services until the federal government passed a law requiring them to do so in 1989 (Sardell 1988).[15] Therefore, the lack of interdependence in policymaking between Medicaid and CHCs until the 1990s is significant, but not in a way that threatens the interpretation of early historical developments.

A second consideration regards how the sheer difference in the size of the policies matters for their political outcomes. Medicaid has always surpassed the CHC program both in terms of cost and recipients. It is important to note that the early NHC grants were indeed quite expensive, with the first two centers receiving $1.17 million each in their first year—which equates to $9.6 million each in 2020-dollars— and one center the Watts neighborhood of Los Angeles receiving $2.38 million—or $19.5 million in 2020-dollars—in its first year alone; indeed, some conservatives were initially critical of the program's high price tag (Davis and Schoen 1978). But Medicaid has undeniably been more costly, and one can logically see why a larger, more expensive program would be more contentious than a smaller, less expensive one. Yet, looking to other policies indicates that CHCs could have been far more controversial even though they were smaller in size. Other programs from the War on Poverty era, such as the Community Action Program and Model Cities, were eradicated due to political conflict despite having modest budgets. Small-sized programs are also highly vulnerable to cutbacks or consolidation via block-grants. Take another example from low-income housing policy: even though housing vouchers are both more costly and have far more users than public housing, there has still been an abundance of political controversy surrounding public housing. The same is true for Title X family planning clinics: Title

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[14] Carter Library, Office of the Cabinet Secretary Jack Watson, Box 291, "1979 Budget Spring Presidential Review."
[15] The final section of the results highlights the 1990s when Medicaid and the CHC began to be strongly linked.

X clinics have garnered significant controversy despite being smaller than the CHC program in both cost and participants.[16] My argument is not that Medicaid should have been less controversial—indeed, most agree that policies targeting the poor are politically unpopular (Korpi and Palme 1998; Skocpol 1995). Rather, I argue that just because the CHC program has always been smaller than Medicaid does not preclude it from becoming a divisive policy issue or a target of retrenchment.

The analyses draw upon primary documents collected from the archives of Presidents Lyndon Johnson, Richard Nixon, Gerald Ford, Jimmy Carter, Ronald Reagan, George H.W. Bush, and William Clinton (located, respectively, in Austin, TX; Yorba Linda, CA; Ann Arbor, MI; Atlanta, GA; Simi Valley, CA; College Station, TX; and Little Rock, AR).[17] The search process at archives involved requesting collections relating to welfare, poverty, health, health care, and the like, and assistance from archivists allowed me to identify key actors on these topics within each time period. I reviewed all materials within pertinent collections in order to decipher the context of each program within the larger fields of political and policy debate. Documents containing substantive information—either by directly referring to the programs or containing relevant information in the surrounding text—were scanned and later reviewed systematically.[18] In total, I collected and analyzed more than 15,000 pages of relevant primary documents from the archives.

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[16] This is a rich comparison to be explored in future research, as Republicans in the 2010s have repeatedly tried to use CHCs as a means of stripping funding away from Planned Parenthood. Leaders like Paul Ryan explicitly referred to the bipartisanship and low level of controversy in the CHC program as a reason the government should only invest Title X funds in CHCs. See: https://rewire.news/article/2017/02/27/health-centers-gop-wants-replace-planned-parenthood-deny-contraception-citing-religion/

[17] I visited all archives except for the Clinton library, which has digitized most materials. I also visited the George W. Bush library in Dallas, TX, but too few of the confidential primary documents have been made publicly available to produce comparable analysis to the other time periods.

[18] Specifically, documents related to Medicaid had to discuss coverage of the poor. I did not collect documents on Medicaid that only pertained to nursing home, long-term care, or persons with disabilities. Some of these topics are found in the same documents, but they are not the focus of my analysis.

The majority of the primary documents analyzed are internal memos and reports between the presidential administration, federal agencies, and Congress. These memos and reports were almost entirely confidential, often describing explicit political strategizing, rationales for policy decisions, and disagreements among political elites. The detail with which these inside actors privately discussed the policies allows for a rich understanding of the issues and what factors undergirded policy decisions. Additional materials included internal deliberation of talking points, drafts of press statements, internal agency reports, proposed legislation, and public opinion polls. I also examined correspondence sent directly to the executive branch from outside actors such as members of the public, state or local politicians, as well as interest groups. Finally, I collected non-confidential materials within the archives, such as legislation, external policy reports, policy proposals, speeches, press statements, and media. To supplement the perspective of the executive branch, I also integrated secondary sources as well as public documents from government agencies, academic journals, and thinktanks.[19]

The analysis uses techniques of pattern matching, or identifying similarities and differences between cases in relation to theoretical mechanisms of social causation, and process tracing, or determining sequences of events and their linkages with various actors or groups' interests that interact to explain outcomes (Mahoney 2003; Ragin 1987). Furthermore, the conclusion uses congruence testing of different cases to identify common patterns, as well as extend and delimit my proposed theoretical model (Mahoney 2003). In the subsequent analysis, I summarize the political history of each program, highlighting key theoretical developments. Within each time period, I first discuss Medicaid—again, the positive case—and then compare against the CHC

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[19] As the focus of this paper is on political contention at the federal level, I do not present comprehensive historical evidence on state or local politics, save for a few highly salient instances. This would be a fruitful area for future research.

program—the negative case—before drawing conclusions on what components can best explain their divergence in political outcomes.

FINDINGS

THE EMERGENCE AND EARLY YEARS OF MEDICAID, 1965-1969

Debates over state provision of health care to the poor have recurred throughout U.S. history, long before the eventual passage of the 1965 Social Security Act (Engel 2006; Hacker 1998; Ruggie 1992; Starr 1982; Stevens and Stevens 1974). Title XIX of this Act, or what is now known as Medicaid, initially received minimal attention from policymakers, the press, and the public at large (Engel 2006). Created by the powerful Democratic Representative Wilbur Mills, Medicaid was the result of a political compromise between both political parties and with organized medicine, primarily the American Medical Association (AMA), which contributed to its crafting. Suffering defeat from Medicare legislation and a loss of political clout, the AMA mostly accepted and some leaders even embraced Medicaid for compensating the profession's charity care as well as suppressing a more comprehensive government insurance program (Olson 2010; Stevens and Stevens 1974). At the time of its passage, Mills and many policymakers believed that Medicaid would be a temporary building block to national health insurance (NHI), but the inability for policymakers to agree on NHI in the following decades would be a key reason for Medicaid's survival beyond the timeline originally envisaged.

Medicaid's main purpose was to incentivize and pay states to provide health insurance for low-income mothers and children who were recipients of Aid to Families with Dependent Children (AFDC), colloquially known as welfare. From its inception, Medicaid was a piecemeal extension of welfare (Stevens & Stevens 1974), incrementally building from the existing structure of grants-

in-aid to state welfare agencies. It was designed to provide the states with freedom, control, and rights over administering their Medicaid programs, and limited the role of the federal government. As described by the Department of Health, Education, and Welfare (DHEW) officials: "Basically, a State can include anybody in its medical assistance program and can offer any service… a State can do anything it wishes." [20] States were thus given the ultimate authority over which poor residents were provided with what services, while the federal government's role was limited to providing fiscal relief. Although the states' rights frame allowed for the ease of passage at the federal-level, states were rather involuntarily thrust into the role of delivering health care to welfare recipients (Stevens and Stevens 1974). Most policymakers at the state-level did not want the fiscal or administrative responsibility of establishing their own welfare medicine programs, resulting in immediate state resistance that has persisted throughout the program's history.

Due to its origins in political compromise and federalist design, Medicaid lacked a unifying philosophy. The program's ambiguity, while providing political viability at the time of enactment, has had negative consequences: "the lack of clearly stated national goals for Medicaid in 1965 was a major and reverberating deficiency" and "perhaps its most basic weakness" (Stevens & Stevens 1974:350, xvii). Ambiguity in the goals of Medicaid resulted in administrative and implementation issues, which affected both the experiences of its recipients as well as the politics the program.

The humanitarian ethos of the 1960s, though, shaped the discourse around Medicaid. The rhetoric was largely in support of equal access to health care and bringing the poor into the "mainstream" of medicine, rather than creating a "separate-but-equal" system that segregated care by social class (Stevens and Stevens 1974). The belief that the poor were deserving of equitable access to health care translated into bipartisan policy activity, as votes for medical bills in both the

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[20] LBJ Library, Administrative History: DHEW, Vol 1, parts XVII & XVIII, Box 9 (1968).

House and the Senate were "virtually unanimous" in the late 1960s because they were "so politically important."[21] Despite—and perhaps because of—this belief that the poor deserved aid to receive health care, Medicaid was framed by policymakers across the aisle as ill-conceived in social, economic, and pragmatic policy terms. Socially, it was seen as inequitable and stigmatizing; economically, at the time it exercised few controls over demand or supply; and pragmatically, it suffered from inadequate administrative capacity and logistical planning (Stevens and Stevens 1974). As critics, such as a Democratic State Representative of Illinois, pointed out:

> I find [Medicaid's] framework to be not only ill-conceived but dangerous. Medicaid is a welfare program and that is enough to ensure its failure... Health care is of such high priority that no stopgap, hastily concerned program can be acceptable... Any scheme which further entrenches the image or reality of disparate treatment for rich and poor may cure the local infection only to further inflame the disease which surrounds it.[22]

All parties involved—bureaucrats, advocates, and politicians—agreed that Medicaid was flawed, resulting in the deployment of similar normative frames about Medicaid across the ideological spectrum. Yet, there were conflicting proscriptive ideas over the best course of action to remedy its shortcomings (Campbell 2002; Schön and Rein 1994). Born out of the politics of accommodation (Starr 1982), Medicaid enjoyed little political support from the beginning.

To summarize, Medicaid's origins in political compromise, structure as a state program, lack of a unifying philosophy, and association with welfare would set the program on a path rife in controversy. Critics immediately pointed to Medicaid's inequities across state lines, as well as its arbitrary means-test and assertion that medical care was only an entitlement for those on welfare. Medicaid was plagued by its link with welfare, leading to its longstanding entanglement in debates over deservingness and morality. Therefore, Medicaid was designed over concern with the rights of *states* and, as an extension of welfare, was framed as correcting for the failures of

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[21] LBJ Library, Administrative History: DHEW, Vol 1, parts I and II, Box 1 (1967).
[22] LBJ Library, Papers of Wilbur Cohen, Boxes 1-3, "DHEW Medicaid Public Hearing: Chicago" p. 152-156 (1968).

individuals. The combination of these features of Medicaid's policy design led to its pervasive framing as *inequitable* and *immoral* (Table 1).

Table 1. Comparison of Initial Policy Frames

	Concerned with **Rights** of:	Correcting for **Failures** of:		*Frames:*
Medicaid	States	Individuals	→	*Inequitable & immoral*
Community Health Centers	Individuals	Markets	→	*Moral & economic*

THE NEIGHBORHOOD HEALTH CENTER MOVEMENT, 1965-1969

In an entirely separate wing of the government, President Johnson's flagship effort with the War on Poverty was to establish the Office of Economic Opportunity (OEO). The OEO was equipped with considerable power, large sums of money, and the authority to direct funding to local communities that bypassed state and county officials (Quadagno 1994). Although health care was not originally a priority of OEO, it soon became clear that participants of their other programs like Job Corps and Head Start had severely unmet medical needs that would inhibit the success of those programs if left untreated (Sardell 1988). To address these medical needs among the poor, doctors from Tufts University proposed a new model of health care delivery, the Neighborhood Health Center (NHC) program, that would provide free care to entire communities and address social and environmental factors affecting health (Davis and Schoen 1978). Beginning as a research and development project, with one clinic in a Boston public housing project and another in rural

Mississippi in 1965, the NHC movement[23] launched inconspicuously under the umbrella of OEO (Geiger 2005).

In contrast to Medicaid (Table 2), the NHC program had clear, concrete goals with a unified identity and cohesive philosophy. The premise was simple: providing free health care in urban and rural areas with high concentrations of poverty and a lack of health services.[24] The NHC program was also boosted by activist bureaucrats (Marcus 1981; Sardell 1988) and policy entrepreneurs (Anderson 2018), who established strong elite support, unlike Medicaid. Senator Edward Kennedy (D-MA) was undoubtedly the most influential political actor for ensuring the program's initial survival. After visiting the first health center in Boston, Senator Kennedy became an outspoken proponent of NHCs. He successfully convinced other elites that NHCs should be distinguished from the controversies of other War on Poverty programs, such as Community Action Agencies, by arguing that NHCs were "run by professionals," "free of corruption," and a "legitimate," "charitable" enterprise (Sardell 1988: 67). Thus, the framing of the NHC program was constructed in direct contrast to other antipoverty programs of the times, which were increasingly associated with racial conflict (Quadagno 1994), and differentiating the NHC program from other Great Society efforts allowed for more widespread support among policy elites. As for interest groups, like their reaction to Medicaid, organized medicine largely accepted the NHC program and did not resist, except for a handful of local disputes, as both programs had features that were in their institutional self-interests. Contemporary commentators noticed "remarkably little opposition," seemingly because "the AMA had cried wolf too frequently and too shrilly to raise again the

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[23] Advocates and scholars have historically referred to NHCs as a social movement, so I adopt this terminology (for example, Sardell 1988; Hollister et al. 1974; Davis and Schoen 1976; Lefkowitz 2007). Indeed, Robert Hollister and colleagues go as far as to argue: "It is impossible to understand [NHCs] without viewing them as a social movement; its development was stimulated by the intersection of several supporting trends and then undermined by the divergence and weakening of these individual trends" (1974:13).

[24] LBJ Library, Administrative History, OEO, Box 1, "National Health Affairs" (1969).

specter of 'socialized medicine' when OEO proposed the establishment of NHCs" (Hollister, Kramer, and Bellin 1974:60-61). In addition, OEO had carefully courted cooperation with local medical groups to minimize conflict, and many of the early grants went to medical schools or hospitals to appease these groups (Hollister et al. 1974; Marcus 1981).

Table 2. Comparison of Policy Origins, 1965-1969

	Medicaid	**Neighborhood Health Centers**
Mission	Unclear, ambiguous goals and no cohesive philosophy	Clear, concrete goals and cohesive philosophy
Economic goal	Demand-side	Supply-side (+ create jobs)
Targeting	States	Local communities
Associated with	Welfare	Civil Rights
Political support	Weak, not aligned with ideology of either party	Strong, aligned with ideologies of *both* parties
Policy design	State control with federal oversight (federalist)	Federal program with local community control (unitary state)

Unlike Medicaid, the NHC program was presented as a humanitarian effort in sync with the social justice ethos of the 1960s. Furthermore, early discussions in OEO centered around using the centers as "an organizing device as a means of increasing the political power of the poor" ((Davis and Schoen 1978:162) and how the program would be a "vehicle for community development and participation" (Sardell 1988:55). With these explicitly political goals, the centers were seen as a radical departure from mainstream health care institutions, which had an enduring history of excluding marginalized groups. Advocates purported NHCs would treat the poor with dignity by providing free health care to all residents of a geographically defined area, rather than requiring a

degrading means-test for aid.[25] Building from the Civil Rights movement, activist bureaucrats and health professionals alike viewed the NHC model as one that would confer health care as a human right, staking its claim as a moral and altruistic program.

Within a short time, though, I found that elite policy actors also quietly solidified a compelling justification beyond progressive and humanitarian ideals: an explicit economic frame that aligned with market principles. In a 1967 closed-door meeting, agency leaders and White House aides discussed how in order to "break through political barriers" and "try to sell" the program—both to organized medicine as well as conservatives—NHCs had to explicitly "relate to supply and demand."[26] The pitch of these Democratic policy elites was that NHCs were a "way to get services and supplies into areas where we now don't have them" and for the government to "organize the supply to meet specific problems" in poor areas (ibid). Due to a lack of providers and the complex health problems induced by poverty, Johnson's top aides argued it was the government's role to balance supply with demand in economically distressed communities.

By 1969, NHCs were touted by policy elites as a solution to economic problems plaguing the health care system, including "rising costs, manpower shortages, and utilization."[27] NHCs would be a "creator of jobs that will directly benefit concentrated poverty communities" and provide "incentives to physicians to locate in poverty communities" (ibid). And most importantly for its future political success, NHCs were seen as necessary to correct for failures of the health care market: "what is needed is a system of incentives that will encourage health manpower, especially physicians, to practice in areas that have severe shortages."[28] The Johnson

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[25] For a short time from 1967-1968, the NHC program did implement a means-test at the behest of the medical establishment who initially viewed NHCs as a threat (Sardell 1988). Ever since, health centers have used a sliding scale rather than a strict means-test to determine the amount of government subsidy.
[26] LBJ Library, James Gaither Files, box 206, "Health Meeting Notes" (1967).
[27] LBJ Library, James Gaither Files, box 232, "Report of 1969 Task Force on Health" (1968).
[28] LBJ Library, Task Force Reports, Box 22, "Interagency Task Force on Health" (1967).

administration, while publicly proclaiming the program's altruistic and social justice features, privately delineated its market alignment, namely that NHCs would (a) reduce overall health care spending, (b) stimulate local economies by providing jobs, and crucially, (c) address market failures because doctors had little incentive to practice in low-income communities, due their elite occupational status (Starr 1982). These economic justifications—which could easily have been articulated for Medicaid as well—would resonate with ideological conservatives who agreed that the government had grounds to intervene where the market was expected to fail. Elites from both parties agreed that targeting disadvantaged communities was sensible, as its residents could hardly be blamed for their lack of access to doctors due to local economic conditions. From the outset, the NHC program was framed as addressing structural economic issues rather than correcting for individual failings, as implied by Medicaid's connection with welfare.

Shortly after its implementation, elites deployed frames that aligned the NHC program with ideologies across the political spectrum: it resonated with liberals' focus on social justice and ensuring health care as a human right, leading to frames of *morality*, but it also resonated with prominent conservative beliefs that the government had a role to play in addressing failures of the market, resulting in persuasive *economic* frames (Table 1). Because of a unified, cohesive philosophy that aligned with both morals and markets, health centers developed early political support and, perhaps as importantly, made few enemies. The result was that, when controversies did arise, they were contained as local issues and never rose to the national level as would future Medicaid scandals. Policy entrepreneurs' articulation of frames that combined morals and markets, both of which were deficient in Medicaid's early development, were necessary for the NHC program to attract political support and subsequently affected how the NHC program could adapt to changing political environments, survive opposition, and gain bipartisan popularity.

During the Nixon administration, the nation was perhaps the closest it had ever been to passing national health insurance (NHI) (Quadagno 2005; Starr 1982). Each policy would have been impacted by NHI in this era: first, the Nixon administration's proposal (and almost all other NHI proposals) planned to replace Medicaid and second, there were proposals to transform and expand NHCs as a pillar to the supply side of Nixon's health reform in line with his Health Maintenance Organization (HMO) vision. The administration's initial national health plan was not passed by Congress in 1971, and the subsequent 1974 version of his legislation—which had a higher likelihood of being enacted—never made it through Congress due to the Watergate scandal and Nixon's resignation. Although no major legislative changes in health policy resulted, the Nixon era was rich with political debates over health policy.

The Nixon administration was guided by the philosophy that the private market should provide health care for the majority of Americans, but maintained that that it was the federal government's duty to ensure that "no American family is ever barred from adequate health care because of inability to pay."[29] The Nixon administration subtly recast Democrats' ideas (Starr 1982) by heavily borrowing from egalitarian rhetoric to build a case against Medicaid:

> Federal dollars are being distributed very unevenly and *inequitably* among the low-income population… Moreover, exclusion of the "working poor" increases the *inequities* of the existing welfare system… encourages marital breakup and discourages the male head of a family from working… an *equitable* program of medical assistance for low-income families… must eliminate geographical *inequities*, categorical *inequities*, work disincentives, and ensure adequate protection.[30] (Emphasis added)

As this quote shows, Medicaid was portrayed during this time period not only as highly inequitable for its geographic variation and means-test, but also as *perverse.* Medicaid was alleged to both

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[29] Nixon Library, WHCF Health, Box 2, Presidential Statement, "Key Facts on Health" (1972).
[30] Nixon Library, WHCF Health, Box 1, DHEW report, "Towards a Comprehensive Health Policy for the 1970s: A White Paper," (1971).

incentivize beneficiaries to remain on welfare instead of seeking work and also disincentivize marriage, seeing as single mothers were the only adults eligible for welfare (and Medicaid) at the time. In a press statement, Nixon claimed that Medicaid "provides an incentive for poor families to stay on the welfare rolls" because "coverage is provided when husbands desert their families, but is often eliminated when they come back home and work."[31] Medicaid thus became vulnerable to attacks based on the perversity thesis, or the idea that policies intended to alleviate poverty actually exacerbate dependence on the state (Somers and Block 2005).

Pointing to its rampant inequities—across state lines and the social classes—Nixon sought to replace Medicaid with a nationalized program using uniform funding and eligibility levels, called the Family Health Insurance Program (FHIP). FHIP would provide insurance for all of the poor—not just those qualifying for welfare—in addition to the working poor, "for reasons of politics and equity."[32] With an entirely federally financed program, Nixon contended that states would be "relieved of a considerable burden."[33] And it was not only Nixon who was attempting to repeal Medicaid. All other proposed health reform plans at the time, of which there were many, proposed replacing or reforming Medicaid (Olson 2010). Virtually no political actors were in support of this program that was seen as a temporary stopgap on the way to NHI. Medicaid's association with welfare was at the core of most criticisms, but stories of waste and fraud also drew a preponderance of negative publicity (Stevens and Stevens 1974). Controversies brewed over the high cost of Medicaid and the program was blamed for increasing health care inflation (ibid). During this period, just five years after its passage, Medicaid's political support waned. Its

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[31] Nixon Library, John Price, Box 14, "President's Press Statement on Health," 2/18/1971.
[32] Nixon Library, WHCF Health, Box 1, "Meeting with Elliot Richardson, George Shultz, John Ehrlichman, Bob Finch and Ed Morgan (11/11/70)."
[33] Nixon Library, John Price, Box 14, "President's Press Statement on Health," 2/18/1971.

founding legislator and policy entrepreneur, Wilbur Mills (D-AR), no longer spearheaded the program, even confessing that Medicaid was "the worst mistake I ever made."[34]

The developments of the NHC program during the Nixon era were in stark contrast to Medicaid. Because NHCs were part of the Great Society, many contemporaneous observers believed that Nixon would try to eliminate the program and that NHCs had little chance of surviving the conservative administration (Marcus 1981). Some of Nixon's advisers warned him to steer clear of NHCs because of their association with the Democrats. Leaders of the Office of Management and Budget (OMB) levelled criticisms at NHCs that mirrored those made against Medicaid, such as geographic inequities, no long-term strategy, and biased grantmaking.[35] But the Nixon administration did not heed advice to terminate the NHC program and, instead, his administration sought to grow and transform NHCs, rebranding them as Family Health Centers.[36] The Nixon administration advanced the HMO model of pre-paid group practice and, because NHCs already followed this model, they were regarded as a steppingstone to achieving the HMO vision and were a crucial element to Nixon's health reform proposal.[37]

Why would the Nixon administration propose the expansion of this Democratic program? Internal memos among agency leaders delineated that the growth of NHCs had the potential to represent a "Nixon building program."[38] The rationale to expand NHCs was compared to Eisenhower's highway system and Kennedy's "moon shot," reasoning that "the American people

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[34] Nixon Library, Kenneth Cole, Box 58, "Mills the Innovator" article in the Washington Post, 4/23/1971.

[35] Nixon Library, James Cavanaugh, Box 25, OMB report, "Access to Medical Care for the Poor: A Preliminary Evaluation of Federal Health Center Programs," (1971). These same critiques would resurface under President Ford.

[36] This finding is based on many internal memos and personal communications amongst OEO and HEW officials that I uncovered at the Nixon library. Other scholars who have studied CHCs, without access to these previously classified documents, have not identified this internal support from agency leaders, and rather focused on the lower appropriations allocated to CHCs at this time as a signal of the administration's opposition.

[37] It is worth noting that this expansion did not pass and, while awaiting health reform legislation, few new clinics were funded under the Nixon administration (Sardell 1988)

[38] Nixon Library, Martin Anderson Files, Box 15, NHC Folder, "Proposal: Development of up to 800 NHCs over the Next 3-6 Years" (1970).

measure accomplishments and the return for their tax dollars in terms of tangible facilities seen" (ibid). The case was made by OEO director Donald Rumsfeld that the "establishment of new, distinct Neighborhood Health Centers, serving not just the poor, but the working man, could be a physical representation of President Nixon's efforts on behalf of the individual's most vital concern—his health" (ibid). Under the Nixon administration, health centers would emphasize not only serving the poor but would aim to become the primary provider for everyone residing in underserved communities. They were a "highly visible and quick pay-off initiative for the President" that would also leave behind a physical manifestation of Nixon's legacy. Despite some skepticism among Nixon's aides about the program, there was agreement over its political appeal: "the development of health centers… is now the most fashionable concept in medical planning circles in that it is contrary to greed, inefficiency, and poor health."[39] Seen as popular with voters and the press, the health center program served a useful political purpose. [40]

There were other reasons, besides optics, for this development. NHCs were perceived as solving "legitimate" supply-side problems. Nixon's staff acknowledged that clinics would always require federal assistance because poor areas would not be economically viable for the private sector to enter on its own. The market failure frame carried over from the previous administration and indeed was strengthened, as the Nixon administration abided by the idea that the federal government had a responsibility to incentivize medical providers to care for the poor.

Furthermore, the program continued to encounter virtually no opposition. Except for a handful of places, NHCs were not seen as competition, and thereby faced little resistance from organized medicine at the national level (Sardell 1988). Not only did AMA have less power to

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[39] Nixon Library, Kenneth Cole, Box 37, "OEO Paper on Neighborhood Health Centers" by Presidential staff assistant, Ray Waldmann, to Ed Harper, special assistant to the President (1971)
[40] Nixon Library, Martin Anderson Files, Box 15, NHC Folder, "Family Health Centers: A Proposal to Create a Balanced Health Delivery System" (1/14/71).

influence or resist government intervention than in previous periods (Starr 1982), but local medical and dental associations also found little to complain about because of the economic benefit, as health centers would "free them of unpaying patients" (Hollister et al. 1974:61). However, there were several local controversies over NHCs that garnered regional or national attention, which largely revolved around racialized conflict and accusations of corruption, like other Great Society programs. Some political disputes centered around health centers targeting migrant communities, tinged by anti-immigrant hostility. One controversy that rose to the state and national level took place in Zavala County, TX, which Nixon aides described as a "hot-bed of political activism by the Chicanos." Local physicians complained that they were not involved in the development of the health center and successfully persuaded the governor of Texas to veto the health center grant. According to internal OEO memos, the doctors' hostility was racially motivated as they "wanted to get the spics down" in this county where 85% of the population was Mexican American. Without Nixon's permission, the OEO director overrode the governor's veto, justifying that "the politics of this are on our side as this is a strong plus with the Chicanos. We can bring their vote around with this project." A similar controversy played out in Othello, WA, where opposition groups stated they were "against anything that will aid the Mexican American segment of our community." With involvement of federal officials, the local opposition was defeated.[41] Barring these and several other instances of localized conflict, the medical establishment generally did not resist the government's funding of clinics in places where most doctors would not voluntarily practice, and the program received comparatively little negative publicity for a Great Society initiative, allowing it to largely avoid the spotlight.

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[41] Nixon Library, WHCF Health, Boxes 2 and 14 respectively (1972).

The centralization of the NHC program's policy design was another important factor during the Nixon administration. Because the program had a broad and open-ended legislative mandate controlled solely by the federal government, policy elites could mold the program to suit their interests and flex their preferences by manipulating funding—in this case, toward Nixon's goal of HMOs. However, this also resulted in the reduction of the political and social justice activities as well as the non-medical elements of the NHC program's original design, retaining primarily the traditional health services model while continuing to target poor communities. The flexibility enabled by the centralized policy design thus spurred the process of institutional homogenization, as the program regressed toward the status quo (DiMaggio and Powell 1983; Starr 1982). Taking on a narrower, more medical structure to survive the new political environment had at least two long-lasting effects. For one, the purely medical model that was aligned with market principles allowed the program to draw more support from ideological conservatives while also placating Democrat elites who were pleased to see this OEO program continue. Compared to the goal of Democrats (like Senator Kennedy) to establish a full national health service, continuing the NHC program was a compromise.

Second, pressure to defend the NHC program during the Nixon era prompted advocates to establish both state and nationwide advocacy networks. Starting with the mobilization of health center activists, leaders, and patients in New York and Massachusetts, a nationwide coalition came together in the early 1970s to form what is now known as the National Association of Community Health Centers (NACHC) (Sardell 1988). This grassroots effort flourished with support from bureaucrats, Congressmembers, and state and local actors (ibid), which eventually laid the multi-level groundwork needed for health centers to successfully mobilize against future attacks (Quadagno 2005). Ultimately, the transition from a social justice to purely medical framework that

both political parties could agree upon allowed the health center program to pass its first test of adaptability and expand its advocacy network, which would be important to its survival in years to come.

PRESIDENTS FORD AND CARTER: FRAUD, FEDERALISM, AND THE URBAN TO RURAL SHIFT, 1974-1981

Following Nixon's failed attempts at health reform, President Ford shifted from trying to repeal Medicaid to instead reforming the program. The Ford administration proposed removing the inequitable state variation in Medicaid by instating universal eligibility. However, negative news coverage brought Medicaid into the public spotlight in the mid-1970s. During the presidential election against Carter, cases of Medicaid fraud and abuse regularly made headlines (Engel 2006; Olson 2010). Most of the scandals revolved around so-called "Medicaid mills," where predatory medical providers would open practices in low-income "ghetto" neighborhoods to profit off Medicaid recipients.[42] As a presidential candidate, Carter suggested that "Mr. Ford [was] responsible for the wasting and stealing of billions of dollars in the Medicaid program." Carter tarnished Medicaid by saying it "has become a national scandal" and that taxpayers were "being bilked of millions of dollars by charlatans."[43] However, President Ford deflected the blame onto state governments, like Carter's home state of Georgia:

> The facts are, of course, that Medicaid is a program operated and administered by the states, using Federal funds. Where the program is run badly, it is the responsibility of the state administration -- specifically of the Governor… No one has suggested that Jimmy Carter was personally involved in the corruption that existed in the Medicaid program in Georgia under his administration. But he was the man in charge. Through the laxity of his administration, these abuses were permitted to develop.[44]

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[42] Ford Library, Spencer Johnson Files, Box 7, "Secretary's Statement on Medicaid Fraud and Abuse" (1976).
[43] Ford Library, President Ford Committee Records, Box H29, Campaign Quotes (1976). First quote is from the New York Times on 9/11/1976 and the second is from the Associated Press on 4/16/1976.
[44] Ford Library, James Reichley files, Box 4, "DHEW Statement on Medicaid for use by Elliot Richardson" (1976).

In this way, Medicaid solidified its status as a political 'hot potato', with the states and the federal government wanting to deflect responsibility for the problems plaguing Medicaid. The state's rights frame was useful for the federal government to avert blame, while also convenient for the states to argue that the federal government was encroaching on their authority. Politicized in the presidential election and criticized in the media, Medicaid's federalist design continued to inhibit its political support among different levels of government (Robertson 2014).

Under President Carter, there was a re-emergence of concern over social justice and human rights among policymakers. The political window of opportunity re-opened for NHI, leading Medicaid to once again be on the metaphorical chopping block. As in the Nixon era, "Medicaid would be changed by all of the NHI options under consideration."[45] Critics continued to lament Medicaid's inequities, continuing to portray the program as perverse by contending that Medicaid disincentivized work and family by penalizing recipients who gained employment or those with residential fathers. Fraud and abuse coverage dwindled after regulations were enacted under Carter, but the stigmatized reputation and accusations of corruption clung to Medicaid. Federal budget constraints due to stagflation tied Carter's hands on social policymaking and ultimately precluded his ability to succeed with national health reform, despite many proposals (Quadagno 2005).

Meanwhile, during this time period the health center program encountered opposition. Similar to the frames deployed in critiques of Medicaid, the health center program was accused of being inequitable. In a memo to Congress, the Ford administration argued:

> The individual Federal grant award for health service delivery presents a basic inequity. It singles out for Federal subsidies a few communities for benefits subsidized by the Federal taxpayer from many other communities similarly situated… [and] equally deserving.[46]

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[45] Carter Library, Max Cleland papers, Box 74, "1980 Spring Planning Review: Health Overview."
[46] Ford Library, WHCF FA 6 Public Health Box 16, correspondence from Ford Administration to 26 Democrats in House of Representatives who opposed CHC spending cuts, 1975.

The equity frames temporarily switched under the Ford administration, with Medicaid representing the potential lever for providing equitable health care to the poor. Health centers were also faulted for being expensive and not using "objective" criteria of need in grantmaking decisions. In response, administrators developed specific geographic characteristics determining need, called "medically underserved areas," which represented a more "equitable" approach to funding that minimized rewards for grantsmanship. It was at this time that the nomenclature changed to the Community Health Center (CHC) program, representing a broader programmatic mandate.

Committed to devolving responsibility to states, the Ford administration attempted to block grant the health center program along with 15 other "special programs" providing health care for low-income people. The argument was that these programs were too "narrow," duplicative of one another, uncoordinated, fragmented, and—most importantly—that they were the federal government "singling out a few communities… for preferential treatment."[47] Ford said his block grant proposal was "designed to achieve a more equitable distribution of Federal health dollars among States and to increase State control over health spending."[48] Rhetoric of equity and rights continued to be primarily concerned with states, rather than people. Yet, the political opportunity structure was not in Ford's favor, and the Democratic controlled Congress repeatedly rejected his block grant proposal. Instead, Congress increased funding for CHCs, with the appropriations committee reasoning that there was no evidence that the private market would offer services in impoverished areas so long as they lacked incentives.[49] Ford's multiple vetoes of the legislation— which would have increased spending on CHCs and other health programs—were overridden in

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[47] Ford Library, WHCF FA 6 Public Health Box 16, Internal memo from Kenneth Cole (aide) to President Ford regarding Enrolled Bill HR 14214 – Health Revenue Sharing and Health Services Act of 1974.
[48] Ford Library, WHCF HE, Boxes 2-3, "Speech to Congress" 2/25/1976.
[49] Ford Library, White House Records Office: Legislation Case Files, Box 57, "Department of Health, Education, and Welfare Appropriations for 1977", House of Representatives (1976).

Congress by a strong majority, even among his own party, who continued to discuss CHCs as necessary to correct for market failures. The unsuccessful block-grant attempt foreshadowed future events under President Reagan and further mobilized NACHC, the national advocacy network.

Residual accusations of inequities in the CHC program and the threat of state devolution lingered under the Carter administration. Infighting among federal agencies took place, as OMB continued to be critical of DHEW's expansion of the CHC program. OMB argued that the formula-based designation of underserved areas were prone to "gerrymandering," and claimed that it was inappropriate for the government to "steer physicians towards more altruistic behavior" by "forcing" them to serve in "less desirable" locations.[50] DHEW countered using moralistic frames that state governments had historically shown "insensitivity to community, urban, minority, and poor person's needs" and that federal grants directly to local organizations "allows support of community participation and recognition of poor and minority needs."[43] Ultimately, the Carter administration sided with DHEW to preserve the structure of the original CHC program, with the federal government maintaining control.

Ford's principles of federalism and block granting could have dismantled the health center program had it not been for the Democratic majority in Congress. It is clear that, at this time, the CHC program remained popular among Democrats and, except for a handful of Ford's administrative leaders, were also acceptable among Republicans until some national health reform legislation could be agreed upon. A key factor in this absence of opposition was that, during the Ford-Carter era, the Rural Health Initiative (RHI) was established, which marked a shift from being a primarily urban program to an emerging rural program. In fact, for about three years, new grants were awarded only to rural health centers (Sardell 1988). This had implications for racial

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[50] Carter Library, Office of the Cabinet Secretary Jack Watson, Box 295, "OMB 1980 Budget: Health Programs."

politics, shifting the program from focusing on predominantly urban Black and Hispanic migrant communities to one that also emphasized poor rural whites. What was once derogatorily referred to as "ghetto medicine" in the 1960s now expanded to low-income rural populations who were predominantly white (Sardell 1988: 117). This transition from urban to rural, at a time when the program was at risk of devolution, was important for the program's support by Republicans, as its constituency was broadened and it became more politically difficult to oppose (O'Connor 1999). There were ample racialized conflicts associated with the CHC program that elites could have exploited (Brown 2013b), but due to its framing as correcting for market failures of the supply side, conservatives instead supported its expansion to a rural white constituency. This shift in geography was an important reason why the CHC program avoided becoming racialized, like other Great Society programs.

PRESIDENT REAGAN: FROM RETRENCHMENT TO ENTRENCHMENT, 1981-1989

The Reagan administration ushered in a new era of debate over health policy, as NHI was out of consideration. With a laissez-faire approach that opposed federal intervention in the market and advocated for the authority of states, "philosophically, the Reagan administration believes that the federal government should do less not more in the health care sector… and only bear direct financing responsibility for a 'safety net' of the 'truly needy.'"[51] The Reagan administration heavily relied on rhetoric of liberating states from Washington, such as saying that "states should be freed of all Federal mandates and constraints."[51] Ironically, though, the Reagan administration

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[51] Reagan Library, Robert Carleson files, Box 15, "Health Policy Under the Reagan Administration," National Health Policy Forum (1982).

ultimately strengthened both Medicaid and CHC programs, providing them with more secure footing for the decades to follow.

Whereas previous administrations had attempted to replace Medicaid with a broader national health plan, Reagan was the first president since its inception to not propose sweeping health reform. Therefore, Medicaid was no longer seen as a program that would inevitably be replaced and it was granted more attention. This made Medicaid more vulnerable to scrutiny, and its future looked dim at the beginning of the Reagan administration. Along with AFDC and food stamps, Medicaid was proposed to be block-granted to the states, which would drastically lower its funding and reduce coverage of the poor. State governors were opposed to this block grant because it would demand more from their budgets, leading to Reagan's proposed "Medicaid swap" in 1982. Under the swap, if states took full responsibility for AFDC and food stamps, the federal government would cover all of Medicaid's expenses. White House aides warned Reagan, though, that federalizing Medicaid would be "disastrous," as it would "give complete control of the programs to the Federal government making it easier for a subsequent Administration to effect National Health Insurance"[52] In a shift away from the visions of Nixon and Ford, who advocated for national eligibility and health benefits for the poor as a principle of equity, the Reagan administration now viewed uniformity as a stepping stone to NHI and a potential political victory for their Democratic opponents. Negotiations over the federalization of Medicaid consequently broke down and the swap never transpired.

However, debates over the swap showed that Medicaid was granted favorable status over welfare and food stamps during the Reagan administration. Medicaid was increasingly regarded by policymakers as a legitimate health program worthy of attention and improvement in its own

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[52] Reagan Library, Martin Anderson Files, Box 24, "Medicaid Federalism Implementation 2/18/82."

right. With Reagan targeting welfare, Medicaid became safe from retrenchment and remained relatively unscathed for the rest of his administration. Indeed, during this time, Medicaid eligibility was extended for the first time to cover low-income pregnant women who were not welfare recipients. The Reagan administration began the process of disassociating Medicaid from welfare, which would be finalized the following decade under Clinton's 1996 welfare reform (Smith and Moore 2015). Medicaid was thus strengthened politically during the Reagan era via the initiation of legislative detachment from welfare.

The CHC program was also to become firmly entrenched during the Reagan administration due to another failed block grant attempt. Unlike Ford, Reagan had the advantage of a Republican majority in Congress. CHCs were originally included in the Health Services Block Grant, but after negotiations spearheaded by policy entrepreneurs, including Senator Kennedy, the CHC program was given its own separate Primary Care Block Grant (PCBG) in 1981. Unlike the other health block grants, the PCBG was optional and states would need to apply for it. The PCBG also carried onerous requirements, including that states needed to fund existing centers at the current level for the first two years, which dissuaded states from participating. Health center advocates argued that states had demonstrated no commitment to providing primary care for the poor and that underserved areas would lose access to basic medical care, especially in rural areas, with the block grant. The nationwide CHC network adopted Reagan's ideological terms, saying that health centers were "highly effective and efficient… locally controlled, private-public partnerships" and argued that health centers had both "strong bipartisan support in Congress and broad public support."[53] This was the first pronouncement I found of bipartisanship for the CHC program.

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[53] Reagan Library, HE004, Box 41, Correspondence from National Association of Community Health Centers to President Reagan, 10/16/84.

Legal battles ensued over the PCBG implementation. The Reagan administration repeatedly vetoed attempts by a sympathetic Congress—where CHCs were evermore in good favor, even among conservatives—to have it overturned. In the three years of the PCBG, only West Virginia and Puerto Rico took up the block grant (Sardell 1988). The PCBG was largely seen as a failure. Congress stubbornly held its ground in support of CHCs and, in bipartisan fashion, enacted legislation sponsored by Senator Orrin Hatch (R-UT) in 1986 to eradicate the PCBG. In fact, both the House and Senate voted *unanimously* to allow CHCs to reinstate their previous form.

What explains the initial turn toward bipartisan embrace of the CHC program? Once again, the context of NHI is an important layer to understanding the political climate of the times. Shifting away from consideration of NHI, Republicans now found themselves in the position of needing to compromise on health care and demonstrate some policymaking effort in this arena. As one White House public liaison deputy wrote in a confidential memo:

> I cannot help but be concerned that [health care reform] is another "hot potato" and one that we should approach with tender caution... This "reform" issue is just the type of thing that the Democrats could link to social security and tar Ronald Reagan and the Republicans for another election. Talk about compassion!! This thing could really backfire, if we are not careful … a decent reform in this area will need to be bipartisan, and I do not see that happening in the current environment. If I were a Democrat looking to 1984, this would be a prime target of opportunity for me to blast Republicans as insensitive.[54]

Republicans anticipated being "tarred" by Democrats as "insensitive" if they did nothing and therefore recognized the need to strive for bipartisan agreement in health policy. This sentiment explains some of the surprising coalescence around health centers among Congress members. Another element, of course, were the political (and economic) benefits Congressmembers gained from the program; losing funding for a health center in their districts could have a negative impact on their popularity with constituents and bids for re-election. Congressmembers had a vested interest in maintaining the program for their own political careers. During the block grant battle,

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[54] Reagan Library, Elizabeth Dole Files, Box 39, "Medicare/Medicaid 12/13/82" confidential memo from Red Cavaney to Elizabeth Dole.

though, many CHCs were defunded, and the scope of continuing centers was substantially narrowed due to budget cuts. However, the block grant attempt also forced the local, state, and nationwide network of advocates to come together in impressive numbers, which further strengthened the CHC program and its future lobbying prowess.

THE BUSH ADMINISTRATION: ALIGNING MARKETS WITH COMPASSION, 1989-1993

Though guided by a laissez-faire philosophy similar to Reagan, President George H.W. Bush was more focused on the poor than his predecessor. The Bush administration regarded the free market as lacking incentives to address poor people's needs and viewed the government's role as compensating for this inevitable failure of the market. Bush's Health and Human Service (HHS) Secretary stated: "I firmly believe that full access to health care in America will continue to require a public sector that provides a safety-net for those whom the market overlooks."[55] Invoking market failures was a common justification for conservative safety net policymaking, and attempts to align Medicaid with the market followed suit when the Bush administration (reluctantly) proposed a health plan in anticipation of his re-election bid. One component of Bush's 1992 proposal guaranteed health insurance for all poor and working-class families, not just those eligible for Medicaid, through a government subsidized tax credit. In testimony to the House, the CBO stated: "this approach would reduce the current work disincentive Medicaid recipients face."[56] Bush's health reform proposal, which failed to gain traction, sought to both expand Medicaid beyond welfare recipients in order to eliminate its alleged work disincentive, as well as strengthen states' flexibility in structuring their Medicaid programs. Once again, Medicaid was oriented more toward

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[55] H.W. Bush Library, Linda Tarplin Collection, OA/ID 08458, "Constraining the Costs of Health Care" (1992).
[56] H.W. Bush Library, Johannes Kuttner Collection, OA/ID 08799, "CBO Testimony Before the Committee on Ways and Means, U.S. House of Representatives" (1992).

the rights of states than individuals and seen by many policymakers as needing to be realigned with market principles.

While Reagan sought to stymy the growth of the CHC program through block grants, Bush took a different tactic—partially due to a greater ideological emphasis toward the vulnerable, and partially due to changes in the political climate. With support from Democrats and lack of opposition from most Republicans, expanding CHCs was a politically viable and low-cost option to appease calls for health reform. In fact, CHCs were a centerpiece of Bush's 1992 health reform, mentioned in most press statements, speeches, and talking points. The administration proposed to increase program authorizations by $2.8 billion and more than double the number of patients served from 6 million to 13.5 million over the following five years.[57] In line with his vision for a "kinder, gentler nation," the recurring refrain was that CHCs were committed to the nation's "underserved" in "inner-city and rural areas." Because these places would be otherwise unable to attract doctors without incentive from the government, the program once again evaded any contestation over deservingness and was clearly framed as correcting for the failure of the market "overlook" the poor.

Beyond the executive branch, health reform proposals across the political spectrum also advocated for growth in the CHC program. House Republicans included CHCs as one of three proposed reform provisions,[58] the Clinton campaign and conservative Democrats proposed expansion, as did various interest groups, including the conservative Heritage Foundation.[59] There was growing consensus around the CHC program for several reasons. It became clear that CHCs

[57] H.W. Bush Library, Linda Tarplin Collection, OA/ID 08459, "Summary on Health Reform Proposal", internal memo between White House and HHS (1992).
[58] H.W. Bush Library, Stephanie Fossan Collection, OA/ID 06981, "Action Now Health Care Reform Act," Republican House Members press release (1992).
[59] H.W. Bush Library, David Bradford Collection, OA/ID 07931, "Comparison of the Administration, Clinton/Gore, and Conservative Democrats' Health Care Reform Proposals" internal memo between White House aides.

would remain a necessary component of the government's efforts to provide health care to the poor, regardless of what kind of health reform was passed, because health insurance would be ineffective without the necessary infrastructure in underserved places. Expanding health centers was also seen across the spectrum as maintaining the integrity of the private sector by targeting government aid only to sparsely populated or economically depressed areas. And finally, for Republicans, the CHC program served as a useful policy alternative to more widespread government involvement in health care.

Although no major health reform was enacted under Bush, two important pieces of legislation were passed in this era that would have a profound impact on the future of the CHC program. Under the 1989 Omnibus Budget Reconciliation Act, the federal government mandated that Medicare and Medicaid must not only reimburse health center services, but also that they would be paid at a higher rate. Prior to this, only one-third of state Medicaid programs reimbursed CHCs for all of their services (Sardell 1988). Requiring that CHC visits be covered by public insurance vastly improved the financial viability of the program.[60] In addition, after lengthy negotiations between the Department of Justice and a bipartisan group of Senators, an agreement was reached in 1992 that the federal government would provide malpractice coverage for health center employees. These two legislative changes—mandated and increased Medicare and Medicaid reimbursements, as well as malpractice coverage—enabled the massive growth of the CHC program in the next decade, because medical providers would now see the tangible economic and legal benefits to acquiring federal status as a CHC.[61] Though Bush and the Republican party sought to *limit* government involvement in health care, these two pieces of legislation laid the

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[60] Clinton Library, Health Care Task Force Collection, OA/ID 1229, "Physician Payment Under Medicaid: Options for Reform", report by the Physician Payment Review Commission (1991).
[61] The formal terminology of Federally Qualified Health Center (FQHC) was coined at this time, and is still used to differentiate health centers receiving federal grants, higher public reimbursement rates, and malpractice coverage.

groundwork for the expansive nationalized primary care delivery system in medically underserved areas that we have today.

THE CLINTON ADMINISTRATION: PARTISANSHIP AND THE MARKET

In the early 1990s, a major window of opportunity opened for health reform for the first time since the Nixon administration. There was a dizzying array of proposals—more than three dozen at one point in 1993—floated among both parties, along with the Clinton administration's version of universal coverage through managed care.[62] Once again, the majority of these proposals called for the repeal or reform of Medicaid. The same issues that had plagued Medicaid since its origins continued to suppress its political support: stigma, inequity, high cost, and inefficiency. The Clinton administration's proposed Health Security Act (HSA) sought to maintain Medicaid only for AFDC and SSI beneficiaries, while moving all other low-income and working-poor adults to a managed care version of universal coverage. The primary arguments employed were, again, that Medicaid served as a work disincentive for those on welfare and that it stigmatized poor people and providers, as explained in an internal policy brief for Hillary Clinton:

> Medicaid coverage can serve as a *disincentive* to join the workforce… Low reimbursement rates and the *stigma* attached to the program have caused many providers not to accept Medicaid patients… The Health Security Act will remove the stigma attached to obtaining health coverage through Medicaid… promising an end to two-class medicine… Health reform will *free* these welfare recipients to pursue work and economic independence.[63] (Emphasis added)

This refrain of liberating welfare recipients from the stigma of Medicaid was common as the Clinton administration attempted to push for reform. They argued that the HSA would "mean that millions of inner-city welfare recipients who want to work will be […] free to seek jobs, and get

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[62] Detailed analysis of what transpired in the early 1990s battle for health reform can be found elsewhere (see Starr, Skocpol…)

[63] Clinton Library, First Lady's Office, Pam Cicetti Files, OA/ID 12500, "HRC's Briefing Book for Congressional Testimony Relating to Health Care" (1992).

off welfare, because they will no longer have to worry about losing medical benefits for themselves and their children."[64] In preparation for subsequent testimony to Congress, Hillary Clinton stated that "for the first time, Medicaid recipients will be just like everyone else" and reassured Congress that the administration's plan would do away with discrimination against the poor and avoid "redlining" of health plans.[65] By depicting the inequities and stigma of the existing Medicaid system, the Clintons claimed that their health reform plan would treat everyone equitably and with dignity, and that the poor would be integrated into mainstream health care. Once again, Medicaid was condemned by elite policymakers as misaligned with both markets and morals.

However, the Clinton administration's reform proposal suffered a resounding defeat by House Republicans in 1994 (Skocpol 1996; Starr 2013). No longer possessing the political capital to push for reform, the Clinton administration subsequently pivoted from criticizing Medicaid to embracing it as a tool to advance incremental policy change. The Clinton administration sought Medicaid expansion through state waivers that promoted experimentation and eventually led to the enactment of the Children's Health Insurance Program (S-CHIP) in 1996. In addition, the passage of the 1996 Personal Responsibility and Work Opportunity Act that famously brought an "end to welfare as we know it" formally delinked Medicaid from welfare. These two momentous changes led Medicaid to be framed as both apart from welfare and in relation to children, lessening its stigmatized political perception. Yet, Republicans continued to propose block grants that would drastically reduce Medicaid funding and coverage. These partisan battles over health reform paved the way for even more controversy over Medicaid in the 2000s, primarily concerning the role and authority of the federal government versus the states. Medicaid's federalist design has been—and will likely continue to be—its clearest and most durable cause of political contention.

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[64] Clinton Library, First Lady's Office, Press Releases and Health Care, "The Health Security Act of 1993."
[65] Clinton Library, First Lady's Office, Melanne Verveer Files, OA/ID 20035, "Health Reform" (1993).

The CHC program underwent a surprising transition in the early 1990s, as the Clinton administration largely ignored CHCs while Republican leaders embraced them. Indeed, Republicans proposed more funding for CHCs than did leading Democratic proposals. The most widely supported health reform legislation put forward by the House Republicans, with 106 co-sponsors, boasted of expanding the CHC program on the first page of their press release.[66] It was at this point that CHCs became a program that Republicans enthusiastically advocated for, rather than one they simply did not oppose.

Why did the Clinton administration not embrace CHCs in health reform? Clinton's reform was designed to give authority to states, whereas CHCs had always curtailed state policymakers in favor of federal-local partnerships. Although CHCs were included as "essential community providers" in Clinton's HSA, the legislation otherwise neglected CHCs and even sought to block grant the program. Health centers thus faced a similar climate in the early Clinton years as they had under Reagan and Ford, compelling advocates to, once again, fight against devolution to states.

Like in previous decades, the block-grant attempt mobilized CHC advocacy networks, which were even stronger and more organized after surviving the Reagan era. The national association, NACHC, activated a robust and coordinated campaign to resist Clinton's turn away from health centers by deploying market failure logics. To convince the Clinton administration of their utility, advocates articulated how CHCs were not, in fact, opposed to free market principles but rather were responses to market failures and thus complementary to market-oriented policymaking:

> Simply put, underserved Americans are in the health care predicament they are in because they have been *rejected by the private market*. The community and migrant health center programs were enacted by the Federal Government in response to the *failure of market forces* to meet the needs of underserved and vulnerable populations. If market forces work for health care like they have in other sectors of the

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[66] Clinton Library, Domestic Policy Council, Chris Jennings Files, Box 46, "[HSA] Congressman Hastert" (1993).

economy, underserved people and communities run the risk of being red-lined, short-changed and, in the end, getting far less than they need or deserve.[67]

In addition to NACHC, Republicans also explicitly referred to the market failure logic. Senator Chafee (R-RI), a strong supporter of CHCs, explained in one piece of proposed legislation: "pure competition may not work in certain areas of the nation, particularly medically underserved areas, both urban and rural. Additional funds and services need to be provided for these special needs populations."[68] Conservative legislators acknowledged that free market principles were ineffective in poor communities, as did members of Clinton's own administration:

> It is clear that some currently underserved areas may have their needs met through the private market. Other areas have such severe problems that they may never attract providers or investment capital… Because of the scarcity of investment capital in underserved areas, facilities serving existing patients as well as new capacity are essential to attract and maintain providers and to allow existing and new providers to compete in the new system.[69]

They argued that underserved areas had such "severe problems" that they could not be expected to "attract providers or investment capital." Given the prestige of the medical profession (Starr 1982), policymakers across the aisle agreed it was rational that poor communities were unable to attract profit-seeking doctors. Market failure framing averted discussion of deservingness, race, and morality that other social welfare policies were vulnerable to and was crucial to winning over Clinton's support. In addition, the Clinton administration became increasingly aware of the popularity of CHCs among Congressmembers. A number of internal memos weighing political strategy made the simple yet powerful claim that CHCs had strong bipartisan ties on Capitol Hill. Therefore, despite the Clinton administration's disinterest in CHCs and preference for granting states full jurisdiction, the activation of market failure framing by the robust CHC advocacy

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[67] Clinton Library, White House Health Care Task Force, Richard Veloz Files, OA/ID 3885, "House and Senate Testimony, Jan-Feb 1994."

[68] Clinton Library, Domestic Policy Council, Chris Jennings Files, Box 47, "Misc Chafee Health Reform Proposals" (1992).

[69] Clinton Library, Office of Policy Development, Ira Magaziner, OA/ID 10009, "Access to Care for Underserved and Vulnerable Populations" Presidential Briefing Book (1993).

network along with bipartisan Congressional allegiance to CHCs rendered the program safe from retrenchment.

RACE, IMMIGRATION, AND POLICY CONVERGENCE, 1993-1996

One final development of the 1990s was that CHCs had become more closely associated with racial minorities and immigrants than in any other era since its origins. Health centers were continually discussed as the government's primary means of serving minorities, "inner-city" poor, Hispanic immigrants, and "illegal aliens." However, rather than inciting racialized conflict (Brown 2013b), CHCs were instead framed positively as "fixing" problems of racial health disparities. Perhaps most surprising was in relation to undocumented immigrants, as CHCs were touted as being a solution to the problem of undocumented immigrants lack of access to health care. As of 1993, CHCs and Emergency Medicaid were the only formal ways that undocumented immigrants could receive health care in the U.S., and an estimated 300,000 were served by CHCs that year.[70] Policymakers recognized the problem of undocumented immigrants being highly uninsured, yet the political barriers to including them in the HSA were seen as insurmountable by the Clinton administration. Promoting CHCs became the standard response when the administration was asked what they would do about health care for undocumented immigrants:

> For humane reasons and purposes of protecting the health of the public it is important that a safety net be in place to care for these individuals... Non-emergency care would be provided through the Community and Migrant Health Centers; these centers now serve all persons without regard to citizenship and will continue to do so.[71]

In this way, CHCs were used as justification for why the government need *not* expand the HSA to cover undocumented immigrants. The CHC program proved its political utility as a tactic to compensate for comprehensive care and tamp down on contentious policy issues, like immigration.

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[70] Clinton Library, Health Care Task Force, General Files, OA/ID 1235, "Working Group Draft" (1993).
[71] Clinton Library, Health Care Task Force, Richard Veloz, OA/ID 3880, "Hispanic Health Care Q&A" (1993).

Debate over the 1996 welfare and immigration reform (PRWORA and IIRAIRA) presented a critical juncture for both CHCs and Medicaid. Initially, Republicans and some officials in the Clinton administration sought to include CHCs on the list of federal programs that immigrants—both undocumented and recently arrived—would be ineligible. The definition of federal public benefits was debated in relation to both PRWORA and IIRAIRA, and it was decided that legal immigrants would now be ineligible for Medicaid during the first five years of residency. In place of Medicaid, newly arrived and undocumented immigrants were expected to receive care via three channels: at CHCs, insurance through an employer or self-paid, or through Emergency Medicaid. Like in 1993 when CHCs were used as validation for why the HSA would not include extending coverage to undocumented immigrants, CHCs were again used in 1996 but now to take *away* Medicaid eligibility from legal, recently arrived immigrants.

The debate over what constituted "federal public programs" explicitly manipulated legal terms in order to allow CHCs to remain available to all immigrants. HHS drafted a definition of federal public benefits that would exclude CHCs because of their focus on places and not people: "since Community Health Centers are structured to serve communities… the centers do not provide federal public benefits to individuals."[72] The emphasis on places was viewed as grounds to exclude CHCs from the list of programs ineligible to immigrants. This is a long-term consequence of the program's strategic market failure framing, which diverted individualistic debate over deservingness that immigration policy often encounters.

Furthermore, advocates effectively argued that lack of access to CHCs would pose a public health risk, because "germs do not ask for a green card before they spread."[73] Despite the prevailing

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[72] Clinton Library, Domestic Policy Council, Elena Kagan, Box 64, "Definition of 'Federal Public Benefit' Under the PRWORA of 1996" paper by Georgetown University Law Center (1998).
[73] Clinton Library, Health Care Task Force, Richard Veloz, OA/ID 3884, "Impact of the Proposed Health Security Act (HR 3600) on Undocumented Immigrants" (1994).

policy climate of restricting immigrants' access to government programs, CHC and immigration advocates persevered. HHS coordinated with White House counsel, including future Supreme Court Justice Elena Kagan, to modify the definition of federal public benefits such that CHCs would not be affected, concluding that this was: "major good news for immigrant advocates, who argued that shutting off these centers to illegals would be dangerous to the public health and to citizen children."[74] This victory exemplified a strong mobilization effort by advocates, coordinated with the Congressional Hispanic Caucus, to ensure that undocumented immigrants would have some way of getting health care. Despite the fact that CHCs are, to this day, one of the only federally-funded programs to which undocumented immigrants are not excluded, the covert maneuvers to arrive at this decision kept CHCs out of the spotlight and avoided partisan backlash.

In sum, CHCs were first used politically to justify the exclusion of undocumented immigrants from Clinton's HSA in 1993, and subsequently to rationalize the restriction of immigrants' Medicaid eligibility in 1996. Only the latter policy was implemented, but it was built on the same arguments and framing as the 1993 debates. The transformation of CHCs into a conservative-supported program in the early 1990s, combined with increasing anti-immigrant sentiment and the severe cutbacks of the nationwide safety net in 1996, inhibited Medicaid coverage among immigrants, even among those who were in the country legally. The convergence of the two policies, both relying heavily upon legality frames (Brown 2013a) to determine access to health care, had the ultimate effect of solidifying bipartisan support for the CHC program but did little to improve Medicaid's popularity among Republicans who continue to exploit racialized conflict in debates over Medicaid policy.

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[74] Clinton Library, Automated Records Management System, Emails Received by Elena Kagan, Box 80, emails between Diana Fortuna and Elena Kagan (1998).

DISCUSSION

This study leverages a comparison of two policies with the same purpose and national-historical context in order to answer the question of why some social welfare policies become more politically contentious than others. Despite the prevailing belief that antipoverty policies inevitably attract partisan conflict and engender stigma, I argue this is *not* a foregone conclusion and needs to be better understood. This study first posits a general theoretical framework for assessing the underpinnings of political vulnerability in social welfare policymaking. Pulling together five interrelated explanations—including deservingness, race, elite support, policy design, and the role of ideas—I assess how each factor contributed to understanding political controversy. However, I ultimately conclude that these explanations are insufficient on their own, and that the extent to which each policy was framed in alignment with market principles was instrumental to the divergence of political contention. As policymaking in the United States shifted away from a social democratic orientation of the New Deal and Great Society and toward the present-day era of neoliberalism, the CHC program was able to attract bipartisan support because it was both framed in moral terms—health care as a human right—and in market terms—as correcting for the market's failure to serve the poor. In contrast, Medicaid was primarily concerned with states' rights and framed as correcting for failures of individual welfare recipients, which inhibited its political backing and incited conflict among a variety of actors. After reviewing existing explanations, I then elaborate on how my concept of the *market failure paradox* contributes to scholarship on partisanship in the U.S. welfare state.

Were there fundamental ideological differences that account for the divergent level of conflict? I found no instances in which policymakers explicitly debated *whether* the government had a role in providing health care to the poor. Even during the era in which conservatives had the

most political power—the early Reagan administration—there was consensus that it was unconscionable to deny health care due to inability to pay. This rhetoric did not necessarily translate into action, as conservatives often did little to improve the health care situation of the poor, and there was dispute about the *extent* to which the government should be involved, but the basic premise of health care for the poor was not as contentious of an issue among policymakers as it has been for other social welfare policies during this time period.

Indeed, this ideological overlap was closely tied with deservingness, as prevailing social norms underscore that the sick *deserve* help: "no one can be against medical care or health for all American citizens" (Stevens and Stevens 1974: 359). In the context of health care provision, the perversity thesis lacked the "cultural resonance" needed for an effective frame (Snow and Benford 1988; Somers and Block 2005). Cultural categories of worthiness deployed in discourse over traditional welfare, thus, did not resonate in the life-or-death matters inherent to debates over access to health care (Steensland 2006). Instead, one of the primary issues plaguing Medicaid was that it was seen by elites as immoral; some thought Medicaid demeaned recipients due to its long-standing linkage with welfare, and others thought it induced disincentives in work and family life. Both conservative and liberal elites attacked Medicaid on these grounds at various times and for differing agendas. Though not nearly as controversial as AFDC, Medicaid was similarly framed as morally corrupting for creating dependency on the state and being anti-family and anti-work, leading to questions of whether its recipients were truly deserving of help. In contrast, the CHC program's originating concern over human rights provided a straightforward moral frame across ideological perspectives. Liberals admired its relation to social justice, while conservatives saw it as a charitable program to help the poor who could not be blamed for the economic conditions and

lack of medical providers in their community. In this way, the CHC program's market failure logics rendered debates over deservingness obsolete.

Relatedly, I also found little evidence that race—either objectively or symbolically—explained much of the divergence in political contention. Objectively, Medicaid and CHCs have historically served roughly the same population demographic, with racial minorities comprising a slightly larger percentage of CHCs patients than Medicaid recipients (Kaiser Family Foundation and HRSA Uniform Data System). However, we know that racialization does not necessarily result from the objective reality of who is benefitting from government aid (Gilens 1999; Seccombe, James, and Walters 1998). Symbolically, the racialization of AFDC undoubtedly clung to perceptions of Medicaid and attempts to retrench the program, especially in conservative-leaning states. There was surprisingly infrequent explicit discussion of race in the context of federal Medicaid policy, but this was largely the result of AFDC absorbing racialized political conflict in place of Medicaid. In contrast, race was explicitly discussed far more frequently in the CHC program. There was a non-trivial amount of local racialized conflict in the opening of clinics (Hoffman 2012; Nelson 2011). In the mid-1970s, the program shifted from targeting urban to rural areas, which was an important reason that the CHC program did not incite racial conflict at the federal level; once poor rural white constituencies were also emphasized, conservative elites viewed the program more favorably. Yet, even when the CHC program became strongly associated with Hispanics and undocumented immigrants during the 1990s, political conflict still did not ensue, in large part because CHCs were seen as a preferable alternative to continuing immigrants' eligibility for Medicaid. If race was a central reason the programs differed, the existing literature would lead us to expect that Medicaid was more racialized or experienced more racial conflicts than the CHC program. This was not the case, as the CHC program experienced equally if not

more racial conflicts than Medicaid in the early years of both programs. However, this was not exploited by policy elites to be politically consequential for the CHC program (Brown 2013b; Neubeck and Cazanave 2001; Prasad 2006). I argue that the lack of sustained racial conflict, despite clear opportunities for conservatives to manipulate racial divisions in the program's targeting at its onset, did not become salient for the CHC like other War on Poverty programs due to the prominence of market failure logics, which effectively scapegoated the market rather than minority groups targeted by the CHC program.

Third, sources of political support proved to be an important though indirect explanation to the divergence in contention. Conflict emerged in Medicaid not because the poor lacked power, but instead primarily because of the program's origins in the politics of accommodation (Starr 1982). Neither political party was in support of Medicaid from its enactment, and there was little effort by advocates to coalesce around compelling frames in order to grow its support base in the early years. The combination of lacking both moral and market frames suppressed the political support for Medicaid as debates over NHI prevailed. With one NHI failure after the next, Medicaid reached a state of institutionalized political contention (Schön and Rein 1994) during the 1990s, which continued through the 2000s and the passage of the ACA. Advocacy groups, notably the Children's Defense Fund, mobilized for Medicaid in the 1990s (Grogan and Patashnik 2003a), but the timing of this support coincided with intense partisan conflict. In contrast, the early CHC program had strong initial support from policy entrepreneurs (Anderson 2018) and bureaucratic advocates, who crafted the moral and market frames that grew its political popularity steadily over time. It was lauded by advocates from the start as a movement for social medicine, which grew into the modern-day grassroots advocacy network at federal, state, and local levels, and organized a formidable force in the face of block grant attempts from Presidents Ford, Reagan, and Clinton.

These advocates established strong ties with Congressmembers as a final line of defense when the executive branch sought to devolve the CHC program. The absence of elite support and grassroots mobilization for Medicaid (after the National Welfare Rights Organization dwindled in the mid 1970s) and presence for the CHC program provides evidence for its role in circumventing controversy. However, the underlying cause of the support came through the channels of policy design and market alignment.

The design of both policies proved to be instrumental in explaining the divergence of political contention. Although affiliated with principles of federalism and the liberal welfare state (Ruggie 1992), the state variation in program design, funding, and participation led Medicaid to initially be viewed as highly inequitable, dampening its support and inciting opposition. Because Medicaid eligibility was initially tied with welfare receipt, it also adopted the long history of stigma affiliated with public assistance and became perpetually entangled in contestations over deservingness (Katz 1989). Thus, Medicaid was structured and framed along the lines of the perversity thesis (Somers and Block 2005), to correct for the alleged failures of individuals who were dependent on the state. Medicaid's federated policy design and pervasive inequity frames stymied the program's ability to gain political support until it was finally disconnected from welfare in 1996. To this day, conflict between states and the federal government continues to be the primary cause of Medicaid's political contention. In contrast, the CHC program's centralized, supply-side design in which the federal government exercises authority, bypassing involvement from state or local governments, allowed for the CHC program to adapt to changing political environments. Starting with Nixon's elimination of the program's social justice elements, subsequent administrations have been able to manipulate the program to suit their policy

preferences. Centralized authority allowed the CHC program to be flexible, though also vulnerable, to the whims of whoever was in power.

Policy design laid the groundwork for the deployment of frames. Ideas about policies were strongly conditioned by the opportunity structures available based on the initial design of each policy. Medicaid was fundamentally constrained in articulating either moral- or market-based frames due to its federalist design and extension of welfare, which both created inequities across state lines and increased "veto points" due to a greater number of political actors involved (Prasad 2018). While the states' rights orientation that led from Medicaid's federalist design was an important factor in getting the legislation passed (Stevens and Stevens 1974), it has also been the centerpiece to its political conflict, continuing through the ACA and Republican governors' opposition toward Medicaid expansion. In contrast, the CHC program had a much wider discursive opportunity structure due to its centralized authority within the federal government that bypassed veto points among state governors and even local political actors in some cases. Without its centralized structure, the effectiveness of the CHC programs' dual moral- and market-based frames may have been irrelevant, and its bipartisan support as well as national advocacy network may have never flourished. An important theoretical contribution is, therefore, that discursive opportunity structures are not only variable across nation-states (Ferree 2003), but also highly contingent upon policy designs themselves, as they generate interpretive policy feedback mechanisms (Pierson 1993; Steensland 2006). Because this study is uniquely able to hold contextual factors constant, I find the resounding influence of policy design—and its path dependent formation of institutional structures—in establishing discursive constraints that extend beyond cultural, attitudinal, or political dynamics.

In addition to these explanations, alignment with market principles emerged from the analysis as a consequential distinction in the way that policymakers discussed and understood each policy. Medicaid lacked clear alignment with the market and, instead, was criticized for going *against* the market by disincentivizing work, being wasteful and inefficient, and causing inflation in health care costs. There are ample ways in which Medicaid could have been framed in alignment with the market. For one, people cannot work if they are sick, and having an insured workforce should improve market productivity. Likewise, a market failure logic could have been deployed: because private insurance companies have little incentive to cover poor people, as they tend to have worse health and be more costly, policymakers could have framed the government's role in insuring the poor as correcting for the failures of the private health insurance industry. Some evidence exists that these economic frames were attempted, but not until the late 1980s (Grogan and Gusmano 2007). Medicaid's lack of initial elite support hampered an effective market frame from taking hold and growing its political base.

In contrast, the CHC program's centralized structure within the federal government enabled its malleability during the rise of laissez-faire policymaking. Indeed, the groundwork of its supply-side framing had been laid as early as 1967, despite the institutional environment's emphasis on Social Democratic policymaking during that era. As market-oriented policymaking took firm hold in the 1980s, CHCs had an effective justification: free market principles of competition simply do not apply in poor areas. In fact, that is the reason why they are underserved, as doctors seeking profit would not rationally choose to practice in these places. This is what I call the *market failure paradox*. Policymakers accepted that market forces could not be applied the same way in poor places because of the competitive nature of the free market. The government's involvement in the CHC program was not seen as a rejection of the market, but an

acknowledgement of its inherent limitations. Evincing the ability of market fundamentalism to survive disconfirming evidence (Somers and Block 2005), market failure frames relied upon the logic of incentives for profit-seeking enterprises to justify the federal government's intervention in poor places. Unlike policies that are framed as correcting for the failure of individuals or the government, which have generated controversy and backlash against a Social Democratic welfare state approach, scapegoating the market paradoxically did not undermine confidence in policymaker's reliance on market principles and, instead, emboldening the role of market principles in social welfare policy. Further, the market failure paradox subverted contestations over deservingness, race, and morality, as poor people cannot be blamed for their local economies or the lack of medical providers. And blaming the market, moreover, allowed for political support to coalesce around the CHC program in an unusually bipartisan fashion for social welfare policy.

The founding frames in alignment with morals and markets set the CHC program on a path toward political receptivity, resonating across the ideological spectrum, but its institutional structure laid the foundation for these frames to be effective among political elites, especially Congress. Ultimately, it was the dual flexibility in both ideology and design that allowed the CHC program to gain political support, overcome controversies it encountered, and achieve bipartisanship. These features were conspicuously absent in the Medicaid program, which lacked support due to its policy design, repeatedly encountered debates over deservingness, and was seen by many elite policymakers as going against morals and markets. Therefore, policy design and degree of alignment with both morals and markets was consequential for the political conflict of these two policies. In the concluding remarks, I demonstrate the utility of this framework in other domains of the U.S. welfare state.

CONCLUSION

Scholars have made tremendous strides in untangling the moral foundations of U.S. social policy (Mohr 1994; Skocpol 1992; Steensland 2006), but have devoted less attention to their relationship to market principles (for exceptions, see Esping-Andersen 1990; Prasad 2006). The argument advanced here, based on detailed empirical analysis of two parallel cases, shows that transposing the morals and markets framework developed by economic sociology sharpens understanding of the politics of the American welfare state (Fourcade and Healy 2007; Livne 2014; Reich 2014). Framing policies as aligned with both morals and markets is instrumental to explaining why some policies have become more politically controversial than others. I argue this is a matter of degree, as some politically successful policies may rely more heavily on moral-based logics—such as those for groups widely deemed as deserving, like children—while others may rely more heavily on market-based logics—such as those using tax credits, like the EITC. But a central conclusion of this study is that social policies crafted to complement both morals and markets are more apt to be politically popular. In the following, I review extension cases in low-income housing and urban development policy to show the viability of this argument beyond health care for the poor.

Low-income housing policy provides a particularly fruitful comparison, as some elements have also been intensely contentious across the political spectrum—like public housing—while others have achieved bipartisan support—like tax credits and subsidies (Goetz 2012; Katz 2010). Housing policy also has a complex history with similar features to health care; housing interest groups have had comparable political power to the vast lobbying capacity of the health care industry, and advocates have shared similar views on the government's role in subsidizing the private market for each. At its geneses, public housing was used to prop up the financial system from the Great Depression and to provide jobs (von Hoffman 2012), creating a clear market-based

frame. However, early framing of public housing also focused on curing the "social ills" of urban slums, which set up individualistic and moralized blame for poverty in policy debates (von Hoffman 1996). Major controversy surrounded the placement of public housing vis-à-vis racial segregation, further deflating its moral framing as it became entangled in racialized conflict across party lines, with liberals blaming public housing for exacerbating racial segregation and conservatives blaming public housing for trying to alter neighborhood racial composition or competing with private market housing (Goetz 2012). Despite having a clear justification in correcting for market failures in the housing industry, public housing became embroiled in individualistic and moralized debates that generated intense political and racial conflict. But later generations of housing policy emerging in the 1980s and 1990s—namely the LIHTC, HOPE VI, and HOME programs—avoided this misstep. These latter policies have been framed as improving housing for the poor while also stimulating investment in economically depressed areas where, *crucially*, the private housing industry would otherwise not be incentivized by the market to locate. Effectively blending moral and market logics, as well as centralized policy design with minimal veto points, has allowed these later generation policies to successfully attract bipartisan support among elites and avoid becoming politically contentious.

Perhaps the clearest and most prolific example of integrating the logic of morals and markets in the U.S. welfare state is in the domain of urban and community development policy. In the decade following the start of the CHC program, early adaptations of this framing technique include the Community Development Block Grant (1975-present), and the no-longer existent Urban Development Block Grant (1977-1988) (O'Connor 1999). Both applied the same approach of validating government intervention based on correcting for the failure of market forces to improve the conditions of economically distressed areas. In the 1990s, Empowerment Zones and

Community Development Financial Institutions followed in their footsteps and perfected the moral and market framework by justifying the use of federal funds to incentivize private firms and financial institutions to locate in low-income communities in order to stimulate economic growth and opportunity for poor residents (Benjamin, Rubin, and Zielenbach 2004; Liebschutz 1995).

Since the early 2000s, a proliferation of economic development programs have been implemented to correct for market failures in disadvantaged communities (Tach et al. 2020). This includes programs under the Economic Development Administration (EDA), which target places negatively impacted by economic downturn (such as changes in trade competition and the coal industry), as well as the HUD-funded Brownfields Economic Development Initiative (BEDI), which used public funds to incentivize redevelopment in places with environmental contamination, since the private market would not otherwise do so. In the wake of the Great Recession, the Obama administration implemented policies like the Neighborhood Stabilization Program (NSP) to counteract the foreclosure crisis and the Building Neighborhood Capacity Program (BNCP) to revitalize economically depressed areas. Similarly, the Healthy Food Financing Initiative (HFFI)—which targeted tax credits, grants, and low-cost loans to areas designated by the federal government as food deserts—was justified using the argument that private grocery industry would otherwise not have an incentive to open locations in underserved areas where the profit margins would be low. To date, these programs have circumvented political controversy, once again showing the efficacy of applying market failure logics to justify government intervention, which mitigates contestations over morality and led to bipartisan approval.

For the CHC program, as well as the aforementioned extension cases, the deployment of market failure frames satisfied both moral and market logics. Scholars of public policy will be well aware that the concept of market failure has been at the crux of policymaking in the modern U.S.;

indeed, textbooks on policy analysis instruct that market failures are a central premise for rationalizing when government intervention is needed (Zerbe and McCurdy 1999). However, some argue that the use of market failures in policymaking is flawed due to its reliance on normative rather than objective assessments (ibid). The concept of market failure is highly theoretical; it is difficult to prove definitively and rests upon a commonsense logic that is open for interpretation or manipulation based on who crafts the argument. I maintain this is the precise reason market failure logics have proven so politically successful in the framing of policies. The market can be argued to fail in a multitude of ways, and policy elites can develop market failure reasoning to suit their agenda. Veiled in the "legitimacy" of market failure, this study has shown how policy elites using this tactic have been able to avoid political contention, as blaming the market for failing to serve the poor resonates across the ideological spectrum. Policies that scapegoat the market avoid individualistic debates about poverty, thereby circumventing debates about deservingness, race, and morality. Whether policies that seek to address local market failures is efficient or effective at eradicating poverty remains an open question (Kline and Moretti 2014). What is clear, though, is that this genre of policymaking has taken firm hold as one of few politically palatable approaches to addressing poverty in the modern U.S. political climate, which therefore matters to the shape of the welfare state.

In closing, it is important to emphasize that political contention does not necessarily determine the long-term viability of policies. Indeed, both Medicaid and the CHC program have been resilient and survived for more than five decades. Both policies have experienced extraordinary growth since the turn of the century, despite intensifying hostility toward Medicaid by Republicans and partisanship rancor over social welfare policies more generally. But political conflict does matter both for how the low-income population experiences the safety net (Soss,

Fording, Schram, et al. 2011), because it creates unequal distributions of government aid that affects the health of our population and democracy (Michener 2018; Montez et al. 2020), and because it influences the composition and design of social welfare policies available to the poor. The distributional effects of political controversy on social inequality are particularly concerning as state fragmentation of Medicaid is associated with disparities in a variety of health outcomes (Buchmueller et al. 2016; Goodman-Bacon 2018; Miller et al. 2019). Historical processes underlying the development of political contention are consequential, therefore, not only to our theoretical understanding of the shape of the welfare state, but also to processes of social stratification and the stigma of marginalized populations who rely upon our nation's social safety net in their everyday lives. This topic will be further explored in the subsequent chapter.

CHAPTER 3

POVERTY, INEQUALITY, AND STIGMA IN THE HEALTH CARE SAFETY NET

The sick get poorer, and the poor get sicker.

INTRODUCTION

As the old aphorism indicates, the cycle between poverty and sickness is a longstanding, entrenched, and persistent issue. One of the key linkages between poverty and health, particularly in the United States, has been insufficient and unequal access to health care for the poor. To address inequalities in access to our country's stratified health care system, the federal government initiated the Community Health Center (CHC) program during the 1965 War on Poverty. The CHC program, which provides health care *regardless of ability to pay*, is a rare institution in the U.S. for defying the rationing of health care based on socioeconomic resources (Hoffman 2012). Once viewed as a radical "experiment in social medicine" (Sardell 1988), the CHC Program has now become a cornerstone of the health care delivery system targeting low-income, medically underserved areas. Since the turn of the century, the CHC the program has more than tripled in the number of patients served and its funding and delivery sites have grown more than five times, due to widespread bipartisan support. Despite its substantial growth in recent decades and the fact that CHCs have regular, direct contact with millions of socially and economically marginalized Americans, scant social science research has examined this institution and its function in alleviating—or perpetuating—inequality.

Lack of socioeconomic resources is considered to be a "fundamental cause" of ill health (Link and Phelan 1995), as socioeconomic status (SES) and health are mutually reinforcing (Case, Fertig, and Paxson 2005; Palloni et al. 2009; Ross and Wu 1995; Smith 1999, 2007; Williams and

Sternthal 2010). Fundamental cause theory posits that access to health care is a key mechanism explaining the SES-health gradient. Thus, having (or not having) access to free or subsidized health care at CHCs could be an important contextual factor for explaining health disparities in the U.S. Yet, this policy intervention on the part of the government, which is intended to reduce disparities, has remained understudied by social scientists. What research does exist has consistently shown CHCs to be effective at improving access to care and health outcomes (Hicks et al. 2006; Politzer et al. 2001; Regan et al. 2003; Shi and Stevens 2007), including a causal reduction in mortality rates (Bailey and Goodman-Bacon 2015) and reduced racial/ethnic health disparities (Goldman and Grossman 1982; Shi et al. 2001; Shi, G. Stevens, et al. 2004). Though the quantitative evidence on the efficacy of CHCs is compelling, we know little about the underlying mechanisms explaining how, why, and under what conditions CHCs effectively serve the poor.

Using a case study approach that concentrates on the perspective of low-income patients and the medical professionals who serve them, this study identifies *interpersonal, organizational, and institutional* mechanisms underlying the CHC program's services. In doing so, it sheds light on three broad areas of research: first, how CHCs intervene in health inequalities; second, how the organizational field has responded to historical trends in the welfare state, as well as how this affects patients; and third, how government intervention matters to the health care experiences of the poor. Moreover, motivated by literature on stigma in government programs, this study further examines the degree of stigma and related phenomena—such as deservingness, paternalism, and poverty governance—as described by patients and staff in association with CHCs. Through focusing on mechanisms that can be extended to other safety net clinics, this research aims to highlight how disadvantaged communities experience treatment in health care institutions organized by the state.

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BACKGROUND

The U.S. has historically stratified access to health care by socioeconomic status, relying upon a rationing approach based on price and insurance coverage (Hoffman 2012). The health care system has left economically and socially marginalized Americans to depend upon the government's patchwork of safety net programs in order to receive even basic health services. With poor Americans' health care in the hands of the government, we know that policymaking at the federal, state, and local level can have a significant impact on health outcomes. Recent literature has delineated the structural factors that affect health, with evidence showing the substantial impact of state and national policy contexts on health disparities (Homan 2019; Montez et al. 2019, 2020; Torche and Rauf 2021). Prior studies have examined the experience of Medicaid recipients in encounters with health care professionals and government bureaucracy (Allen et al. 2014; Grogan and Park 2017; Grogan and Patashnik 2003; Michener 2018; Stuber et al. 2000; Stuber and Kronebusch 2004), but significantly less research has focused on the institutional setting where the federal government delivers primary care to the poor population: Community Health Centers (CHCs).

Originating in the Great Society, the CHC program has historically followed in the tradition of social justice and civil rights advocates that maintain health care is a right and not a commodity. Indeed, CHCs were born in the so-called "era of federal involvement," where the central value in health policymaking was concern over equity (Scott et al. 2000). The CHC program's mission to provide services, regardless of ability to pay, means that unlike other health care entities, no one will be turned away from CHCs due to lack of socioeconomic resources. CHCs have proudly advocated for a different approach to health care—some calling it "social medicine"—that does

not ration care but instead treats everyone equitably, and that seeks to address root causes of ill health among the poor by providing comprehensive medical and nonmedical services (Sardell 1988).

However, as the CHC program developed, the sociopolitical and economic landscape simultaneously shifted from an era of welfare state expansion to one of austerity in the name of the free market. Market-orientation in policymaking modified approaches to how the state addressed both poverty and health care, which emphasized deregulation, minimizing the role of the state in resolving social issues, and delegation of decision-making to the free market (Light 2004; Scott et al. 2000). Funding for domestic programs was slashed under President Reagan, and an age of marketization was set in motion for the decades to follow, which particularly impacted changes in the health care system (Light 2004, 2011; Starr 2017). Concomitant trends of privatization also blurred the boundaries between public and private entities, as well as between for-profit and non-profit organizations, such that the role of the state has been largely obscured from the public's purview (Mettler 2011; Scott et al. 2000).

Sociological research reveals that these historical pressures to commodify the health care industry have shaped both institutional change and the ways that medical organizations and actors manage the tension between moral- and market-based logics (Reich 2014). This struggle is particularly acute for safety net settings, which must navigate government mandates as well as the institutional isomorphism of the health care industry toward free market competition (DiMaggio and Powell 1983; Scott et al. 2000). Furthermore, privatization and cuts to social spending have put safety net providers in a difficult position of taking on the role of advocating for patients as they navigate complicated and underfunded social service bureaucracies (Horton 2006). Fiscal austerity measures and contraction of the welfare state have created a "double burden" for health

care providers serving disadvantaged populations, with significant implications for health disparities (ibid). Nearly fifty years into its history, we know surprisingly little about how the CHC program's ambitious goals to provide health care as a right in our country's highly stratified health care system has fared in the climate of marketization. And because CHCs come into direct contact with millions of poor patients every year, this safety net setting could have significant implications for research on health disparities and poverty governance.

The lack of scholarship on this program is an especially glaring omission considering government assistance in the U.S. has an extensive history of stigmatization, as it is unclear to what extent CHCs follow in this tradition. Indeed, longstanding debates over antipoverty policy hinge on the idea that targeting the poor is more stigmatizing and politically unpopular than policies designed to have universal eligibility (Skocpol 1995). Scholars have argued that universalism—rather than targeted programs to the poor—can reduce stigma due to the negative perception of government aid to the "undeserving" poor (Brady and Bostic 2015; Korpi and Palme 1998; Skocpol 1995). The CHC program represents a unique case in that it is both targeted toward low-income places—including strict eligibility criteria based on metrics like poverty status and physician shortages—but is also universally available to all members of the community they serve. It is not strictly means-tested, but CHCs do means-test low-income patients who need to rely upon the sliding scale fee, which is subsidized by the government. Thus, the CHC program aligns with what some scholars have termed a universalism-within-targeting design (Grogan and Patashnik 2003b), in contrast to targeting-within-universalism that others have advocated for (Skocpol 1995).

There is mounting recognition that stigma has macro, structural, institutional roots, which also shapes population health inequities (Hatzenbuehler and Link 2014; Hatzenbuehler, Phelan, and Link 2013). Driven by ideas of deservingness and the perversity of the poor (Katz 1989;

Somers and Block 2005), studies have demonstrated the trend of paternalism and surveillance in social welfare programs, which generates feelings of stigma among the poor (Charmaz 2020; Soss, Fording, and Schram 2011). In these ways, macro-level institutional practices are linked with micro-level experiences of stigma. This is particularly important because the stigma of receiving government assistance can hinder access to services (Stuber and Kronebusch 2004). Many scholars have argued that poverty governance—both historically and contemporarily—intentionally fosters a sense of stigma to reduce participation in government programs, which has become increasingly apparent in the neoliberal welfare state regime of the U.S. since the 1980s (Charmaz 2020; Hansen, Bourgois, and Drucker 2014; Piven and Cloward 1993; Somers and Block 2005; Soss, Fording, and Schram 2011; Whittle et al. 2017).

This leads to the question: to what extent is the Community Health Center setting stigmatized? I explore the presence of stigma across the *interpersonal, organizational,* and *institutional* mechanisms analyzed in this case study. Interpersonally, patients may feel stigmatized if they describe medical providers treating them differently, called treatment stigma, or if they feel embarrassed for requiring charity care due to poverty, known as identity or poverty stigma (Allen et al. 2014; Reutter et al. 2009; Stuber and Kronebusch 2004; Stuber and Schlesinger 2006). At the organizational level, patients could feel stigmatized if they perceive that CHCs are seen as "sub-par" or "second-tier" relative to mainstream medicine, or if the broader community has attached stigma to the organization due to a poor reputation (Devers et al. 2009; Hudson 2008). And institutionally, patients may feel stigmatized if the perception exists that this is a government-funded program, eliciting discourse around deservingness and welfare stigma (Katz 1989, 2001; Rogers-Dillon 1995; Sykes et al. 2015).

The previous literature on stigma and social welfare programs has focused primarily on other publicly funded benefits (such as Medicaid, SNAP, and AFDC/TANF), as well as the experience of identity stigma or stigma of certain health conditions (such as HIV, obesity, substance use, and mental illness), but it is not clear whether CHCs evoke the same sense of stigma among the poor. One set of studies, which used CHCs to recruit AFDC and Medicaid recipients, found a sizable amount of treatment stigma among these patients, but did not seek to connect stigma with the institutional setting of the safety net clinic (Stuber et al. 2000; Stuber and Kronebusch 2004; Stuber and Schlesinger 2006). Another study that examined stigma in the health care safety net found that uninsured people delayed or avoided care because of cost, described negative experiences relative to private medical settings, and reported differential treatment based on lack of health insurance (Becker 2004). However, Becker's focus was on public hospitals and only briefly discussed CHCs, which again leaves unclear how the organizational and institutional field of safety net clinics differs from other settings inclusive of the poor. Another study found that Medicaid recipients reported receiving worse quality of care and felt stigmatized from being ignored and disrespected by medical professionals—with some patients describing stigma within CHCs and others not (Martinez-Hume et al. 2017). The prior literature gives reason to anticipate that CHCs may induce stigma among the poor, but because it has not focused specifically the CHC program and only tangentially considered this setting, we have an incomplete understanding of how poor patients' experience of the safety net. Therefore, this study will isolate CHCs as a unique institution and examine whether and to what extent patients and staff describe the aforementioned processes of stigmatization in relation to their experiences at a health center.

DATA AND METHODS

The data come from a qualitative case study of a small-town health center, Crownsville Community Health Center, hereafter referred to as Crownsville.[75] Crownsville opened in the early 1970s as a consolidation of three clinics run by the local county health department. Rural dairy farmers were the initial target population, though Crownsville has now grown to encompass five clinics that include the small-town focused on in this study as well as its surrounding rural areas. Today, the community is a post-industrial town in the Rust Belt that, like many other towns across the country, has suffered economically since the departure of large manufacturing companies in the early 1990s. Residents perceived the town to be struggling and stagnant, without job opportunities or hopes for economic mobility, and increasingly affected by the opioid crisis. Politically, the county swung toward President Trump in 2016 and 2020. The population size was just under 19,000 as of 2019, depopulating by 2.5% since 2010.[76] The majority of the town is non-Hispanic white (90%) and about one quarter of the town's population falls below the federal poverty line. Likewise, roughly 93% of Crownsville's patients were white and the majority (41%) lived below the poverty line as of 2019.[77] Just under one-third of Crownsville's patients were on Medicaid, 6.5% were uninsured, 12% were on Medicare, while 43% received private insurance. In comparison, the national CHC patient population has far fewer privately insured patients (19%), more patients under the federal poverty line (68%), and more racial/ethnic minorities (62%) than the small-town health center in this case study (NACHC 2021). It is important to emphasize that Crownsville is a more racially and socioeconomically homogenous setting than the average CHC. Also, because the state where Crownsville is located expanded Medicaid, fewer of the patients

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[75] Crownsville Community Health Center is a pseudonym.
[76] https://www.census.gov/quickfacts/fact/table/US/PST045219
[77] https://data.hrsa.gov/

were uninsured compared to CHC patients in non-expansion states, though some referenced previous experiences of attending Crownsville when they were uninsured before the passage of the ACA.

My approach aligns with case study logic (Yin 2014): sampling proceeded sequentially, and data collection adapted to each case and informed the next case until saturation was reached (Small 2009). I conducted in-depth, semi-structured interviews with 23 patients and 10 staff members over the course of ten months in 2019. Interviewing multiple sources on the same unit of analysis yields insight from those who have different relationships to Crownsville, allowing for triangulation and the identification of different levels of mechanisms (Creswell 2014; Roy et al. 2015). Patients were recruited through tabling in the clinic's waiting room and staff were recruited via email correspondence. For staff to be eligible to participate, they must have worked at the health center for at least one year. Patients must have attended the health center for at least one year and/or visited at least three times, and also be older than 18 years of age to be eligible to participate. Interviews were conducted with patients at the place of their choosing, most commonly at their homes or public places such as McDonalds, Dunkin Donuts, or a local park, and staff interviews were primarily conducted in the clinic or administrative office. On average, interviews lasted for an hour and a half (ranging from 45 minutes to 2.5 hours) and patients were compensated $25 in cash for their time. The patient interview guide asked about accessing the health center, barriers to care, medical services they had received, non-medical services, general experiences at the health center, and program awareness. The staff interview guide varied depending on their role within the organization, but in all I inquired about the community context, patient descriptions and relationships, programmatic rules and regulations, experiences at work, and program awareness. Each interview guide also included questions on respondents' background characteristics such as

socioeconomic status, employment, insurance, political leaning, and family background (see Appendix A for both of the interview guides). All interviews were recorded, professionally transcribed, and analyzed using NVivo software. I followed the "flexible coding" approach, first indexing the transcripts based on central themes in the interviews, then applying analytic codes that focused on emergent concepts, and finally identifying trends across cases (Deterding and Waters 2018). Throughout the data collection and coding, I sought contradictory evidence to improve the theoretical validity (Creswell 2014) and, in the following results, highlight several of these disconfirming cases (Deterding and Waters 2018). Pseudonyms are used in place of real names to protect anonymity.

Mirroring the community at-large, all of the interview participants in this study were white and almost all of the patients I interviewed were poor or very poor. Just three of the patients could be considered by some measures to be middle-class; two graduated from college (Meg and Loretta) and one had experienced upward mobility due to her husband's employment (Melody). Yet even these respondents did not describe themselves as financially comfortable; Melody had been uninsured or on Medicaid until recent years and Meg lived solely off of her disability income. Most of the patients were unemployed, with a handful working part-time, low-wage jobs, and a large share relied upon disability benefits as their primary source of income. The majority of patients were insured through Medicaid and used other government programs (mostly food stamps, housing vouchers, and heating assistance) as well as local charities to make ends meet. Although I did not specifically ask about health conditions to maintain privacy, patients often volunteered descriptions of their complex and debilitating health problems that prevented them from being able to work and had them attending the health center on a frequent—weekly or monthly—basis. A large share of the patients had been attending Crownsville for many years, or since they were

children, making it difficult to pinpoint what led them to start going there; for those who could remember, need for pregnancy or family planning services often initiated care. Most of the patients were born and raised in the area, as were all but one of the providers, who was born abroad and migrated to the U.S. for medical school. The staff had varying backgrounds, ranging from MDs who were raised in upper class families, to medical assistants and care coordinators without a college degree and who came from working-class or poor backgrounds themselves.

FINDINGS

INTERPERSONAL MECHANISMS IN THE SAFETY NET

Low-income patients reported overwhelmingly positive experiences going to Crownsville, spoke highly of the quality of care they received, and only one described feeling treatment stigma in the safety net setting. All were asked a number of questions about their experiences at Crownsville, how it compared with other medical settings, how they would describe Crownsville to a friend, and were asked to rate Crownsville and explain why. These questions elicited mostly glowing remarks and high ratings. Ruby, Veronica, Cynthia, and Audrey, who were all single mothers recovering from drug addiction and barely making ends meet, described the health center in strikingly similar terms. They thought the health center was a "clean" and "friendly" place with "polite" staff and "attentive" providers who "listened carefully" and with "compassion." Ruby, a 35-year-old mother living in a halfway house, put it simply: "they'll do what they can to fix [you]… they pretty much have everything right there… it's a pretty homey-type setting, comfortable." Cynthia, who worked in the home care industry, noted the professionalism at Crownsville, saying "to me, they're wonderful." Audrey, who cleaned for a living, was particularly impressed by the cleanliness of the facilities. Because Veronica had been a patient for many years,

when asked how it compared to other doctors she said "I'm more comfortable at [Crownsville] 'cause I've gone there for so long… I could just walk in there like I own the place." Helen, a low-income 66-year-old with a sarcastic sense of humor, described the staff as being "really nice and sweet and polite," remarking on their patience despite the difficult work environment: "I don't know how they can do it, at times; keep that frame of mind up after seeing everybody in here and everybody's complaints, and then not feeling good yourself, I couldn't be that cheerful. Nah. They never said an off word to me, were impolite, or rude." One of the middle-class patients, 71-year-old Loretta, who has worked in the reproductive health field, rated Crownsville an "easy" ten out of ten, explaining:

> I have nothing bad to say … Any issues I've had, I feel have been dealt with completely and with compassion and care. They don't pretend that they know what's happening if they don't know what's happening. They're always very cautious … The staff … always have been very welcoming and caring, expedient … I've always felt listened to. It's holistic.

In addition to these positive remarks, some patients also discussed becoming very close with their doctors, sharing intimate details of their lives that included non-medical and personal issues standing in the way of good health. One low-income patient, 29-year-old Madison, recalled her doctor stepping in during a major health crisis. Discussing her high-risk preterm birth, she recounted with deep adoration how her doctor rode with her in the ambulance to the large regional hospital when it became clear that her condition was an emergency. Once at the hospital, her doctor "got me into the room, made sure I was settled, made sure I was comfortable before she even left. Come to find out after I had the baby… she'd already been calling the hospital and checking on him." Madison repeatedly called her doctor "amazing" and that she was "always there" for her and her children.

Patients with chronic conditions expressed particularly high praise for Crownsville, claiming that their doctors knew every last detail about their cases. They fully entrusted their providers with coordinating complex care across a variety of specialists and treatments. Frances, a 58-year-old woman with a terminal illness who passed away shortly after our interview, described her doctor's "passion" and "commitment," referencing that she knew her "patient number and password by heart" because she was constantly checking on her specialist care. Frances said: "that is dedication. I've been to other doctors where I wasn't sure that they even knew what [terminal illness] was, and I felt like I might have to educate them." Another chronically ill patient, Meg, a 61-year-old cancer survivor with a long list of other health issues, said of her doctor: "When she walked in the room, the world stopped and all I was, was her patient, and that's what you want." Once again, many patients felt carefully attended to by providers at Crownsville. Carol, a 63-year-old woman who suffered from chronic pain and severe disc disease, believed that other doctors she had seen "wanted a quick fix" and "didn't want to listen to you," but regarding her doctor at Crownsville she said: "Honey, as far as I'm concerned, she's almost God… she not only helped me, but she helped me understand why this is happening and what I can do to correct it… I know she cares about me." Carol revered her doctor as being godlike who, in her eyes, could do no wrong. Perhaps Blanche, a 56-year-old very poor patient, captured the general sentiment best when she said of her beloved doctor: "she talked to you like you were a human being and not a number." To these patients, Crownsville providers were indisputably first-rate care that felt like mainstream medicine, not the safety net.

To be sure, some patients had grievances. The most frequent complaint was the waiting time, sometimes in getting an appointment but mostly the time spent in the waiting room. Criticism did emerge from one middle-class respondent, 56-year-old Melody, who responded when asked

about the quality of medical care: "It's supposed to be good, but it's probably not the best thing for you." Shortly after when I asked how she would describe the clinic to a friend, she responded "I'd say if you got nowhere else to go and you don't have insurance, this—it's better than nothing." Despite this negative perception, Melody still rated Crownsville with high marks and discussed no imminent plans to leave, possibly because there were few other options in the area.

The sole instance of treatment stigma that I encountered came from Cynthia, who had been addicted to opioids and had also been convicted of welfare fraud several years before we met. She mentioned feeling humiliated that her arrest had been on the front page of the local newspaper. Cynthia perceived that the staff and providers did not "believe" her and were suspicious of her medications and request for refills, saying "it got to the point where even the front office staff was just looking at me like, 'Oh God, here she comes again.'" Cynthia had formerly been a nurse, which amplified the stigma she felt over her substance use in her interactions with providers.

> Interviewee: I was on a first name basis with [provider] because she, from the beginning, had a lot of respect for me because I was a nurse, but when I got sick, all of a sudden, all that respect left.
>
> Interviewer: Why do you think that was?
>
> Interviewee: I think it was because of all the medications I was on… I feel like they think that I was just looking for drugs because of the way that our culture is today.

Cynthia's description of treatment stigma was tied to her own identity stigma in relation to drug addiction and conviction for welfare fraud. Her feeling of poor treatment was compounded by the fact that she had previously felt "respected" due to her nursing background. Plenty of the other respondents had a substance abuse history, though, and did not report treatment stigma, so Cynthia's case proved to be the exception.

Another way to assess the validity of the lack of treatment stigma is from patients' comparisons of their treatment at other health facilities. One low-income patient, 52-year-old

Nicole, drew a stark contrast with another clinic located in a nearby city, Ruston, which I will also return to later in the results. Nicole only went to the Ruston clinic once after separating from her husband and losing her health insurance. She had only negative things to say about it, claiming she would "never step foot" in there again:

> It was awful… A lot of times I think … they look at you differently, because you're going to this clinic, rather than a private doctor or finding your own doctor. You're coming here. You're low income. You know what I mean? I think sometimes that feels less-than.

Nicole then proceeded to describe the Ruston city clinic as being "like hell," and that it gives off the image of "stay away, run. Run as fast as you can." Not only did she say she felt like they "look at you differently," but also that it was because of her low-income that they treated her "less-than." This is an important comparison because the Ruston city clinic is part of the CHC program, like Crownsville, but Nicole's experience could not have been more different. In combination with Cynthia's story, this shows that poor patients' experience of CHCs can indeed involve treatment stigma depending on the circumstances, despite being uncommon at Crownsville.

The lack of treatment stigma discussed by Crownsville patients was even more surprising given the fact that some of the staff made stigmatizing comments about low-income patients being "simple," "dirty," smelling badly, as well as a host of welfare stereotypes like "babies having babies" and "stop feeding the bears." While the staff felt comfortable expressing their opinions privately with me, they clearly had a different front-stage relationship with patients. Why did the poor not perceive stigma in their treatment from providers at Crownsville? I identified three interrelated interpersonal mechanisms affecting the lack of stigma in the interactions at Crownsville. First, providers were selected into this safety net clinic due to a strong sense of commitment to serving the disadvantaged. Roger, the Chief Medical Officer (CMO), said he recruited physicians who are "clinically competent and mission-minded… I really want someone

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who's like, 'Yeah, I want to work here because this really lines up with my values, with what drives me as a provider.'" According to Roger, CHC providers often had backgrounds in public or global health, were drawn to medicine for moral rather than for financial reasons and viewed poverty as a structural rather than individual issue. The selection of providers for these reasons may partially explain the lack of treatment stigma. Second, all but one of the staff I interviewed were born and raised locally, which meant they were embedded in the small-town networks and happenings. Third, because of these local connections the providers were often made aware of patients' personal lives, which made them able to curate their medical care accordingly or become informally involved in helping patients. Together, these three mechanisms fostered a sense of community and familiarity, and buffered the social class disconnect between providers and poor patients that often leads to treatment stigma in other health care settings (Waitzkin 1991). Melissa, a nurse practitioner who, despite making several stigmatizing comments to me about the poor, passionately explained her connection with low-income patients:

> It's challenging to work with them, but I guess I can understand that they're usually very hardworking and that their lives aren't easy, 'cause I grew up in that. I was one of them, so I can identify with them. I know what it's like growing up in the same household with step-parents and parents that have to work different shifts to make money. I know what it's like to have abuse at home. On many, many different levels, I can connect with them… I want people to think, when I take care of them, that I'm like a part of their family.

Melissa could easily relate to her patients because she felt like she was "one of them." Growing up under conditions of economic and family hardship made her able to relate to her patients who were going through difficult times. In describing her relationship with patients as wanting to feel "like a part of their family," she continually expressed compassion and empathy, as well as approaching difficult topics in a non-judgmental fashion. Melissa sometimes went above and beyond her role as a medical provider, getting involved in her patients' everyday troubles. She

recalled one instance when a baby kept getting a "horrid" diaper rash that led him to be admitted to the hospital three times. At the follow-up appointment, the mother admitted that she did not have any money to spare for diaper ointment, so Melissa bought two packages of diaper ointment for her. This story led her to describe the way she thinks of Crownsville's role in the community:

> I feel like we're here to give care to whoever needs it… that's our job, to make sure that people can access health care regardless of their ability to pay, but I think, personally, regardless of their ability to access goes beyond. Like, how do I help get them here, or how do I help get them to their specialist or to their lab draw… It's so much more than, of course, insurance and reimbursement. It's so much more.

Melissa's statement encapsulates the ethos of the original mission of the CHC program—to provide holistic and comprehensive services beyond traditional medical care. Her dedication to serving poor patients outweighed the negative, stigmatizing stereotypes she employed to describe them. This dynamic among staff likely also contributed to the lack of treatment stigma.

Furthermore, connections with the community aided providers in their work. One physician, Brady, with an upper-class upbringing, explained how the small-town networks improved care delivery:

> Our nurses are all from town, and they all went to high school there, and they know people really well… Many of them have known each other for 20, 30, 40, 50 years. Our front desk staff all live in town, too… They're like, "Oh, that's actually so-and-so's cousin." … It can be pretty helpful 'cause sometimes they'll be like, "Oh, yeah. She just got out of prison." That's why she no-showed to her last three appointments, she was in legal trouble. Maybe she was in jail and then out of jail and then had court appointments and whatever. The problem is she's off all of her meds—right?—'cause they probably weren't continued, or maybe they technically were, but then she wasn't released with any, so she needs her meds.

In this way, staff and providers' longstanding connections with the community was meaningful in the clinic setting where patients may not be as forthcoming or communicative with what else is happening in their lives. This information helped Brady assess his patient's health needs and adjust how he would approach the clinical interaction. Surely these personal connections also have

drawbacks, and some patients and staff described feeling awkward about knowing one another, with one provider saying that she stopped going to Walmart years ago to avoid running into patients. But by and large, that the staff were from the local area and providers could modify treatment regimens based on transmission of information through small-town social networks was an important mechanism to suppressing treatment stigma in the safety net setting.

The overwhelmingly positive interpersonal relationships with providers that the patients described could suggest one reason why CHCs may effectively improve health outcomes among underserved populations—their patients trust them, disclose personal information, and the staff provide quality care with a personable touch. However, in part because of these close provider-patient relationships, I also found that patients were distressed by frequent physician turnover, which made them wary of entrusting new doctors with their complex health issues. The National Health Service Corps (NHSC) offers loan forgiveness to recent medical graduates if they work at a CHC for several years. Patients often described feeling excited by getting new, young doctors, but were simultaneously hesitant to trust them after they had experienced losing a beloved provider in the past and were exhausted by having to reeducate newcomers about their complex cases. When I asked Samantha, a 39-year-old with a rare, complicated, and severe condition, what it was like when her doctor left, she responded: "it was hard. Yeah, I'm trying to break in the new doctors to actually hear what I'm saying and look back in my chart… [former doctor] knew my case, inside, outside, backwards and upside down." Samantha also described that ever since her primary care doctor left, she has had trouble getting new doctors to believe her; she described a neurologist who cast doubt on her as saying, "that couldn't have happened, you're making that up." Because her doctor had taken charge of managing both her primary and specialty care, Samantha experienced additional hurdles just getting back to the same starting line once her doctor had left.

Madison, who had the high-risk childbirth, said she was distraught when her provider told her she was leaving: "I cried. I was so sad that she left. I yelled at her. I said I can't believe you're leaving me." Madison had been seeing this doctor since her teenage years when she went in search of birth control. After experiencing trauma and abuse in her childhood and being placed in a foster home, the loss of this close relationship with her doctor was devastating to her and she had yet to build up the same trust in a new provider. Furthermore, recall that terminally ill Frances had nothing but glowing remarks about Crownsville. But Frances lamented the frequent "changeover" she had experienced over the years, saying:

> It is so discouraging to find people that you really like, to build that relationship, and then to have them leave because it's my understanding that they can come and get loans forgiven and things like that, and then they go on so they can make more money… it's really hard to start over with other people once you get to know and trust them and begin to feel like, okay, they've got my back. They know what they're doing, and yet, there they go. Bye. [Laughter] Now we've got to get used to somebody else.

Frances, despite trying to make light of it, described both the emotional tumult and her awareness that the turnover was due to money. Continuity of care and trust in providers is especially important for terminally ill patients like Frances. Having a close bond with her doctor presented a double-edged sword: Frances praised the high caliber of the physicians at Crownsville, but just when she felt like they "got her back" they left which made her "discouraged" about having to start from square one with building the relationship. Therefore, although Crownsville had an overwhelmingly positive reputation and did not elicit many feelings of treatment stigma as found in other safety net settings, patients also anticipated and were distressed by their doctors leaving for greener pastures once their stint caring for the poor had concluded. Turnover in the safety net thus remains an enduring issue with implications for continuity of care (Lutfey and Freese 2005), as well as patients' emotional turmoil involving trust and adoration of their providers followed by loss and distress at their departure.

ORGANIZATIONAL MECHANISMS: "FOR THE POOR, BUT NOT ONLY THE POOR"

Despite its historical roots as an antipoverty policy, Crownsville's status as a program for the poor was not widely recognized. In response to being asked if Crownsville was seen as a low-income clinic, most patients did not perceive it as such, nor did most staff members. This section explores why and identifies three mechanisms through which Crownsville has avoided organizational stigma: the appearance of the facilities, the role of the community context, and the presentation of Crownsville as a business entity that (selectively) enforced rules in a paternalistic fashion to the deviant poor.

To start, the appearance of the health center was the primary reason patients and staff did not perceive Crownsville as a place for the poor. As found in other studies, the aesthetics and hospitality of the health care setting was instrumental to patient's perceptions of quality (Young and Chen 2020). Carol said it was not seen as a low-income clinic simply because "it doesn't look like one. I mean, it's a nice facility. Clean, they play cool music… Everybody's friendly." Frances concurred that Crownsville "doesn't come across" that way because "the building, I don't think there's a persona that they are, necessarily. Maybe just more all-inclusive, but the facilities are nice and everything. It doesn't scream, 'we're barely floating here.'" She added that Crownsville doesn't give "the impression that they're kind of like a Planned Parenthood that may not be open next month." And Jocelyn, a care coordinator at Crownsville, agreed that "it looks like a regular doctor's office. It doesn't look like some shot-up, run-down slumlord—anything." Jocelyn associated low-income clinics as appearing "run-down" and in poor condition. Most interviewees did not perceive the health center as part of a program targeting the poor primarily due to the high-quality and newness of the facilities and equipment, which created the perception that it was financially stable.

Because the health center is one of the only medical providers in the surrounding rural area, they do serve a mixed-income clientele, which also plays an important role. Patients referenced the fact that they saw middle- or upper-class people attending the health center as evidence that it was not only a place for the poor. Audrey explained:

> I think tons of different people went there. I've just seen a lady who probably makes five times as much as me go in there as well. She works at the job I work at. [Laughter] I'm sure she's not poor. I'm sure she makes a good chunk of money every year. I'm sure there's all types of people. Old, young, rich, poor. Maybe they're just going there 'cause of the location and friendly people.

The appearance and socioeconomic mixing at Crownsville made poor patients feel like this was not a "second-tier" institution where segregated or sub-par care was delivered, resulting in a pronounced lack of organizational stigma among poor patients. However, one college-educated patient did perceive stigma attached to the organization. Returning to Melody, the 56-year-old stay-at-home mother of four who had been raised in a working-class farming family, she did indicate a stigmatized perception of Crownsville after I asked if she had friends who also went to the health center:

> I think a lot of my friends are too hoity-toity to go there. When I tell them where I go, you can tell they kind of like, yeah…. I can see it in their faces—I can tell… Because it's obviously for—I guess maybe not obviously. I guess the reputation is that it's for lower income. You know what I mean? That's why, unfortunately, I'm ashamed of myself, but if I had—if I pursued it, I would go to a nice little practice where the doctor knew me and maybe served coffee in the waiting room.

Melody, who had experienced upward class mobility in her lifetime and now found herself in circles with "hoity-toity" friends, felt "ashamed" about where she went to the doctor. When her kids were young, their whole family was on Medicaid. However, as her husband transitioned from being a truck driver to managing a trucking service and they enrolled in a private insurance plan, Melody had yet to change providers and hinted that being a patient at the health center did not match her current social class standing. This disconfirming case demonstrates possible social class distinctions in perception of the health center, although this was not found among the two other

middle-class respondents, suggesting that some—but not all—of the non-poor community members may be hesitant to attend Crownsville due to organizational stigma.

Furthermore, some of the staff I spoke with were proud that they and their families attended Crownsville themselves, and were adamant that the organization did not have a stigmatized reputation. For instance, one of the care coordinators who was raised in an upper-middle class family, Beth, told me her parents had long been patients. In response to being asked whether people in the community see Crownsville as a program for the poor, she said:

> I think they know that it's—everyone's accepted, they'll work with anybody, no money, $5 for an appointment. I think that kind of word gets around, but I wouldn't say that that really deters people from coming here if they're not part of that population. Because you do see the regular people that come for their care, you know?

In this quote, Beth expressed that Crownsville is viewed as inclusive of the poor, but that this does not "deter" what she thinks of as "regular" people—meaning the non-poor members of the community, like her and her parents. As Betsy, another care coordinator, pointed out, the community context matters as well:

> I can honestly say I don't feel that we're the "for poor people" place. Maybe if it was a larger city, and there was more diversity in that, in income-wise. We're pretty middle class, and lower class, is the main thing here. No. I don't think it's seen as anything different. It's just, "Do you like that doctor?"

That the organization itself was not widely seen as stigmatized is likely due, in part, to contextual factors; the community itself was fairly homogenous both socioeconomically and racially, and there were few other primary care providers in the area to choose from, such that the health care settings were not clearly stratified. Thus, although some of the more advantaged community members may perceive the health center as stigmatized, this perception was not shared among the poor patients, nor universally among the non-poor, as made clear through interviews with staff.

But contextual factors do not fully explain this outcome. Interviews with providers and leaders of the organization showed that, although the health center is demonstrably proud to serve anyone regardless of ability to pay, they have also explicitly and intentionally attempted to disassociate the organization with their earlier reputation as "a program for poor people." Alice, on Crownsville's leadership team, stated that:

> I feel like there was also a stigma around [the health center], which we've been trying to overcome for a long time. We're still working on it, with, like—'they're a community health center, they're meant for the poor people, for those that can't afford a real doctor, that's where you go'. We've really tried to beat that image… We've renovated all of our health centers in the past five years… they're beautiful, they're high-tech.

Here, Alice is clear that reducing the stigma associated with being "meant for the poor people" has been an active priority, and one of the key strategies has been to renovate the facilities. Alice also discussed their marketing efforts in this regard, and Betsy, a care coordinator, confirmed that they are not seen as "the place for poor people" because "we're marketed the same as private" health care entities. Thus, to reduce the organizational stigma associated with targeting poor patients, the health center recognized the importance of not only physical appearance, but also developed a marketing strategy in an attempt to portray themselves like a private business. As the long-time CEO put it:

> In years past, people seemed to equate the fact that we're often called a clinic and that we treat everyone without regard for their ability to pay, as meaning somehow that we were a cheap alternative and somehow a not quite up-to-date medical facility. The truth is that we do serve everyone, and we are justifiably proud of that, but we are state-of-the-art, we have some of the best providers and staff in [the state] and our facilities are virtually brand-new.

This quote encapsulates the tension in how Crownsville presented itself to the community: while they were "justifiably proud" that they treat everyone regardless of "ability to pay," there was a misperception that they were a "cheap alternative." To counter this idea, the CEO pointed out their "brand new", "state-of-the-art" facilities and the high quality of their providers to lessen the stigma associated with being called a "clinic." The strategies of enhancing the facilities, promoting the

quality of medical care, and marketing themselves had the effect of presenting to the community as a private, for-profit health care setting. In fact, many staff members referred to Crownsville as a "company" and a "business," seeming not to realize that it was in fact a non-profit entity, evincing the blurred boundary effect of marketization and privatization of the health care system (Scott et al. 2000). Therefore, the organizational strategy to present as *for the poor, but not only the poor* is an important mechanism in understanding why this health center, and perhaps others, was able to serve marginalized populations without the stigma typically associated with government programs targeting the poor.

The organization walked a fine line in navigating the longstanding tension between health care as a right versus a commodity. Nowhere was this conflict, and its consequences, clearer than in Crownsville's sliding scale practices and billing rules. In theory, anyone can receive free care at CHCs based on the program's legislative statute, but in reality, each CHC establishes its own sliding scale fees[78] and billing policies that vary in leniency and inclusivity. Despite the rights-based rhetoric of treating anyone "regardless of ability to pay," in practice I discovered that Crownsville patients could not book their next appointment until they had paid their previous bill. Cynthia explained that the receptionist was blocked from booking her next appointment and that they were "adamant" about paying the back bill, saying "it doesn't matter if it's $5 or $500, they don't allow it."

This meant that, though Crownsville would not *initially* turn anyone away, they also would not welcome back a patient who had an overdue bill. In exceptional circumstances, providers would advocate on behalf of a patient who could not spare any money to pay their bill. But I learned this rarely happened, and only when providers went to great lengths to convince the billing

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[78] The sliding scale is determined using income thresholds, similar to other means-tested programs, but varies across CHCs.

department that their patient was truly in need and "deserving" of free care. Therefore, Crownsville was inclusive to a point but then shut the door on patients who were financially struggling and not able to win over the sympathy of a provider. In turn, patients gleaned that this was a profit-seeking institution, not one in which they had a "right" to health care, regardless of their financial situation.

Nick, a 39-year-old patient, relied upon the sliding scale to pay for his visits when he was unemployed and waiting for approval from Medicaid. He recalled that the sliding scale took off about "75 to 80 percent of the normal bill" and acknowledged that he appreciated saving the money. But he also said it was difficult for him to pay that amount still, which prevented him from going to the doctor. When he did try to make an appointment, he recalls being told, "Well, you still owe us this much money, so until you start making a payment arrangement or you pay it or whatever, we can't see you." His response to being told this was:

> Interviewee: I'm not trying to *not* pay you. It's just – I'm not a magician. I can't make [money] just randomly appear. They're like, "What can you do?" I would say, "I could try to get this." Sometimes, they would say, "If you could try and do that, then we'll talk about going further with your care. If not, then…" [trails off].
>
> Interviewer: What was that like for you?
>
> Interviewee: Quite frustrating, to be honest with you, because—when you know your health care's up in the air, you don't know what you can do, it's very frustrating. Especially when you know you are gonna need it eventually. What do you do if there's no one to turn to? Especially if you need a doctor but you know you can't see one, what do you do? Just kind of… hope and pray.

Despite wanting to pay Crownsville for his care, Nick could not afford to, as he was barely able to meet basic needs due to his unemployment. The response by Crownsville administrators had a tone of paternalism, assuming he was being an uncooperative or irresponsible patient rather than empathizing with his situation. It led to Nick's feeling of frustration and despair that he did not have anywhere else "to turn to." Nick had a chronic health condition in need of regular medical attention, and later in the interview responded rhetorically when asked what he did when he could not afford medical care: "well what choice do I have, but to go without?" Nick's experience of

being turned away due to inability to pay, or in his words "because of my bank balance," goes exactly against the stated mission of Crownsville, as well as the broader CHC program. Though they professed to be proud to serve the poor, the safety net clinic created barriers that left patients like Nick to resort to "hope and pray" that he would get the care he needed.

But this paternalistic approach to chasing up patients for overdue bills was not always the course of action, showing that providers and administrators at Crownsville used their own discretion. When Madison had to use the sliding scale to cover her high-deductible plan through her former employer, the Dollar Store, she described a more positive experience:

> They wouldn't make me pay right then and there. They'd just send me a bill and say "Okay, well if you can't pay it all at once, just give us a call and we'll do a payment plan whether it's $5 here, $5 there" and they worked really, really well with me. I actually forgot about a payment once and they refused to put it in collections. They said 'okay just make a $5 payment and we'll keep it out of collections.'

Madison was clearly treated differently than Nick, as she was trusted to make small incremental payments as well as given flexibility and forgiveness when she missed one. Provider involvement seemed key to determining the divergent course of action with billing issues. Melissa, the nurse practitioner, explained her experience navigating issues with her patients' overdue payments:

> I do have a bunch of patients who probably owe back money, who I'm always like, "Why don't you—" They maybe can pay $5 on their bill in order to come in for an acute visit or something. I'm always willing, if they really need to come in, to call billing and say, "No, they really need to come in today." We can override it if they're really sick… Depending on their history, in terms of "Are they really, really sick, or are they constantly manipulative and missing appointments and stuff?"

This quote shows that, at the organizational level, the provider's word was taken over the patient's. Although Melissa was a committed advocate, especially for her very poor patients, the process she described created a paternalistic system where patients needed to prove their sickness to her in order to be able to make an appointment, and this required her to not think of them as "constantly manipulative." Roger, the CMO, explained the process to me in more detail, saying that "we try

and collect what money we can" but if the person is "absolutely destitute" the providers are able

to fill out a form to reduce the fee, which must then be sent to and approved by the CEO. He said

that the fee is almost always then waived, but when asked how often this process occurred, he

replied:

> Not that often. Usually, it's when we really want that patient to come in, and they're saying, "I can't come in. I don't have the money." We say, "Come in anyway. We'll waive the fee." This might be because we're worried about, they just got out of the hospital. They need follow-up. Things like that where we want them to come in, and they're saying finance is the barrier, so we get that barrier to go away.

Not only was waiving overdue bills infrequent, due to a cumbersome bureaucratic process, but the

CMO acknowledged that it was only in response to the preferences of the provider. Notice his

usage of "we," meaning the providers, indicating their discretion in allowing this process to unfold

or not, and on their timetable. In essence, the difficulty of waiving fees meant that providers

selectively chose when to intervene on behalf of their poor patients who they thought were

deserving, indicating that a rights-based approach to medical care was the exception rather than

the rule. However, while in many instances this paternalistic approach would incite stigma among

the poor, as found in studies of welfare recipients and encounters with frontline bureaucrats (Soss

2002; Soss, Fording, and Schram 2011), this was decidedly not the case among the poor patients I

interviewed. Rather than paternalism engendering stigma, in this case it had the opposite effect of

mitigating stigma among poor patients as it upheld the reputation of Crownsville as a private, for-

profit business. The key difference, which I will argue below, is the concealed role of the

government in the CHC program.

INSTITUTIONAL MECHANISMS: ROLE OF THE STATE AND WELFARE STIGMA

In tandem with the perception that Crownsville was not a low-income clinic or place for the poor,

the patients and staff had little or no awareness of the federal government's involvement in funding

Crownsville or of the broader nationwide CHC program. A couple of the patients who had worked in health care had a vague sense that Crownsville was subsidized by the government but had little understanding of the scope. Likewise, I was surprised to learn that many of the staff, save for the MDs and leadership, were also unaware of Crownsville being part of the CHC program and what made their clinic unique in the health care system. Why was the role of the government largely obscured in this safety net clinic? I identify three mechanisms: the facilities did not "look like" the government, the lack of emphasis by the organization itself due to the conservative bent of the community, and the macro-level institutional development of the CHC program that avoided becoming a politically contentious policy. As I will show below, the combination of these three mechanisms contributed to a lack of welfare stigma associated with Crownsville.

First, the initial response from patients was that the appearance of the facilities did not evoke what they associated with the government. Given that all but one of the patients had at some point relied upon government assistance of some kind, they were very familiar with the county's Department of Social Services (DSS) building and thought that was what government "looked like." Patients often contrasted the appearance of Crownsville with DSS and other high security places, like prison. Samantha explained: "Cause it just feels like a doctor's office. When you're thinking government funded, you're thinking more like bars on the windows or something, just saying, more security to get into, that kinda thing." Veronica, who had been incarcerated for dealing drugs, broke out in hysterical laughter when asked if the health center looked or felt like it was a government program:

> It's not welfare [laughing]. You go to DSS. That will make you feel like it's from the government. No, definitely not. No. That's crazy [laughing]. Does it look like it's federally funded? No… It's cleaner. It don't have security guards.

Clearly, the benchmark Veronica and Samantha used when thinking of government programs did not align with Crownsville's facilities. Carol concurred, saying that to her, government-funded

meant "dirty and rundown buildings," which Crownsville was decidedly not. Similar to the way that the appearance obscured Crownsville's image as a place for the poor, the lack of security as well as the cleanliness and newness of the facilities discouraged any idea that Crownsville was associated with the government. This phenomena has been found in other studies, such as on the EITC and how detaching receipt of government benefits from the local welfare office and instead with private tax preparers reduced stigma among the poor (Halpern-Meekin et al. 2015).

In addition to the facilities, leaders of Crownsville acknowledged that the government's involvement was not something they "broadcast," as Alice said. She elaborated: "with providers, we shout it, we love it, we're [a CHC], like we're very proud of it. With patients, I'm not sure they would understand what that means." While Alice was proud of Crownsville's government funding—and the benefits that go along with it, including higher reimbursement rates from Medicaid and Medicare, as well as malpractice coverage—they did not feel the need to share this information with patients. And Roger, the CMO, hinted the fact that patients were unaware of the government's involvement was not by accident: "it's not something we emphasize with people… we're not saying, 'we get federal grant money.' That's not usually a winning statement." He acknowledged that in their area, which leans conservative, it was probably a "good thing, because if we're seen as an extension of the federal government, people may not like that." From all accounts, then, Crownsville was presented to and viewed by patients as separate and apart from the government.

Third, I argue that the absence of political conflict at the national level, described in the previous chapter, contributed to a lack of awareness and stigma of the CHC program at an institutional level. Below I leverage an informative exchange with Nicole, the respondent who had

once gone to the nearby urban CHC in Ruston and had an exceptionally negative experience. When I told her Crownsville was part of the same program as Ruston, she said:

> Interviewee: I think it's great that they have them, even, because I thought they were all like Ruston. I didn't even know I was going to a clinic until after I had gone there. That's a big deal right there. That's really cool.
>
> Interviewer: You said that you didn't know that it was—
>
> Interviewee: Didn't even know it was a clinic.
>
> Interviewer: - a clinic. How did you find out it was?
>
> Interviewee: I think I was there my second time and I heard somebody say something about a clinic or something. I had asked one of the nurses when they took me in and took my blood pressure. I said, "This is a clinic?" She said, "Yeah, this is Crownsville clinic." She said, "Like Ruston clinic?" "Oh no." I said no. That's when I—and then I got on, Googled it, read a little more about. I was like, "Wow, what a difference." It was nice. A lot of people you can't do that with. You can't fool them like that. You can fool me… I always thought when you went into a clinic, they were all like Ruston… If somebody told me, "Hey, go here," I would've said, "Nope." I wouldn't have gone.
>
> Interviewer: Interesting. Did you know that the Ruston one was federally funded?
>
> Interviewee: Nope.
>
> Interviewer: What was your impression of what it was?
>
> Interviewee: State maybe. It was a state-run, we're here only because we have to be, basically. Not because we wanna be, not because of your health, but we have to be here. Here we are.

This exchange demonstrates several important theoretical points, which together suggest that the lack of awareness of the government's involvement in Crownsville may not be an outlier. At other times in the interview Nicole indicated suspicion of government programs, but when I told her Crownsville was part of the federal CHC program, she continued to see Crownsville positively and, in large part, because of its contrast with the urban clinic. She was unaware that she was "going to a clinic" until she was informed by a nurse on her second visit. This usage of the word "clinic" indicated her awareness that there was something different, and potentially stigmatizing, about this setting from a private practice, but without knowing it was part of a federal program. She describes feeling "fooled" because she did not realize Crownsville was a "clinic" and, had she

known, she thinks she would not have gone. Even though Nicole had a very negative view of the Ruston city clinic, she still did not know it was part of a federal program and said she thought it was a "state-run" facility. This is not incorrect, as most CHCs do receive funding from the state government. But the lack of awareness of the federal government's involvement specifically suggests that the political development of the CHC program, and particularly its accomplishment of bipartisan support, has muted awareness of the scale and spread of CHCs. In connection with chapter two, the lack of controversy over the CHC program at the macro-institutional level is likely a significant mechanism explaining why poor patients did not perceive welfare stigma in this setting.

Despite many holding anti-government and anti-welfare views, patients reacted either positively or neutrally to learning about the government's involvement in Crownsville and did not indicate that it changed their perception of Crownsville in a negative or stigmatizing way. Patients more or less thought it made sense for the government to become involved because their community was struggling. When Nick heard the federal government funded Crownsville, his reaction was that "it's definitely a good thing because, for people who can't afford it, then it helps low-income people. It really does. Because then they have more access to health care that they more than likely need a lot more than, say, ya know, higher-income people." Acknowledging that low-income people needed "a lot more" medical services than those with more resources, Nick believed this justified the government stepping in to subsidize health care in their town. For Madison, the government's involvement provided the recognition that their community needed help: "It's literally the government just telling people that 'Hey, you may not have all the money in the world, but we are still here to help you.'" Viewing the state as benevolent in this way, when

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I explained that the sliding scale fee was due to the government, Madison also said "that's nice because it makes it so that people are not afraid to go if they can't pay."

Rather than tainting their perspective, learning it was a government program actually gave some respondents greater respect for Crownsville and the providers working there. When Carol, the respondent who compared her doctor to being "almost God," learned that the health center was a government funded facility, she said: "Well, that's even more kudos for [her doctor]. I mean, she could work in the best place there is, but she chose poor people. She's all right." With both an appreciation for having such a high-quality physician and acknowledgement that most poor people do not receive this level of care, learning of the government's involvement improved Carol's opinion of the health center as well as her provider.

Reactions to being informed that the health center was federally funded frequently incited comparisons with "welfare"[79] among patients, without my prompting, and how government involvement with programs like CHCs was viewed more favorably. Sally, a 66-year-old with severe bipolar, thought it was "really good" that the government subsidizes health care in communities like theirs:

> They [the government] need to have more offices like that, that will help people. There's so many people struggling to pay medical bills and to pay for gas, and for food, and shelter. It's costing a lot of money. The government needs to—not welfare. People need to get off welfare and go get a job. Because taxpayer's money pay that."

In fact, taxpayer dollars do subsidize Crownsville, as it receives several million dollars a year in grant funding, plus much more from Medicaid and Medicare reimbursement. Regardless, Sally viewed the government's involvement in Crownsville in a positive light because health care costs are prohibitively expensive and because going to the doctor was not associated in her mind with

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[79] I use quotes here because patients referred to welfare as a catch-all for government aid, even though traditional cash assistance via AFDC or TANF is now uncommon, with SSDI and SSI comprising the primary source of government support in the community.

work ethic, unlike "welfare." Helen, similar to the other patients, viewed the government's involvement in Crownsville as "ideal" because "at least you can afford to see a doctor if you have to." Like Sally, Helen also drew a contrast between Crownsville and other government assistance programs. She started off by saying that in "this area, nothing against them, but you figure 90 percent of them are on welfare, social services, Medicaid… They take advantage. They don't care who's paying for it, as long as they aren't." When I probed further for her to explain how this was different from Crownsville, she explained:

> Well, it's not actually a freebie to you. It's subsidized so you're getting some help but you're not— they're not paying the full bill for ya. With the welfare, the Medicaid, you go in and the whole thing's paid. You don't pay a cent. Just never thought that was right. I don't begrudge the little kids that, but the parents should know enough to try to go out and find a job.

Once again, Helen's comparison hinged upon the supposed poor work ethic and laziness of people receiving government assistance. Helen said that Crownsville was different from other programs because it wasn't a "freebie." Similar to how the presence of fees resulted in patients perceiving little organizational stigma, this quote further indicates the consequences of Crownsville not operating fully with a rights-based mission: patients do not perceive the welfare stigma that is typically attached to government programs.

Poor patients regularly referenced government involvement in relation to "welfare" and the stigma and stereotypes attached to it. Unlike negative views on "welfare" that evoked categories of deservingness in relation to work ethic, patients voiced near unanimous sentiment that everyone deserves access to health care. After discussing how she and other poor people in the community were struggling, Carol explained: "The government should help with medical stuff, because *we don't ask to be sick. We just are*. We need help." To Carol, government involvement was justified because poor people do not "ask" to be sick, but rather the conditions of poverty incite ill health. Similarly, Madison also stated:

> In my opinion everybody deserves medical care. A lot of medical situations aren't because of your lifestyle. They're genetic or something like that. It's not your fault. You deserve to get help too. I understand people get hooked on drugs, […] They deserve medical care to be able to get out of it… Everybody deserves to be healthy.

Madison agreed that poor health was not anyone's "fault" and that "everyone deserves to be healthy." And Meg, like other low-income patients, recognized the social class inequalities rife within our health care system, saying: "it shouldn't get to the point where only the rich should survive… and people that don't have money—they don't get to see, they don't get to hear, they don't get to whatever because they can't pay into it." In contrast with most patient's low regard for those who used "welfare," there was consensus that when it comes to health, the government has a responsibility to intervene and that everybody—regardless of socioeconomic standing—deserves access to health care, because individuals cannot be blamed for ill health. Although these were strongly held beliefs across the board, which one might expect to translate into political support of progressive health care reform, many of the respondents—patients and staff alike—had never voted, meaning these views were missing at the ballot box.

DISCUSSION AND CONCLUSION

In a society where social class is deeply intertwined with health and access to health care, the Community Health Center program is a unique institution for attempting to decouple money from medicine. This study provides insight into this now widespread health care institution through a detailed examination of how patients experience the CHC setting. I identified mechanisms across interpersonal, organizational, and institutional levels, some of which are overlapping, and all of which relate to the extent of stigma—including treatment, organizational, and welfare stigma—in the safety net. Below I review the main findings, discuss their theoretical and practical

implications, and conclude with how this study contributes to research on health disparities, stigma, and public policies for the poor.

Using a case study design that draws from interviews with patients and staff at a small-town health center, I found that the longstanding tension between health care as a right versus a commodity ran deeply through this setting, and likely other safety net clinics (Portes, Light, and Fernández-Kelly 2009). Despite the rights-based rhetoric that no patient would be turned away, both the perception and actions of the CHC were more clearly aligned with the commodification and marketization of health care as a for-profit business (Reich 2014). In this case, Crownsville struggled to cling onto its rights-based mission while undergoing institutional isomorphism to the market-based model of health care (DiMaggio and Powell 1983; Scott et al. 2000), and this contradiction had significant implications across interpersonal, organizational, and institutional levels.

Patients described high-quality care in handling their often-chronic health conditions and I found little evidence of treatment stigma at the interpersonal level. To explain this, I identified three interrelated mechanisms. First, Crownsville made a concerted effort to recruit mission-oriented providers, meaning those selected into this setting were both trained in and committed to treating poor patients, unlike many other health care settings where poor patients are the exception, not the norm. Second, the majority of staff were from the local area, identifying personally with their patients' struggles as well as the issues facing the larger community, which often buffered the "us" versus "them" mentality in how patients and staff described their interactions (Waitzkin 1991). Third, because of this involvement in the community, staff received information via small-town social networks on what was happening in patients' lives and often shared this with providers, which informed the delivery of care and informal involvement of providers in patients' lives. I

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argue these three interpersonal mechanisms were important to the positive descriptions that most patients gave of both Crownsville and their providers.

However, while Crownsville was able to attract what patients described to be topnotch providers through its participation in the National Health Service Corps, this also presented disadvantages. Providers, burned out from the difficulties and "double burden" (Horton 2006) of caring for the poor, often leave CHCs after their medical school loans are repaid by the government. Frequent turnover led to patients feeling both nervous that their cherished providers would go at any minute and distressed when their providers did ultimately leave. This provides further evidence on continuity of care issues in the safety net setting, which can impact poor patients' health outcomes in a variety of ways (Lutfey and Freese 2005), and it also demonstrates the prevalence of anxiety that poor patients felt about being left behind by the providers they had entrusted to manage their often complex medical cases.

At the organizational level, I found that low-income patients generally saw Crownsville as being no different from any other private doctor's office—not a "second-tier" institution or a low-income clinic (though one middle-class patient did feel this way). In part, this was due to the community context that was fairly homogenous socioeconomically and racially, and because there were few other providers available in the small town. But even more so, this was the result of an organizational strategy to present a fractured image of being *for the poor, but not only the poor*. Crownsville marketed themselves as compassionate yet business-oriented and renovated their facilities to reduce its formerly stigmatized association with the county health department. These strategic decisions meant that poor patients did not recognize organizational stigma attached to Crownsville, and even the middle-class patient who saw Crownsville as stigmatized continued as a patient, suggesting the stigma was not strong enough to deter her.

However, Crownsville's fractured identity also resulted in contradictions between the organization's statements and actions. The staff at Crownsville were proud to say they never turned anyone away due to inability to pay, but in practice, they did present obstacles to patients who had overdue bills, resulting in poor patients being unable to receive timely care when they were struggling the most. Both patients and staff described paternalistic approaches to enforcing payment of bills, with exceptions made only in rare circumstances where providers advocated for patients who were truly in need and considered "deserving" of free care. It is important to note that overdue bill policies are not unique to Crownsville but have been incentivized by the profit-oriented ethos of the health care system and its institutional environment, further evidence on how the rights-based logics of the CHC program now must conform—at least in some ways—to the commodity model. Therefore, although the lack of stigma associated with the clinic effectively made poor patients feel like they were receiving first-rate care, it was also at the cost of not being a truly inclusive institution. Though providers at Crownsville did try to be inclusive of the poor, they were influenced by the institutional environment of marketization in health care that incentivized CHCs to be competitive and profitable; thus, the enforcement of overdue bills created friction to discourage patients from treating Crownsville like a safety net or charity where they could receive free care.

And at the institutional level, few were aware of the federal government's involvement, resulting in a pronounced lack of "welfare stigma" that is typically associated with government funded programs. Why were patients, and even some staff, unaware of the role of the state? Once again, respondents explained that the appearance mattered in that Crownsville did not "look like" what they associated with a government facility—mostly the county welfare office and prison. Furthermore, leaders of Crownsville said that they avoided emphasizing the government's

involvement due to the conservative bent of the community, which they thought might negatively impact how patients viewed Crownsville due to aversion of government involvement in private matters. And finally, I argue that the macro institutional development of the CHC program and how it has avoided political controversy matters to the lack of awareness of the government's role in both the micro-level interactions and the everyday organizational practices of Crownsville. This is indicative of what Suzanne Mettler (2011) calls the "submerged state", in which the government's role in people's everyday lives has become obscured. Mettler (2018) further demonstrates how this disconnect between citizens and their government can have a negative impact on political engagement and participation. For a conservative-leaning community like Crownsville, many patients espoused anti-government and anti-welfare sentiments but reacted positively to learning of the federal government's involvement in Crownsville, saying this was the type of program the government should have more of (often patients indicated this was in opposition to welfare). Patients also proclaimed unanimously that everyone "deserves" health care, many complaining of the prohibitively high costs and how unfair it was that only the wealthy could afford care. In the case of Crownsville, and likely other CHCs, the lack of association with the federal government suppressed welfare stigma but simultaneously meant that patients did not credit the government (Mettler 2018), which has broader implications for political participation. Indeed, a number of the respondents in this study had never voted.

Taken together, the perception that Crownsville was a for-profit business, disconnected from the government, resulted in poor patients expressing little indication of stigma—interpersonally, organizationally, and institutionally—in this safety net setting. However, it also meant that patients were unaware of their rights to be treated without payment, demonstrating on the disjuncture between the inclusive mission of the CHC program and the everyday reality of

CHCs that must perform in a context of fiscal austerity. This, once again, exposes the inherent tension in our country's public-private welfare state. Though CHCs purport to serve as a universally available public safety net, they are not exempt from encountering the financial incentives and disincentives posed by the private health care industry. Rights-oriented CHCs are pressed to act like any for-profit health provider, leading patients and staff to interpret this setting as "just like any other doctor's office." While the commitment to providing health care to all, regardless of ability to pay, unites the CHC program, the lack of adequate resources—due to cutbacks and marketization of the U.S. welfare state—made it difficult to follow through on this mission to help poor patients. But once again, the impact was not clearly positive or negative: in this case, a neoliberal paternalistic approach did not lead to stigma as found in other studies (Soss, Fording, and Schram 2011), and instead made poor patients feel like they were part of the mainstream health care system and treated no differently from those with greater socioeconomic means, adding complexity to how scholars think about the effects of contemporary poverty governance.

The theoretical mechanisms identified here can be applied to the study of other safety net clinics. There is a wide spectrum of CHCs, and as some of the leaders at Crownsville told me: "when you've seen one health center, you've seen one health center." CHCs are highly variable in quality, services, appearance, patient composition, provider background, organizational mission and vision, location, community context, resources, and other dimensions. This is both a strength and weakness for the CHC program. On the one hand, it enables each center to tailor itself to the community and provide services in a way that matches local mores. It also allows for different approaches, such as centers that are more business-oriented, social justice-oriented, faith-based, special population-focused (like immigrants, the LGBT community, and public housing residents),

or issue-focused. But on the other hand, the wide variability in quality and perception of CHCs may mean that patients have drastically different health care experiences depending on where they live. For example, residents of states that have not expanded Medicaid coverage or residents in racially and economically diverse urban settings may have a much different experience at CHCs than described here. Though this case study is not representative of all CHCs, my focus on mechanisms at interpersonal, organizational, and institutional levels can be extended in future research to shed light on how variations in the CHC program matter to the way that the poor experience the health care safety net.

The findings also suggest practical implications for how government safety net programs targeting the poor can be administered such that the poor feel they receive equal treatment to those who are socioeconomically advantaged. That our federal government can operate such a vast network of clinics without the rampant stigma typically associated with state interventions targeting the poor is a testament to the potential for other public policies to do the same. Like others have argued, the targeting-within-universalism design is likely a key component of the CHC program's popularity (Grogan and Patashnik 2003) among both politicians and local communities, as the poor have an opportunity to be integrated into what feels like mainstream medicine when CHCs are also catered toward serving the non-poor. In closing, the study shows how the historical shifts toward marketization and privatization in the U.S. welfare state have impacted the health care safety net, adding nuance to our theoretical understanding of stigma and poverty governance at the nexus of debates over health care as a right versus a commodity.

CHAPTER 4

SPATIAL VARIATION IN ACCESS TO THE HEALTH CARE SAFETY NET FOR

HISPANIC IMMIGRANTS, 1970–2017

Regardless of nativity, Hispanics have historically been disproportionately uninsured relative to the non-Hispanic population in the United States (Rutledge and McLaughlin 2008). Despite substantial health insurance coverage gains from the Affordable Care Act (ACA), Hispanics continue to have the highest uninsured rate of any racial/ethnic group, which is even more pronounced in states without Medicaid expansion (Chaudry, Jackson, and Glied 2019). This disparity is largely due to the fact that federal and state policies have restricted or made it difficult for immigrants to qualify for public insurance (Ku and Matani 2001; Warner 2012). Even for immigrants who are lawfully present or eligible for assistance, many avoid enrolling in programs like Medicaid out of fear that it will jeopardize the residency status for them or their families (Derose, Escarce, and Lurie 2007). Others remain uninsured due to language barriers and difficulty navigating the system (Kaiser Family Foundation 2019). These dynamics, along with the fact that low-wage occupations rarely provide employer-sponsored health insurance, have long depressed measures of Hispanic immigrants' access to health care.

Although disparities in health insurance are well-documented, studies of Hispanic immigrants' access to health care have generally overlooked the vast network of federally-funded safety net clinics targeting medically underserved populations. In 2019, Community Health Centers (CHCs) served nearly 30 million predominantly low-income patients in almost 13,000 delivery sites (NACHC 2021). As a stipulation of their federal funding, CHCs provide care to any patient regardless of financial resources, health insurance, or citizenship status. Considering that

Hispanic immigrants have historically been restricted or discouraged from using governmental assistance (Castañeda and Melo 2014; Derose et al. 2007), and that CHCs remain as one of the only medical institutions available to undocumented immigrants (Marrow and Joseph 2015), surprisingly little is known about how accessible CHCs have been to Hispanic immigrants. Further, with the dispersion of Hispanic immigration from "established gateways" to "new destinations" (Lichter and Johnson 2009; Massey 2008), it remains unclear how availability of CHCs has been geographically distributed over time in relation to changing migration patterns.

Access to this widespread, immigrant-inclusive safety net program could have long-term ramifications for spatial inequalities in Hispanic immigrant health, as well as for broader dynamics of immigrant integration and social mobility. This study provides the first systematic evidence of the programmatic reach of CHCs into Hispanic immigrant communities, focusing on the following questions: to what extent have CHCs been accessible to Hispanic immigrants over time, and how does spatial proximity to CHCs vary across established gateways and new destinations? Through analyzing novel administrative and population- level data, the results show that a large segment of the Hispanic immigrant population has had access to CHCs, suggesting that spatial proximity to CHCs should be incorporated into future studies assessing Hispanic immigrant health.

BACKGROUND

IMMIGRATION AND THE HEALTH CARE SAFETY NET

Immigrants' access to health care is largely determined by federal, state, and local policy contexts (Perreira and Pedroza 2019). In recent decades, the U.S. has increasingly used citizenship status to delineate eligibility for safety net programs, instituting categorical inequalities in health care access (Light 2012; Massey 2007). Since the 1996 immigration and welfare reforms, federal

policies have restricted or made it difficult for immigrants to qualify for health insurance (Warner 2012), as undocumented or recently arrived legal immigrants have been ineligible from enrolling in Medicaid (Hagan et al. 2006). The passage of the Affordable Care Act (ACA) further brightened the symbolic and social boundaries in the health care system based on legal status (Marrow and Joseph 2015). A host of restrictive state-level immigration policies have also been enacted, which have negative impacts on the health and health care use of immigrants (Dondero and Altman 2020; Philbin et al. 2018).

Public policies that enforce boundaries based on citizenship legitimate the exclusion of immigrants from institutional resources (Menjívar and Abrego 2012). Increasingly severe "public charge" regulations—which take into account usage of public benefits in decisions about immigration status—are a prime example of how immigration and criminal law have converged in recent years (Menjívar and Abrego 2012). Though public charge rules apply to those seeking a visa or lawful permanent residence, they have broader "chilling effects" by making many immigrants wary of becoming involved in governmental programs (Derose et al. 2007) and they stoke fear and avoidance of health care institutions (Castañeda and Melo 2014; Hagan et al. 2006; Tuohy 2019). Undocumented and mixed-documentation families, in particular, face severe political barriers to health care (Torres and Waldinger 2015). Medical legal violence, or the combined enforcement of stringent health and immigration laws targeting both patients and clinic workers that undermines the wellbeing of noncitizens , further compels immigrants to rely on the uneven patchwork of safety net clinics (Van Natta 2019). Categorically excluded from many U.S. institutions, access to clinics that do not impose financial, legal, or linguistic barriers to health care can thus be an important resource for Hispanic immigrants.

THE COMMUNITY HEALTH CENTER PROGRAM

The modern-day Community Health Center (CHC) safety net grew out of the federal Migrant Health Program established in 1962—which provided free health services to migrant agricultural workers—and then developed further under the 1965 War on Poverty. CHCs now form an expansive network of primary care providers that offer comprehensive medical services to any patient, regardless of ability to pay. The CHC program is a rare U.S. institution that both has bipartisan political support (Lefkowitz 2007) and does not formally enforce codified social or symbolic boundaries between those deserving and undeserving of health care (Willen 2012). CHCs must be located in federally designated "medically underserved areas," determined through a combination of poverty and infant mortality rates, physician to population ratio, and share above age 65. CHCs are not explicitly funded on the basis of racial/ethnic or immigrant composition. This study will provide new evidence on whether this institution follows the pattern of exclusionary immigration policy in the U.S. safety net or if its historical focus on migrants has informed allocation of CHCs that target immigrant communities.

Existing research indicates that CHCs increase access to care for medically underserved populations through higher acceptance rates of new patients, treatment of the uninsured, and comprehensive delivery of preventive services, especially for rural Americans, racial minorities, and those with chronic conditions (Hicks et al. 2006; Lo Sasso and Byck 2010; Politzer et al. 2001; Regan et al. 2003; Richards et al. 2014; Saloner et al. 2018; Shi and Stevens 2007). Furthermore, evidence shows that CHCs improve health outcomes and are associated with reduced health disparities. Access to CHCs has a causal effect on mortality rates for older adults: the establishment of a health center in a county caused a 7 to 13 percent reduction in age-adjusted mortality rates within ten years, largely driven by decreases in cardiovascular-related deaths (Bailey and

Goodman-Bacon 2015). Studies have found no significant racial/ethnic disparities in health among patients who regularly attend CHCs (Shi et al. 2001) and that CHCs are associated with reduced racial/ethnic disparities in a range of birth outcomes (Shi, G. D. Stevens, et al. 2004; Thorsen, Thorsen, and McGarvey 2019).

Living near a health center also improves health care access for low- income and immigrant populations. After accounting for endogeneity, closer proximity to CHCs is associated with improved access to care for the uninsured, resulting in fewer who had unmet medical needs, and more who had a usual source of care (Hadley and Cunningham 2004). Low-income adults and children who reside in cities with more CHCs also have significantly greater odds of visiting a physician (Andersen et al. 2002). Among immigrants, living near a health center increased the probability that children of Mexican immigrants visited a doctor by 50 percent (Graefe et al. 2019). For the uninsured in California, closer distance to safety net providers is associated with higher probabilities of reporting a physician visit and usual source of care, but only for those who were Limited English Proficient (Cordasco et al. 2011), implying that CHCs are particularly important resources for foreign-born populations.

Taken together, the prior research suggests that physical proximity to CHCs is positively associated with both access to care and health outcomes, and that proximity is even more salient for immigrants and their children. Although low-income populations face a range of other barriers to health care, at both individual- and community-levels, living near a health center is a significant "enabling" characteristic (Andersen et al. 2002) that increases the potential for accessing free or affordable care to those living in the geographic vicinity. While existing research has established that people both attending *or* living near CHCs experience better health outcomes, it has yet to document the spatial and temporal distribution of the populations who have had access this safety

net institution, which limits our understanding of how, when, and where highly uninsured populations like Hispanic immigrants can or cannot access care.

HISPANIC IMMIGRANT DESTINATIONS AND ACCESS TO HEALTH CARE

Places reinforce inequalities in opportunity for immigrants. The community context structures immigrants' access to services, engagement with institutions, and exclusion from public policies (Acevedo-Garcia and Almeida 2012; Cervantes and Menjívar 2020). Scholarship on spatial disadvantage contends that people with worse access to resources—like immigrants—are highly reliant upon the local *organizations* available to them, the *systems* in which organizations are embedded, and the *institutions* that control both (Allard and Small 2013). From this multi-level perspective, CHCs can conceivably impact spatial inequality for Hispanic immigrants as one of few local organizations within the broader health care system that U.S. legal institutions mandate to provide health care regardless of citizenship. CHCs thus have the potential to address health disparities in the communities where they are available but also to reinforce disparities when underserved populations, like Hispanic immigrants, cannot easily access them.

Historically, the large majority of immigrants resided in a small number of metropolitan areas (Singer 2013), known as "established gateways." The geography of Hispanic immigration to the U.S. has dispersed in recent decades, with more Hispanic immigrants migrating to what scholars call "new destinations" (Johnson and Lichter 2008; Massey 2008). Established gateways are typically densely populated places that have had a sizable Hispanic population for decades. In contrast, new destinations are generally less densely populated places that are characterized by rapid growth in the Hispanic population during and after the 1990s. Scholars have documented differences in the receptivity context, socioeconomic conditions, community resources (Crowley

and Lichter 2010; Lichter et al. 2010; Ludwig-Dehm and Iceland 2017), and health insurance and mortality (Brazil 2017; Fenelon 2017; Monnat 2017) across established and new destinations.

Though this is a nascent literature, established gateways are more likely than new destinations to have pre-existing safety net systems, culturally sensitive services, and community-based organizations that support immigrants (Derose et al. 2007). The limited evidence on health care draws similar conclusions. Mexican-American adults are more likely to report having unmet needs for medical care when living in new destinations (Gresenz et al. 2012). In the early 2000s, significantly more Hispanics residing in "major Hispanic centers" lived within five miles of a health center than those residing in "new growth communities" (Cunningham et al. 2006). One study found a new destination disadvantage in access to health care driven by negative receptivity climates, but also showed that living near a CHC increased the proportion of Mexican immigrant children who received care (Graefe et al. 2019). Therefore, established gateways may have more robust CHC infrastructure than new destinations. However, considering the recent federal- and state-level policy trends restricting immigrants' access to services, CHCs may have less often located in traditional immigrant destinations and instead targeted the predominantly white and native-born populations in new destinations. With limited prior research on the historical location of these federally funded clinics, the analysis will explore to what extent Hispanic immigrants have had differential access to this community resource depending on where they settle.

DATA AND METHODS

This study uses an original, historical dataset containing the location and year that health center sites were established since 1963. Historical records on the geographic coordinates of 10,400 delivery sites were obtained from the federal agency, Health Resources and Service Administration (HRSA), but contained missing or incorrect information. Through a data validation process, I drew

upon multiple sources—including historical directories of health centers, grantee websites, local newspaper archives, and direct communication with grantees—to verify the correct grant year for each CHC site. The majority of validations, either confirming or disconfirming, resulted from cross-checking with other government data sources. Ultimately, I identified and corrected incomplete or inaccurate information on 17.4% of all health center sites from HRSA. For this analysis, I exclude the 718 administrative-only sites, which do not directly serve patients, and 456 mobile sites, which do not have defined addresses. The final analytic sample is comprised of 8,582 CHC delivery sites.

The historical data was linked with decennial Census and American Community Survey (ACS) data on population demographics that was linearly interpolated for the years of 1970–2017 (Logan, Xu, and Stults 2014). Because the 1960 Census did not include many of the key variables of interest and has discrepant geographic boundaries, the analysis begins with 1970 Census data and treats each health center that began in the 1960s as existing prior to the start time of the analysis. Two levels of geography are used from the Census—tracts and counties—with synchronized 2010 boundaries, as detailed below. Distance to CHCs is calculated from the centroid of each census tract at every year to produce fine-grained, annual population-level estimates of spatial proximity. County-level data are used to classify Hispanic destination types, following prior studies (Brazil 2017; Johnson and Lichter 2008; Monnat 2017).

MEASURES

Population Measures. Measures at the tract-level include population size, race, ethnicity, nativity, and poverty status. Tract-level Census data do not include population estimates for Hispanic immigrants prior to 2000. Therefore, I rely upon historical Census measures of the poor Hispanic,

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Mexican-origin, and foreign-born populations to proxy for Hispanic immigrants from 1970 to 2000. These three overlapping population groups are compared with the non-Hispanic white poor as a reference, like other studies assessing Hispanic health and health care access (Berdahl, Kirby, and Stone 2007; Brazil 2017; Fenelon 2017; Hummer et al. 2007; Rutledge and McLaughlin 2008). With data on nativity-by-ethnicity available at the tract-level from the 2000 Census, as well as ten waves of the five-year ACS from 2008 to 2016 (Manson et al. 2018), I then disaggregate estimates for U.S.- and foreign-born Hispanic populations. Finally, I provide recently available estimates from 2010 to 2016 on the uninsured Hispanic, foreign-born, and native-born populations from seven waves of the five-year ACS.

For consistent historical measures at the tract level, the analyses are focused on proximity for the poor Hispanic population. Because CHCs are typically located in high-poverty areas and a large majority of patients live below the federal poverty line, concentrating on poor Hispanics provides estimates of the population most in need of subsidized care. Robustness checks using county-level data show that poor Hispanics are the closest historical proxy to Hispanic immigrants (see Appendix B1). For instance, 13% and 15% of foreign-born and poor Hispanics, respectively, lived in a county with a CHC in 1970, and the comparable figures amounted to 52% and 53% by 1990. Data on Hispanic ethnicity at the tract-level was not collected in the 1970 Census and, therefore, population counts of poor Hispanics are linearly interpolated based on subsequent population counts. Robustness checks at the county-level show that the 1970s linear interpolation of poor Hispanic aligns with the actual population counts of foreign-born Hispanics (Appendix B).

Hispanic Destinations. I follow a similar classification approach as other studies by measuring three Hispanic destination types: established gateways, new destinations, and non-destinations (Crowley and Lichter 2010). I operationalize "established gateways" as counties that were

comprised of at least 10% Hispanics in the 1990 census. "New destinations" counties had a Hispanic population below 10% in 1990 but experienced substantial growth in the 2000 or 2010 census: specifically, the counties must have grown by 150% and added 1,000 Hispanics from 1990 to 2000, or 1990 to 2010. Small counties below 20,000 people with 150% growth that exceeded the national average of percent Hispanic in 2000 (12.5%) or in 2010 (16.3%) but did not increase by over 1,000 Hispanics are also counted as new destinations (Monnat 2017). Those counties not meeting the above criteria are considered to be "non-destinations." Nearly all (95%) of established gateways are in census-defined metropolitan areas, compared to 88% of new destination counties. Because differences in population density complicate comparisons between metropolitan and non-metropolitan areas, I present separate results for established and new destinations of the same urbanicity. Metropolitan status is designated using the Census defined Metropolitan Statistical Areas, which consist of a core population of at least 50,000 people.

Proximity Measures. Rather than measuring county- or city-level aggregate counts of CHCs, as prior studies have done, these data contain the exact latitude and longitude of each delivery site. Using the geographic coordinates of each census tract centroid, I calculated the Euclidean distance from every census tract to its nearest health center coordinates for all years between 1970 and 2017. I then constructed five distance thresholds: less than one mile, two miles, five miles, ten miles, and twenty miles (similar to Cunningham et al. 2006; Gresenz et al. 2012; Hadley and Holahan 2003) from each tract centroid. The following results focus on the two-mile distance threshold as it produces more conservative estimates of population-level proximity, but the results are substantively similar across all distance thresholds (see Appendix B).

ANALYTIC STRATEGY

Once counties were classified into one of the three types of destinations—i.e., established destinations, new destinations, and non-destinations—I conducted a spatial join between destination types at the county-level with the geocoded CHC data using QGIS. To ascertain population-level access to CHCs over time, the data were transformed to tract-year-distance format (N = 22 million). For every census tract-year, I calculated whether that tract was within each distance threshold from a CHC. For population-level estimates, I applied the total counts of each population group in the tract as a frequency weight. The resulting summary statistics represent the proportion of each population that was proximate to a CHC at every time point within that distance threshold. After mapping and describing trends in the distribution of health centers, I assess historical proximity for poor Hispanics, Mexican-origin, and foreign-born populations, relative to poor whites as a reference group. I then stratify the proximity results by Hispanic destination type and urbanicity determined at the county level. I first show the full historical results for the three population groups that proxy Hispanic immigrants, and then present specific estimates by nativity and insurance status for the more recent time period where data is available at the tract-level.

FINDINGS

SPATIAL DISTRIBUTION OF CHCS AND IMMIGRANT DESTINATIONS

There has been extensive growth in the geographic coverage of CHCs over the past three decades, coinciding with the influx of Hispanic immigration to the U.S. Prior to the immigration wave in the 1990s, most Hispanics lived in established gateways, many of which did not contain any CHC delivery sites [see Figure 2]. A large swath of established gateway counties near the Mexican border in Texas, Arizona, and New Mexico were without any safety net clinic prior to the 1990s. Meanwhile, California was exceptional for having CHCs in the majority of its established gateway

counties. Notably, for the counties that would experience increasing flows of Hispanics in the subsequent decades—meeting the criteria for new destinations—CHCs were largely absent. In particular, many counties in the Northwest and Southern states were without health centers before the 1990s.

Figure 2. Hispanic Destinations and Distribution of Community Health Centers in 1990
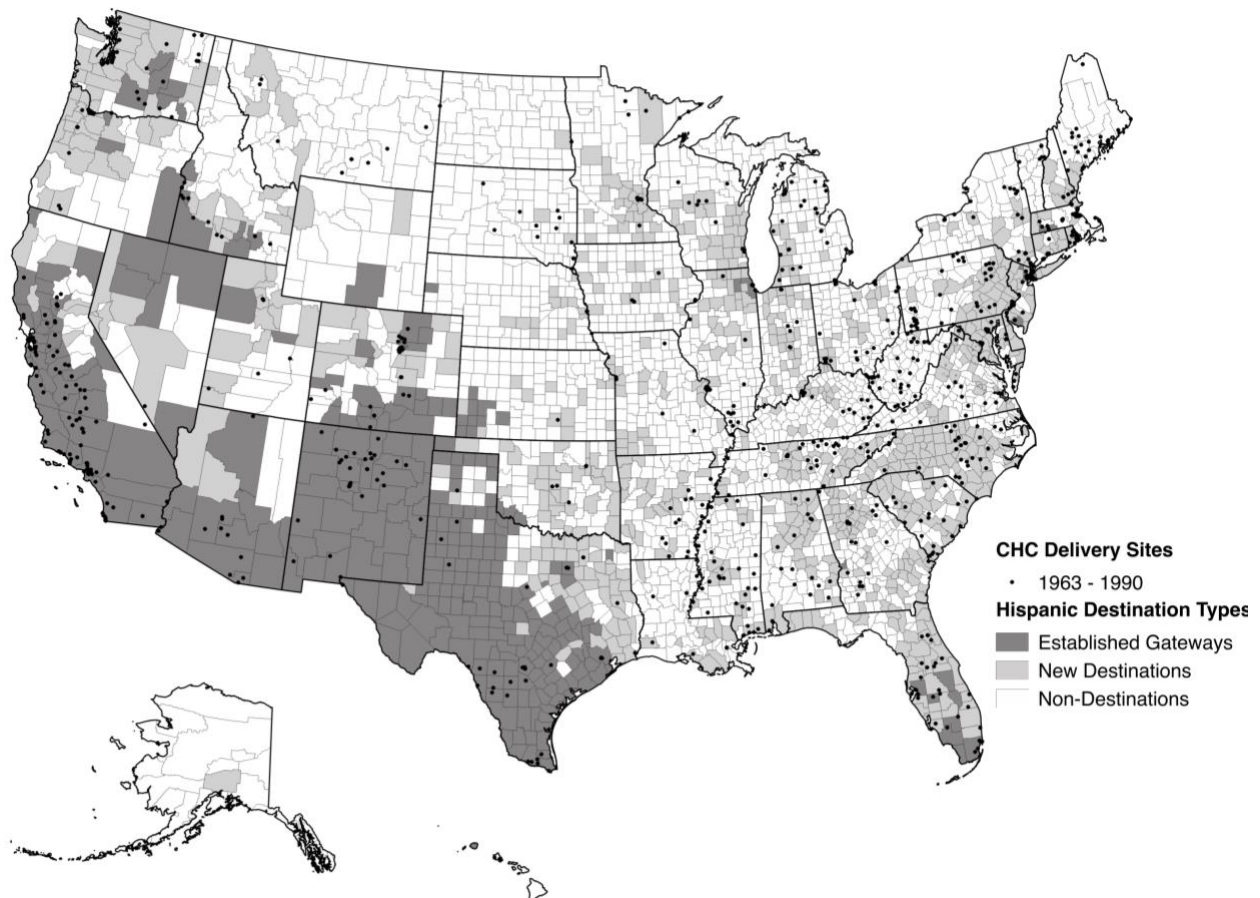
Source. Author's calculations using HRSA administrative records and Census data (1990-2010).

Although CHC infrastructure was initially lacking in places that would become new destinations for Hispanic immigrants, bipartisan political support led the health center program to flourish after the turn of the century. Expansion began in earnest during the administration of President George W. Bush and grew even more rapidly during President Obama's administration with additional funding from the Affordable Care Act. Hence, the geography of CHCs in the 2010s is far more

widespread than in the 1990s [see Figure 3]. Health centers are located in most counties where Hispanic immigrants tend to reside. While the availability of CHCs has increased for most parts of the country, there remain bands of the Upper Midwest, the Plains, and the Southwest regions of the country that are without health centers. In some established destinations of rural Texas and in much of Nevada, safety net clinics continue to be particularly sparse.

Figure 3. Hispanic Destinations and Distribution of Community Health Centers in 2018
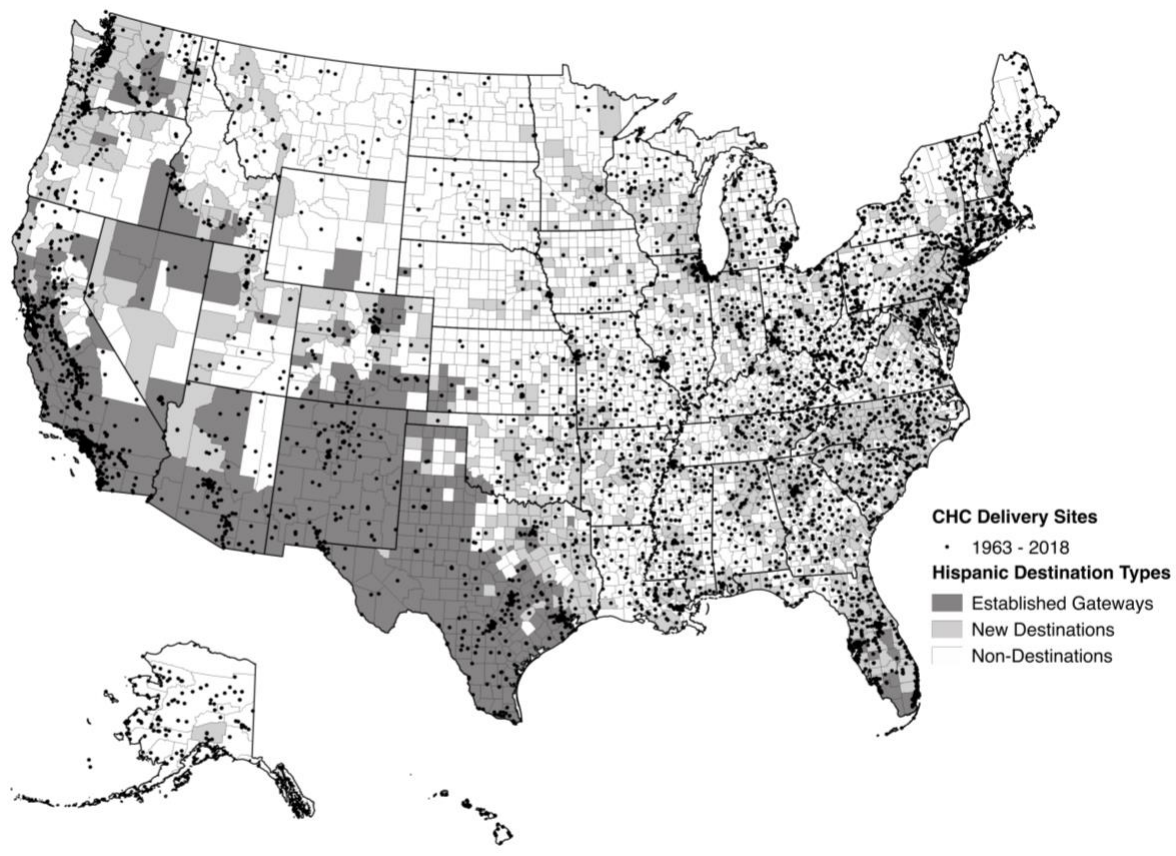
Source. Author's calculations using HRSA administrative records and Census data (1990-2010).

Table 3 shows the cumulative number of health centers per county over time and how the CHC landscape has changed in relation to Hispanic destinations. Whereas established gateway counties had an average of 1.96 health centers in 2000, new destinations contained only 0.68. By 2017, the average grew more than four times to 8.6 versus 3.3 CHCs in established and new destinations, respectively. This pattern holds on a per capita basis, as established gateways had 2.89 health

centers per 100,000 people in 2017 while new destinations had just 1.86. Although the absolute level of CHCs has been consistently greater in established gateways, the rate of growth has been higher in new destinations: between 2010 and 2017, new destinations experienced a 98% increase compared to 81% in established gateways. This difference in growth rate results, in part, from the lower initial level of CHCs in new destinations. Aggregate county-level findings illustrate that more health centers have been located in established gateways than in new destinations, but that new destinations have experienced proportionately more growth in health center infrastructure.

Table 3. Number of Community Health Centers per County, by Hispanic Destination Type

Year	Established Gateways (N=330)			New Destinations (N=884)		
	Total	Mean	Per Capita (100,000)	Total	Mean	Per Capita (100,000)
1970	22	0.07	0.05	18	0.02	0.03
1980	143	0.43	0.26	148	0.17	0.17
1990	310	0.94	0.45	275	0.31	0.25
2000	648	1.96	0.81	598	0.68	0.47
2010	1,437	4.35	1.60	1,361	1.54	0.94
2017	2,846	8.62	2.89	2,895	3.27	1.86

Sources. Author's calculations using HRSA administrative records. Census and ACS data is used to determine destination type and population counts.

POPULATION PROXIMITY TO COMMUNITY HEALTH CENTERS

To ascertain population-level proximity to safety net clinics, Figure 4 shows the proportion of poor Hispanics, Mexican-origin, and foreign-born populations who have lived within two miles of a health center from 1970 to 2017. Again, due to historical data limitations, these overlapping population groups were selected to approximate the highly uninsured Hispanic immigrant

population. The estimates are compared to poor non-Hispanic whites as a reference group, like other studies (Berdahl et al. 2007; Brazil 2017; Fenelon 2017; Hummer et al. 2007; Rutledge and McLaughlin 2008).

The pattern is striking: CHCs have been substantially more proximate to poor Hispanics, Mexican-origin, and foreign-born populations than to poor whites throughout nearly the entirety of the historical time period. In 1990, nearly one-third of poor Hispanics, 22% of the foreign-born, and 18% of the Mexican-origin population lived within two miles of a CHC, compared with 10.5% of poor whites. In 2017, 58% of poor Hispanics and more than half of Mexican-origin and foreign-born populations lived in close proximity to a CHC, compared with 31% of poor whites. The poor Hispanic-white gap in access has widened steadily over time, from a difference of 21% in 1990 to 26% in 2017. This finding suggests that, unlike other exclusionary policies, CHCs have instead systematically targeted immigrants. However, the growth rate in the proportion of poor whites with CHC access has been greater than for poor Hispanics, especially since the early 2000s. For example, between 2010 and 2015, poor whites experienced a 40% growth rate in access to CHCs compared to 20% for poor Hispanics. Again, the different growth rates also reflect lower levels of access among poor whites at the starting period.

Given that citizenship status is a central axis of stratification in the U. S. health care system, I also compare estimates by nativity and insurance [Table 4]. In contrast to most research that finds native-born populations have greater health care access, I find the opposite for the CHC program: substantially more foreign- than U.S.-born Hispanics have lived within two miles of a health center since 2000. The nativity gap has widened over time, from a 3% difference in 2000 to 8% in 2016. This is an important finding because foreign-born Hispanics are more often uninsured and restricted from Medicaid, and thus more likely to benefit from close proximity to CHCs.

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Disaggregating by health insurance coverage, 41% of uninsured Hispanics lived within two miles of a CHC in 2010, which surpassed 50% five years later. I also find that access to CHCs for the uninsured has favored foreign-born populations since 2010. While more than half of the uninsured foreign-born lived within two miles of a CHC in 2016, less than one-third of the native-born uninsured had comparable access. This finding suggests a concerted effort by the CHC program to locate specifically in communities where uninsured immigrants reside.

Figure 4. Proportion of Total Population Group Living within Two Miles of a CHC
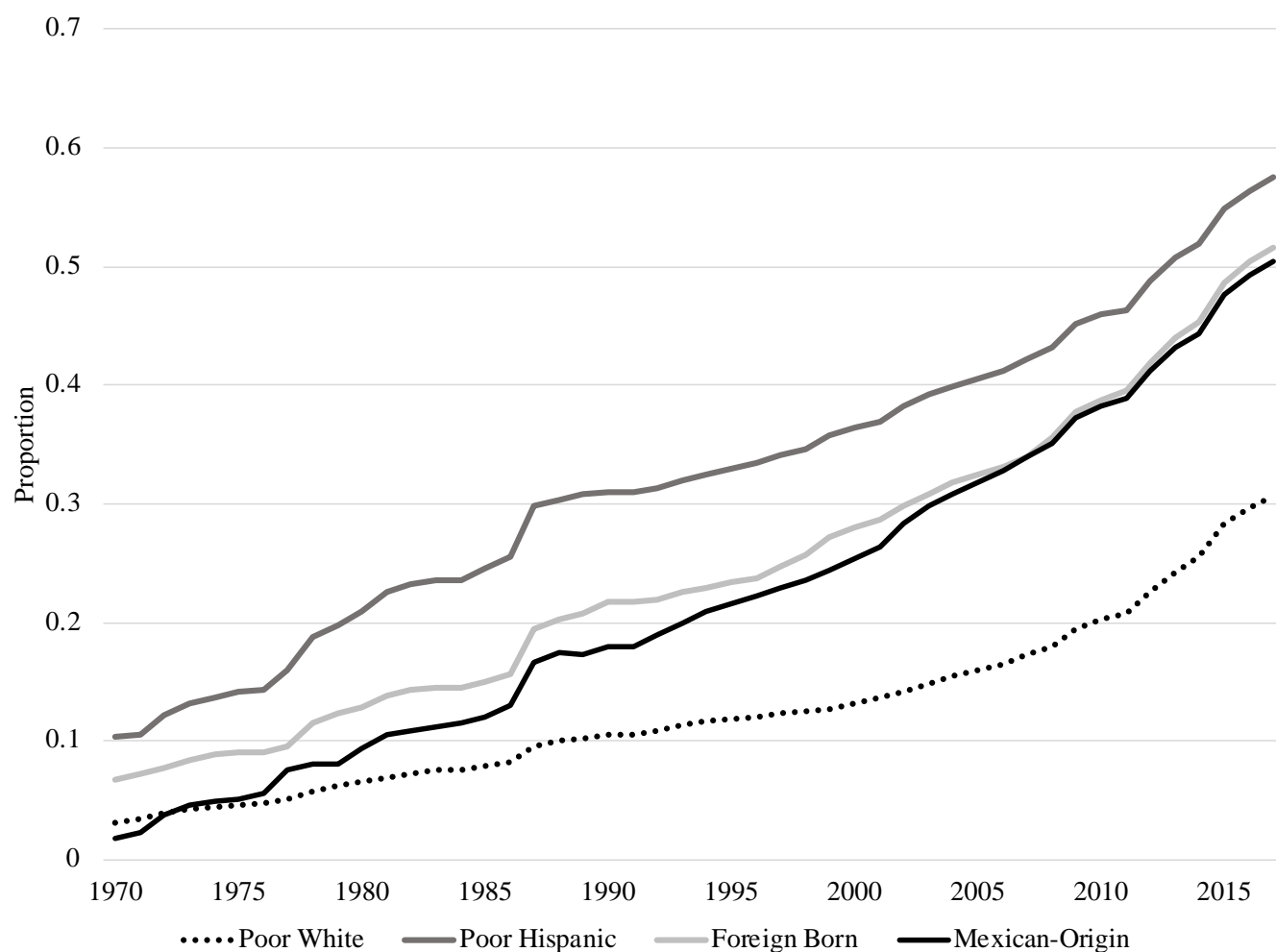
Notes. Estimates produced using population counts of every census tract and the distance from tract each centroid to its nearest Community Health Center.
Sources. Author's calculations using HRSA administrative records, Census, and ACS data.

Table 4. Proportion within Two Miles of a CHC, by Nativity and Insurance

Year	Poor Hispanics [a]	Foreign-Born Hispanics [b]	U.S.-Born Hispanics [b]	Uninsured Hispanics [c]	Uninsured Foreign-Born [c]	Uninsured U.S.-Born [c]
2000	0.36	0.31	0.28			
2001	0.37	0.32	0.29			
2002	0.38	0.34	0.30			
2003	0.39	0.35	0.32			
2004	0.40	0.36	0.32			
2005	0.41	0.37	0.33			
2006	0.41	0.38	0.34			
2007	0.42	0.39	0.36			
2008	0.43	0.40	0.35			
2009	0.45	0.43	0.37			
2010	0.46	0.44	0.37	0.41	0.42	0.23
2011	0.46	0.45	0.38	0.42	0.42	0.24
2012	0.49	0.48	0.41	0.45	0.45	0.26
2013	0.51	0.50	0.43	0.47	0.48	0.28
2014	0.52	0.52	0.44	0.48	0.49	0.29
2015	0.55	0.55	0.47	0.51	0.52	0.31
2016	0.56	0.56	0.48	0.52	0.53	0.32

Notes. Estimates produced using population counts of every census tract and the distance from tract each centroid to its nearest Community Health Center.

Sources. Author's calculations using HRSA administrative records. [a] Data source is the Longitudinal Tract Database, using 2000 and 2010 Censuses and American Community Survey data. [b] Data source is the NHGIS using 2000 Census data, and merged 2005-2018 American Community Survey data. [c] Data source is the NHGIS using merged 2008-2018 American Community Survey data.

In sum, the results show that CHCs—both historically and contemporarily—have been far more spatially proximate to poor Hispanic and immigrant populations than to poor whites. In recent decades, more of the foreign-born Hispanic and uninsured populations have lived near a clinic than the U.S.-born Hispanic and uninsured populations. However, still upwards of two-fifths of poor, foreign-born, and uninsured Hispanics did not live within two miles of a clinic in 2016, providing further evidence on persistent spatial inequality in access to care in the U.S.

ACCESS IN ESTABLISHED GATEWAYS AND NEW DESTINATIONS

To compare proximity between established gateways and new destinations of the same urbanicity, Figure 5 displays the proportion of poor Hispanics, Mexican-origin, and foreign-born living within two miles of a CHC in metropolitan areas. Here, I find support for the infrastructural advantage of established gateways over new destinations, a pattern which holds for all three population groups approximating Hispanic immigrants. In 1990, 34% of poor Hispanics in metropolitan established gateways and 21% in metropolitan new destinations lived within two miles of a health center. As of 2017, fully two-thirds of poor Hispanics lived within two miles of a safety net clinic in established gateway cities as compared to 48% of poor Hispanics in new destination cities. Yet, since the early 2000s the growth rate has been greater in new destinations: poor Hispanics experienced a 22% increase between 2005 and 2010 and a 37% increase between 2010 and 2015 in new destinations, compared with just 14% and 17% respectively for poor Hispanics in established gateways. Overall, immigrants, Mexican-origin, and poor Hispanic populations living in metropolitan new destinations have had consistently less proximity to CHCs compared with their counterparts in established gateways, but access has been growing at a faster rate in new destinations.

For non-metropolitan areas, a similar pattern persists that established gateways have had an advantage in physical access to CHCs over new destinations for all three population groups approximating Hispanic immigrants [see Figure 6]. The gap between established and new destinations has remained fairly consistent since the mid-1980s in non- metropolitan areas. In 1990, about 10% of poor Hispanics in non-metropolitan established gateways lived within two miles of a CHC, compared to 2% of their counterparts in new destinations. For those living in non-metropolitan established destinations, the absolute level of access has consistently been greater,

with just over 30% of poor Hispanics living within two miles of a health center in 2017. New

destinations experienced a sizable increase in proximity to health centers in the early 2000s, and

then again in the mid-2010s, with nearly one-fifth of poor Hispanics living within two miles of a

health center as of 2017. Again, for poor Hispanics the rate of growth for non-metropolitan new

destinations has been greater than in established gateways (44% vs. 20% between 2010 and 2015).

Figure 5. Proportion Living within Two Miles of a CHC in Metropolitan Areas, by Hispanic Destination Type
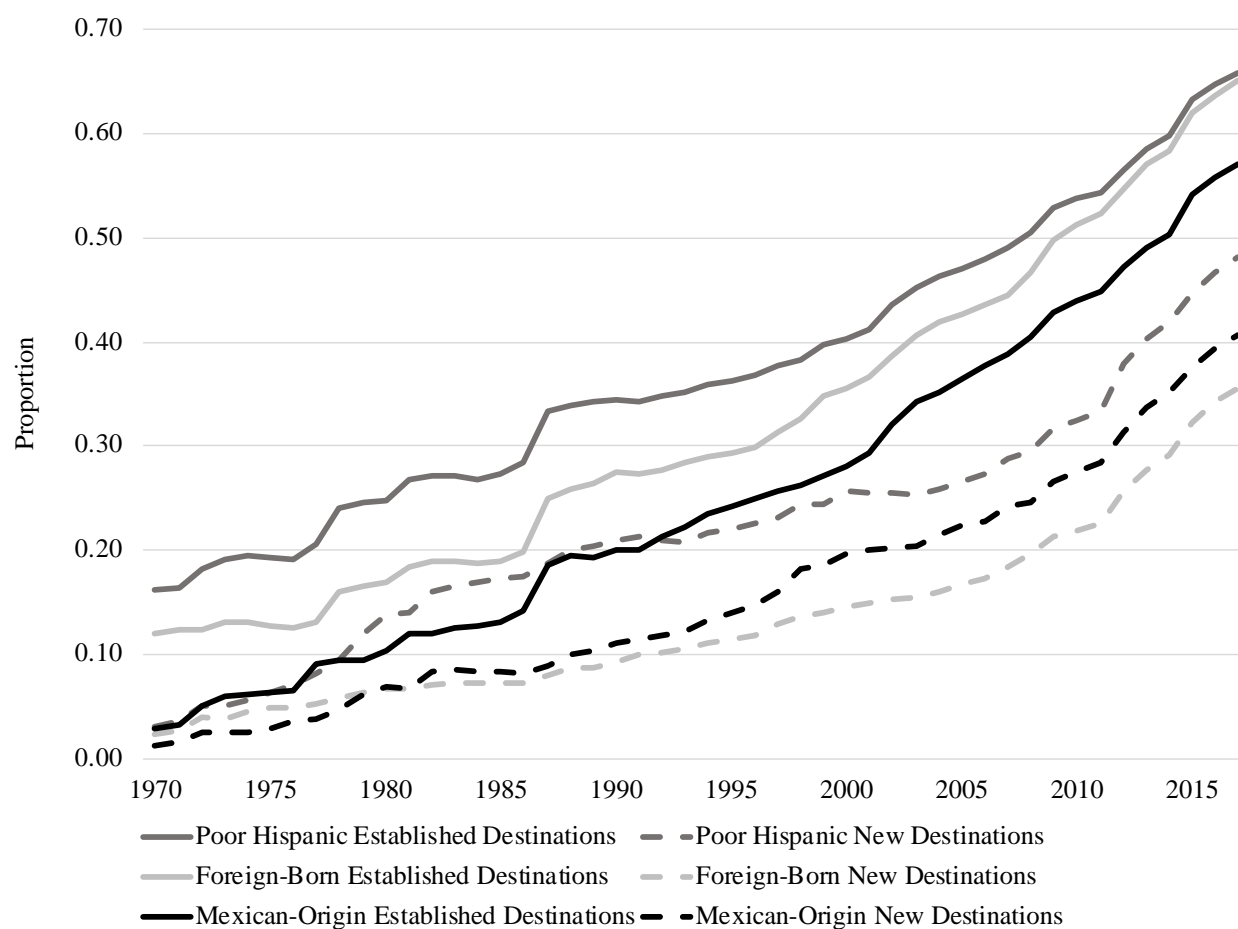
Notes. Estimates produced using population counts of every census tract and the distance from tract each centroid to its nearest Community Health Center.
Sources. Author's calculations using HRSA administrative records, Census, and ACS data.
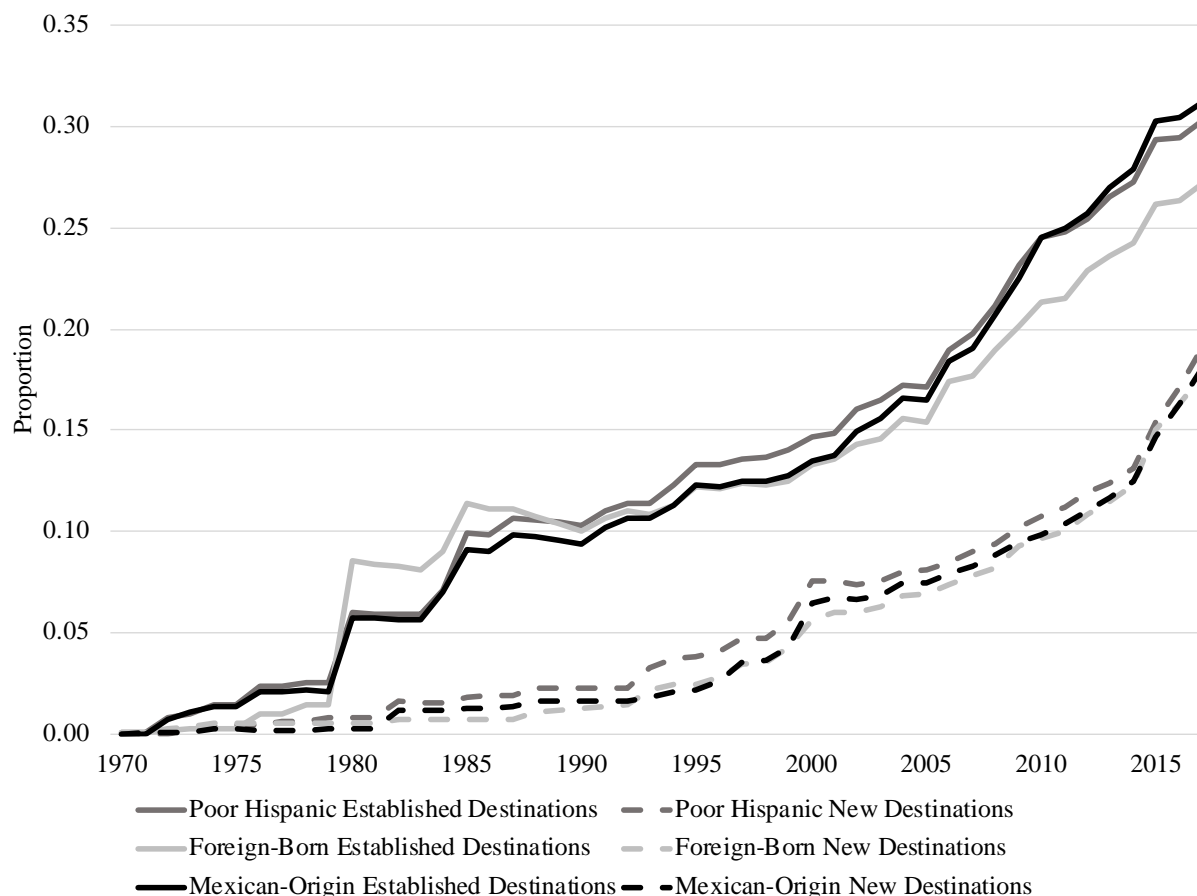
Figure 6. Proportion Living within Two Miles of a CHC in Non-Metropolitan Areas, by Hispanic Destination Type

Notes. Estimates produced using population counts of every census tract and the distance from tract each centroid to its nearest Community Health Center.
Sources. Author's calculations using HRSA administrative records, Census, and ACS data.

Turning to nativity, I find that CHCs have been more spatially proximate to foreign-born than U.S.-born Hispanics living in established destinations and that this nativity gap has grown since the turn of the century [Figure 7]. In 2000, the Hispanic nativity gap in established destinations was 5% and has grown to a difference of 10% since 2013. As of 2016, 64% of Hispanic immigrants in established gateways lived within two miles of a health center, relative to 55% of U.S.-born Hispanics. In contrast, the Hispanic nativity gap is minimal in new destinations, widening slightly since 2008, also in favor of foreign-born Hispanics. These results provide evidence that, since

2000, Hispanic immigrants living in established destinations have had a sizable and growing advantage in proximity to CHCs over U.S.-born Hispanics, as well as relative to those residing in new destinations regardless of nativity. Yet, the overall growth rate has been greater in new destinations than established gateways for both foreign- and U.S.-born Hispanics since 2000. These findings show that CHCs have indeed been more spatially proximate to foreign-than U.S-born Hispanics, especially in established gateways, underscoring the potential for this institution to reach the Hispanic immigrant community.

Figure 7. Proportion Living within Two Miles of a Community Health Center, by Nativity and Hispanic Destination Type
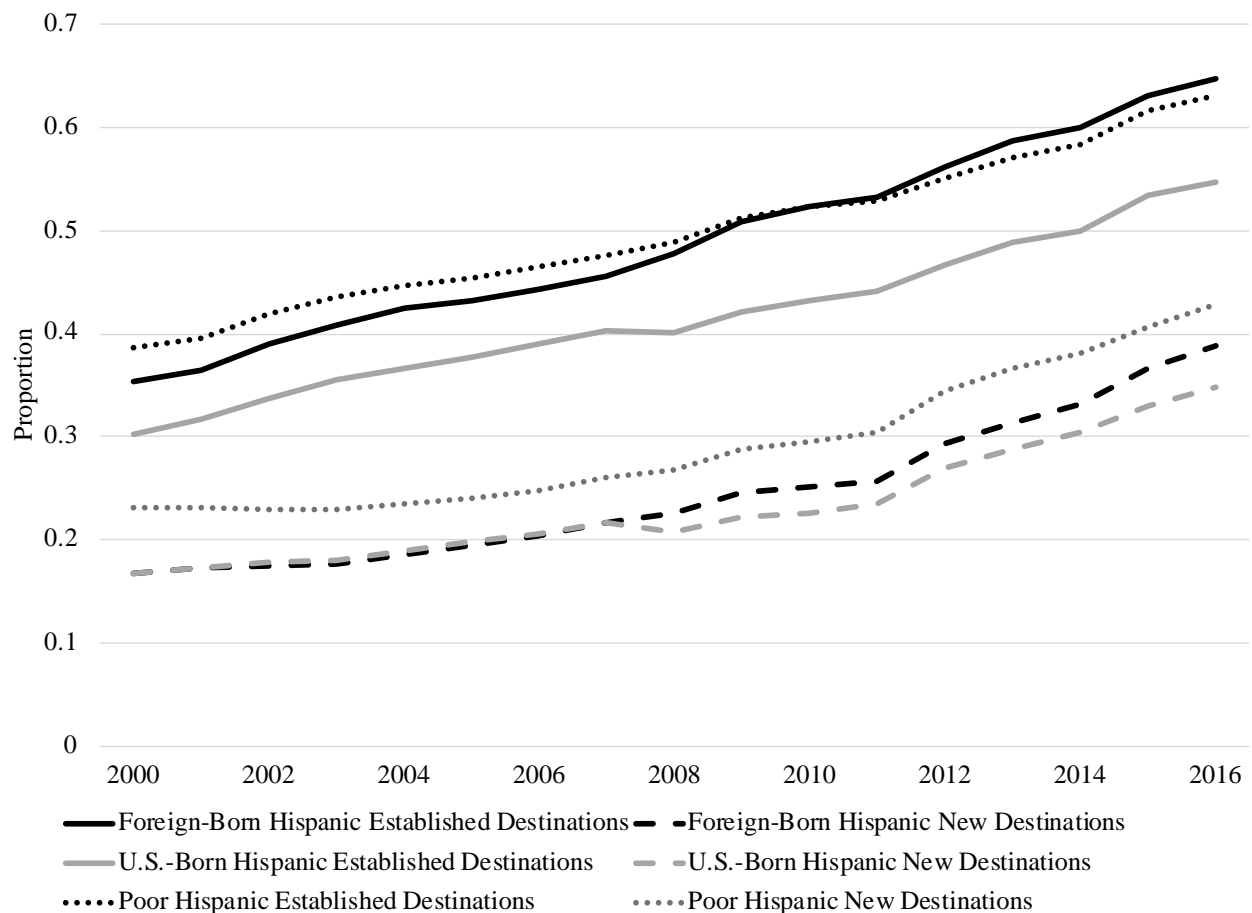

Notes. Estimates produced using population counts of every census tract and the distance from tract each centroid to its nearest Community Health Center.
Sources. Author's calculations using HRSA administrative records, Census, and ACS data.

DISCUSSION AND CONCLUSION

The interaction of stringent health and immigration policies both undermines the health and well-being of noncitizens and leaves many immigrants reliant upon safety net institutions, like CHCs, as one of the only places to receive health care (Menjívar and Abrego 2012; Van Natta 2019). The implication of these policy restrictions is that immigrants have vastly different health and life chances depending on the communities where they reside in relation to the limited and geographically dispersed safety net (Marrow 2012). To shed light on these spatial inequalities, this study provides the first systematic evidence on the distribution of CHCs over time as Hispanic migration patterns have evolved.

While U.S. federal and state policies have become decidedly more exclusionary toward immigrants in recent decades (Perreira and Pedroza 2019), the CHC program has not followed this trend. In contrast, CHCs have historically been spatially proximate to a sizable population of poor and foreign-born Hispanics. Between 1990 and 2017, the proportion of poor Hispanics living within two miles of a health center has almost doubled, from 31% to 56%. Although the U.S. health care system has traditionally favored native-born and white populations, in the case of CHCs, far more immigrants and poor Hispanics have lived near a safety net clinic than poor whites (56% vs. 30% as of 2017). Within the Hispanic population, more of the foreign- than U. S.-born have had close physical proximity to a health center since 2000. A similar pattern holds for the uninsured population, who are most in need of free or reduced-cost care. More than half of the uninsured Hispanic and foreign-born population lived within two miles of a CHC in 2016, while roughly one-third of the U.S.-born uninsured had comparable access. These findings suggest that, unlike many federal programs that exclude or restrict noncitizens, the CHC program has an institutional history of allocating funding toward Hispanic immigrant communities.

However, there is considerable variation in proximity to CHCs depending on where Hispanic immigrants live. A greater proportion of poor and foreign-born Hispanics residing in established gateways have lived within two miles of a health center than those in new destinations, providing evidence of worse safety net access in new destinations (Graefe et al. 2019; Gresenz et al. 2012; Monnat 2017). For most years since the early 2000s, about twice as many Hispanic immigrants living in established gateways have had convenient access to CHCs than those in new destinations. This conclusion holds regardless of urbanicity: roughly two-thirds of all poor Hispanics and immigrants residing in metropolitan established gateways lived within two miles of a health center in 2017, compared with 48% of poor Hispanics and 36% of immigrants living in metropolitan new destinations. These results underscore that the uneven reach of the CHC program, particularly in new destinations, cannot adequately compensate for broader health policies that use citizenship status to determine eligibility. In addition to advocating for more immigrant-inclusive federal policies, policymakers should make a concerted effort to encourage local governments, medical providers, and community-based organizations in new destinations to apply for CHC funding in order to more equitably distribute care.

The findings have at least three practical and theoretical implications. First, for Hispanic immigrants who are often excluded from or wary of health care institutions (Derose et al. 2007), the results show that CHCs do have the geographic potential to reach this highly uninsured population. This is consequential for how scholars and practitioners both design and assess efforts to improve population health for this underserved group. While most previous research shows that Hispanic immigrants are disadvantaged in health care access relative to whites, the CHC program provides a notable exception to this pattern, suggesting that this institution could be an important but neglected component of understanding Hispanic immigrant health, including the

epidemiological paradox. Future research should examine whether close proximity to CHCs is a potential mechanism explaining the relatively favorable health of Hispanic immigrants, given their generally low socioeconomic status and high rates of uninsurance.

Second, the evidence suggests that the health center program has an institutional legacy of locating in places proximate to Hispanic immigrant communities. Although the CHC program does not formally allocate funds based on racial/ethnic composition, there are several potential reasons for this finding. For one, its origins in the 1962 Migrant Health Center program could have had a long-lasting influence on bureaucratic decision-making. Another possibility is that communities where Hispanic immigrants reside may be more apt to mobilize the resources needed to apply for CHC funding. Furthermore, the residential segregation and concentration of poverty among Hispanics (Lichter et al. 2010; Ludwig-Dehm and Iceland 2017) means that strategically placed CHCs have the potential to reach more Hispanic immigrants than populations that are more spatially dispersed. Regardless of the reason, CHCs do not demonstrate a pattern of institutionalized exclusion like other safety net programs, and instead I find evidence that the program has effectively targeted poor and foreign-born Hispanics.

Finally, the findings reveal an uneven patchwork of safety net infrastructure available to immigrants. As of 2016, more than 40% of poor, uninsured, and foreign-born Hispanics lived further than two miles away from a safety net clinic. While nearly all (over 90%) of these populations have lived within ten miles of a CHC in recent years (see Appendix B2), longer distances present barriers in terms of travel time and arranging transportation. Further work will be needed to assess how these factors impact Hispanic immigrants' access to care. The results of this study show the potential of CHCs to address basic inequities in our health care system, but it is clear that CHCs also generate spatial inequities in who has the opportunity to conveniently

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obtain medical services, especially in new destinations. Therefore, the CHC program can conceivably reduce health disparities in some communities and exacerbate them in others that are further away from CHCs, highlighting that place and local resources are especially vital determinants of health for immigrants.

There are some notable limitations to this study. First, there may be additional barriers for Hispanic immigrants in accessing CHCs beyond physical proximity. These include lack of information, cultural or linguistic barriers, fear of immigration enforcement, and confusion navigating the bureaucracy (Joseph 2017; Portes, Fernández-Kelly, and Light 2012). Indeed, some research has suggested that factors such as gatekeeping, scrutiny, and bureaucratic filtering may hinder the use of health centers by undocumented immigrants (López-Sanders 2017a, 2017b). Other qualitative research has suggested that rural CHCs may not meet immigrants' needs for specialized care, and that sliding scale fees can be too costly (Cervantes and Menjívar 2020). An experimental audit also found that CHCs in new destinations lack availability of bilingual services (Nathensen et al. 2016). Therefore, physical proximity—along with legal mandates to serve anyone, regardless of citizenship or ability to pay—does not necessarily reduce barriers to care for immigrants, which is an important area of inquiry for future research. A key policy implication is that the CHC infrastructure is, indeed, now geographically proximate to the majority of poor, uninsured, and foreign-born Hispanics. However, additional outreach and engagement may be needed to convert proximity to a health center into the use of services among Hispanic immigrants.

Second, physical proximity to CHCs does not directly correspond with utilization of services. Not everyone living within two miles of a CHC will attend regularly or at all, and some CHC patients reside outside the two-mile threshold used in this study. The two-mile threshold is presented because the number of poor Hispanics within this catchment area corresponds most

closely to the actual CHC Hispanic patient count in recent years. Findings are also consistent across five different distance thresholds (see Appendix B2). The results should not be interpreted as utilization rates, but rather ecological estimates of the potential population who can attend these safety net clinics, a significant "enabling" characteristic of health care access (Andersen et al. 2002). Third, the results may be affected by the closure of health centers, which were not systematically identified in the compiled historical dataset prior to 1996. By triangulating with other governmental data sources, I found that roughly one center closed per year, on average, from 1996 to 2018, while fewer than one closed per year from 1974 to 1996. This data limitation likely has a negligible impact and, if anything, would lead to conservative population estimates.

A final limitation is that this study does not compare access to CHCs with other health care facilities. Although proportionately fewer poor whites have lived in close proximity to CHCs this population has historically had greater access to enroll in Medicaid and lower rates of uninsurance than Hispanics (Rutledge and McLaughlin 2008). The findings should not be construed as poor whites having worse access to health care, as they have traditionally had more sources of care available, including access to private physicians and hospitals. Nevertheless, CHCs are located in underserved areas where there are typically few, if any, other options for primary care, making them an important resource for the low-income population, regardless of race or ethnicity. Given the robust ecological impacts of CHCs on population health, a fruitful direction for future research will be to examine the differential proximity to health centers for other groups disenfranchised by the U.S. health care system.

In an era of heightened immigration enforcement and stringent "public charge" restrictions, variation in proximity to CHCs matters for both the health and institutional context of reception for Hispanic immigrants. Access to health care for Hispanic immigrants has primarily been

measured by lack of health insurance, leading research to largely neglect the role of health centers, which we know are associated with both reduced mortality (Bailey and Goodman-Bacon 2015) and racial/ethnic health disparities (Shi et al. 2001; Shi, G. D. Stevens, et al. 2004). Given the scale of the program and the close proximity of CHCs to now a majority of poor, foreign-born, and uninsured Hispanics, incorporating geographic proximity to safety net clinics is essential for future scholarship assessing health access and outcomes for Hispanic immigrants. As one of the few U.S. institutions defying stratification by socioeconomic and citizenship status, additional research on the CHC program is needed to identify the long-term effects of spatial inequalities in access to health care for Hispanic immigrants.

CHAPTER 5

CONCLUSION

The U.S. welfare state has undergone significant transformations since the start of CHC program, from the Great Society's expansion of state intervention to an era of contraction and marketization since the 1980s. Despite this evolution, the CHC program adapted to survive multiple attempts at retrenchment, successfully attracted and maintained popular political support, and has now grown to a scale greater than most early observers imagined would be feasible (Davis and Schoen 1978; Sardell 1988). This dissertation tells the CHC program's story from three angles, drawing upon distinct theoretical and methodological approaches as well as data sources. First, I explored the program's institutional history and how this antipoverty policy has become a uniquely bipartisan program even in our modern era of political polarization. Second, I conducted a case study to examine the qualitative experience of patients who attend a health center and the staff who serve them, focusing on the interpersonal, organizational, and institutional mechanisms underlying the delivery of care in this setting. Finally, I documented population-level variation in spatial proximity to CHCs for Hispanic immigrants, a group that has been systematically excluded from many health and social welfare policies in the U.S. Collectively, this dissertation advances scholarship on this understudied safety net institution and paves the way for future social scientific inquiry on how the CHC program impacts population health, poverty, and inequality.

While the prevailing assumption in the literature is that policies targeting the poor are politically vulnerable and stigmatizing (Quadagno 1994a; Skocpol 1995; Weir et al. 1988), this dissertation presents a rare exception to this widely held conclusion. In Chapters 2 and 3, I conducted detailed explorations of how the CHC program avoided this fate. With Chapter 4 finding

that CHCs have effectively targeted communities where Hispanic immigrants reside, the avoidance of political controversy and stigma is even more surprising given that other public policies targeting racial and ethnic minorities have tended to generate political (and racial) conflict as well as stigma. Political conflict and stigma related to public policies affect one another but are the result of distinctive and multifaceted phenomena. What unites the two, in this particular intervention by the state, is the ubiquitous role of the market. In Chapter 2, I argue that the CHC program was able to avoid political conflict primarily because of its alignment with market principles: specifically, policy elites deployed market failure frames from its outset, which effectively absorbed blame from individuals and avoided debates over deservingness, race, and morality typically encountered by social welfare policies, like Medicaid, which was devoid of market alignment. Frames in relation to both morals and markets allowed political support to coalesce across ideological divides, such that the CHC program now boasts unique bipartisan support for a policy targeting the poor. Although policies targeting the poor tend to be vulnerable to partisan backlash in the modern climate of polarization, this chapter demonstrates that a concerted effort to position policies in alignment with morals and markets can lead to the evasion of political contention in the U.S. welfare state.

In Chapter 3, I found that this historical alignment of the CHC program with the market impacted the ways that poor patients experienced their care at Crownsville Community Health Center. Rather than viewing Crownsville as a place for the poor or a government facility, poor patients perceived Crownsville as "just like any other doctor's office." In turn, this resulted in the widespread absence of stigma among the poor across multiple levels including treatment stigma, organizational stigma, and welfare stigma. However, I found evidence of a paternalistic approach to poverty governance through enforcement of overdue bill payments, despite proclaiming to not

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turn anyone away. I argue that the presentation of Crownsville as a market-oriented entity—rather than a government facility or a charity—was an important reason why poor patients did not detect stigma in the safety net. But it also meant that patients were unaware of their right to be treated, regardless of ability to pay, and this resulted in delayed or foregone care. These results present a nuanced portrait of marketization in the safety net, showing that from poor patients' perspective there are both positive and negative consequences of market orientations and approaches, which potentially obstructs inclusivity while also suppressing stigma.

Chapter 4 demonstrates that, unlike many other federal policies that have historically restricted access to communities of color, the CHC program contradicts this trend and has instead effectively targeted areas where low-income, foreign-born, and uninsured Hispanics tend to reside. As described in the final results section of Chapter 2, policymakers used the CHC program as a justification for restricting Medicaid coverage from recently arrived or undocumented immigrants in the 1996 welfare and immigration reforms. Excluded from Medicaid or other insurance coverage during a wave of Hispanic migration, policymakers expected immigrants to get care at CHCs. The empirical findings of Chapter 4 show that the government has indeed made a concerted effort to place CHCs in close proximity to Hispanic immigrants, with fully 56% of poor and foreign-born Hispanics living within two miles of a health center as of 2017. CHC have also been substantially more accessible to the foreign- than U.S.-born Hispanic and uninsured populations. This study shows the geographic ability of CHCs to provide care to underserved immigrant communities, concluding that these safety net clinics have the potential to both compensate for inequities in the health care system while also generating spatial inequities in access to care.

Taken together, the results from this dissertation have a number of important policy implications. Regarding the policymaking process, the results from Chapter 2 imply several

general conclusions on how policies for the poor can avoid political contention, namely the importance of gaining elite support from the beginning, that centralized policy design can result in less conflict than federalist state-based designs, and that articulation of frames in alignment with the market are instrumental to attracting bipartisanship. As for the operation of safety net clinics, the results from Chapter 3 suggest that employing members of the community was highly effective at quelling treatment stigma but issues of provider turnover had negative consequences for patients' continuity of care and emotional experiences of anxiety and distrust in the safety net. The issue of retention at CHCs should be of utmost importance to policymakers, as continuity of care presents significant downstream health effects. Finally, Chapter 4 shows that although the CHC program is now within close proximity to a majority of poor, foreign-born, and uninsured Hispanics, additional outreach and engagement is needed to convert proximity to a health center into the use of services among Hispanic immigrants who still report lack of regular access to providers. Access to CHCs alone cannot counteract the systematic exclusion of marginalized groups from public and private insurance that uses citizenship and socioeconomic status to determine eligibility.

Further attention on the CHC program from social scientists will be necessary in order to understand the impact of this federal institution on population health and inequality. Knowing that political support is fluid and ever-changing in America's contemporary polarized climate, inquiry on the politics of the CHC program and how it is used as a political tool will be essential in years to come. In addition, future research should attend to the uneven spread of CHCs to learn whether access to CHCs contributes to spatial inequalities in health, and whether this varies across places and populations. Because CHCs likely differ in relation to local contextual factors, additional qualitative case studies across varied settings—such as in cities with greater socioeconomic and

racial diversity or in states with restrictive Medicaid policies—will be essential to understanding how the poor experience the health care safety net. Our society has long lived with the unsettling reality that many Americans cannot access health care when they need it, leaving life-or-death matters somewhere in between the hands of the state and the market. Whether and how the CHC program can be part of a solution to this unconscionable social problem will be essential for social scientists to examine in years to come.

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A1. PATIENT INTERVIEW GUIDE

Thank you for agreeing to participate in this interview. I am doing research on community health centers and am interested in your experiences attending Crownsville. **Your participation is completely voluntary and confidential**. If we come to any questions you do not want to answer, just let me know and we'll move on.

With your consent, I'm going to audio record the interview so that I can concentrate on what you're saying. After the interview, the recording will be transcribed and then erased. Your interview will then be identified by a number and your name will never be identified in the study. Does that consent to participating in the study?

{Obtain verbal consent}

Do you have any questions you'd like to ask me before we begin?

*** BEGIN RECORDING ***

Warm Up:

- Could you start off by telling me a little bit about yourself? *(Probe on where grew up, how long lived there)*

- Do you have any family in the area? *(Probe on marital/parental status)*

- Who do you live with?

- How do you make ends meet?
    - If **employed**, what do you do for a living? How long have you been working there? How did you find your job?
    - If **unemployed**, how long have you been unemployed? What was your last job? Do you receive any government assistance?

- In general, how is your health these days?

- Do you currently have health insurance?
    - If **YES**, what kind of plan is it? How long have you been enrolled?
        - If **NOT PUBLIC**: Are you insured through your employer?
        - Tell me about your experiences with [health insurance name].

- o If **NO**, have you ever had health insurance? When was the last time you had health insurance?
- o *If have children/partner, ask about their health insurance.*

Access: *Now I'd like to ask you questions about Crownsville Community Health Center where I met you.*

- About how long have you been going to Crownsville?
- Can you tell me about what led you to start going to Crownsville? *(Probe for insurance, sliding scale, location, services)*
  - o How did you find out about Crownsville? *(Probe for personal connections)*
- About how many times have you gone to Crownsville in the last year?
  - o If **PARENTS**: How often have your children gone?
- Is Crownsville the main place you go when {you/your family} need health care?
  - o If **NO**, where else do you go?
- Do any of your friends or family go to Crownsville?
  - o If **YES**: Have you referred any friends or family to Crownsville? Have they referred you?
- Would you refer friends or family members to Crownsville in the future?
- How would you describe the other patients that go to Crownsville?
- Do you know any of the staff who work at Crownsville on a personal level?
  - o If **YES**, how do you know them? What is that like for you to know someone at your doctor's office?

Barriers to care:
- Have you ever had difficulty making appointments at Crownsville? *(Probe for work schedule, long waits, financial/insurance issues)*
- Have you ever had difficulty with transportation to Crownsville? *(Probe for usual way they get there)*
- Have you ever used the sliding scale option at Crownsville?
  - o If **YES**, how often? What's the experience been like?

- Have you had any issues with providing documents to prove eligibility? What about owing money to Crownsville?
- What do you think about the amount you have to pay? Is it fair? Did this amount ever make you hesitant to go to the doctor?
- Have you ever not shown up for a scheduled appointment?
  - If **YES**, do you remember why? How often? What did Crownsville do about no-shows?

Medical services: *Now I have some questions about the services you've received at Crownsville. Remember, you do not have to disclose your personal medical information to me, you can answer in general terms.*
- Tell me about the quality of medical care you've received at Crownsville.
  - How are you evaluating the care you receive there?
- How would you rate the services you've received there on a scale of 1 (the worst) to 10 (the best)? Why?
- How responsive have the Crownsville staff been to your medical needs? Can you provide any specific examples?
- Do you have a regular primary care doctor at Crownsville? If so, for how long? If not, why not?
- How would you describe your interactions with the staff at Crownsville?
  - Have you had any particularly positive experiences with staff? What about particularly negative ones?
- How comfortable do you feel talking to Crownsville's staff about your medical needs?
- Do you feel like your doctor listens to you? How can you tell whether they're listening?
- Do you feel like your doctor remembers you between visits? Why or why not?
- Do you feel like Crownsville staff respect you and your wishes? How can you tell?
- How much do staff at Crownsville know about your personal life or circumstances?
  - Would you feel comfortable confiding in them? Why or why not?

Non-medical services:
- Do you know if Crownsville offers services beyond medical care?
  - *Ex: counseling, help enrolling in other programs, referrals to other community organizations, transportation, health education, etc.*

- Have staff at Crownsville ever helped you with non-medical needs?
  - What about your friends or family members?
- In the future, would you go to Crownsville for help with problems that are non-medical?
  - Why or why not? Where else would you go?

Experiences at health center:

- What do you like most about going to Crownsville? What do you like least?
- Have you had any particularly positive experiences going to Crownsville? Any particularly negative experiences?
- How does your experience going to Crownsville compare with other places you've received medical care?
- Would you change anything about your experience going to the doctor?
- Where would you get medical care if Crownsville did not exist?

Program Awareness:

- How would you describe Crownsville to a friend?
- What is the reputation of Crownsville in your community?
- What do you know about Crownsville's history in your community?
- Crownsville is a Federally Qualified Health Center. Do you know what that means?
  - If **NO/UNSURE**: Federally Qualified Health Centers like Crownsville are part of a nationwide, federal program that funds health care services for people living in medically underserved areas.
  - **ALL**: What do you think about government-funded medical care programs, like this one?
- Does Crownsville look or feel like it's government-funded? Why/why not?
- Do you think other people in your community are aware Crownsville is government funded? Why or why not?
- Do you think people see Crownsville as a program for poor people? Why/why not?
- Tell me about the other experiences you have had with government programs.
- How do you feel about government assistance?
  - Who do you think deserves help from the government? What about for medical care specifically?

- How do you think Crownsville compares with other government-funded programs?
  - Now that I've told you Crownsville is government-funded, do you think of it any differently?
  - Do you think the government should do more to support medical care for you or your family?

Cool Down: *We're almost done, I just have a few more questions about your background.*
- How old are you?

- What was the last year of school that you completed?

- How would you describe your race/ethnicity?

- Do you consider yourself to be religious? If so, what religion?

- Politically, would you say that you lean more conservative or liberal? Do you tend to vote for one political party more than others?

- If not ascertained… What is your marital status? Do you have children?

- Tell me a little more about your family. *(Probe geography and intimacy for closest relatives)*

- Tell me about your parents' educational background *(Probe for highest level of schooling completed)*
  - How did they make a living? *(Probe for mother's job and father's job while respondent was living at home)*

- Who would you turn to in a time of need? *(Probe on up to three closest friends/family)*

- How much longer do you anticipate going to Crownsville?

Alright, that's the end of my questions. Is there anything else that you would like to add that we didn't talk about?

- Is it okay to get in touch with you in the future with follow up questions? (Verbal Consent)

Feel free to reach out to me in the future, my contact information is on the consent form. Thank you for your time.

A2. STAFF INTERVIEW GUIDE

Thank you for agreeing to participate in this interview. I am doing research on community health centers and am interested in your experiences working at Crownsville. Your participation is completely voluntary and confidential. If we come to any questions you do not want to answer, just let me know and we'll move on.

With your consent, I'm going to audio record the interview so that I can concentrate on what you're saying. After the interview, the recording will be transcribed and then erased. Your interview will then be identified by a number and your name will never be identified in the study. Do you consent to participating in the study?

{Obtain verbal consent}

Do you have any questions you'd like to ask me before we begin?

BEGIN RECORDING

Warm Up:

- Could you start off by telling me a little bit about yourself? *(Probe on where grew up, where they live, how long lived there)*

- Can you tell me about your current role working at Crownsville?

    o How much of your everyday work is serving patients?

- Tell me how you came to work at Crownsville.

    o How long have you worked at Crownsville?

    o Have you worked at other health care facilities? *(If yes, probe on what those experiences were like compared to current job)*

    o How did you get your job at Crownsville? *(Probe on whether used personal connections to get job)*

- What made you want to work at Crownsville?

    o How did you decide this was the right path for you?

Community context:

- How would you describe the community that Crownsville serves?

- What do you think are the primary **health** issues in your community?

- What about other **social** issues that may affect the community you serve?

- How does Crownsville respond to your community's needs? *(Probe for examples)*

- Does Crownsville collaborate with other human and social services in your community? *(Probe for examples of other institutions in community)*

Patient Descriptions: *I have some questions about Crownsville's patients. I don't expect you will know the exact answers so please feel free to estimate.*

- In general, how would you describe the patients that attend Crownsville?
  - What about the general demographic characteristics of your patients?
- What percentage of Crownsville's patients would you estimate are uninsured? Medicaid? Medicare? Private?
- How do your patients tend to become connected with Crownsville?
- How far do patients typically travel to get to Crownsville?
- How often is Crownsville the main source of care for your patients?
  - Do they tend to be short-term patients, or long-term?
- How often do your patients miss appointments? What happens when someone misses several?

Sliding Scale

- About what percentage of your patients use the sliding scale fee option?
- Can you explain to me how the sliding scale eligibility is determined at Crownsville?
- What happens if someone does not have the necessary documents to determine sliding scale eligibility?
  - Are there ever situations when you make exceptions to the sliding scale eligibility criteria? If so, when/why?
  - If not, do others at Crownsville make exceptions to eligibility criteria?
  - What happens if a patient cannot pay anything for services? When was the last time this happened? Can you describe it?
  - What happens if a patient owes money to Crownsville?

Patient Relations:

- Do you know any of the patients who attend Crownsville on a personal level? What's that like for you?

- How common is it for you to serve multiple patients from the same family? What's that like for you?
- How much do you know about the personal lives or circumstances of your patients?
  - Do you ask them questions about personal issues that may get in the way of patients' health? How do you ask about this?
  - Does knowledge about their personal life change the way you serve them? How?
- Tell me what it's like for you to serve a primarily low-income population.
  - How do you address issues of poverty among your patients?
  - How do you address other taboo issues among your patients? *(Ex: mental health/substance use)*
- Do you notice that certain patients are more comfortable talking to you about their needs than others?
  - If YES, can you describe those patients that are most comfortable talking to you?
  - What about patients who are less comfortable talking to you? Can you describe what they're like?
- Would you say that you have served patients who have different cultural backgrounds from you? (i.e. immigrants, refugees, different religions, etc)
  - Have you experienced challenges serving these patients? How do you address cultural norms?

Services:
- Tell me what you think about the quality of medical care provided at Crownsville.
  - How do you think Crownsville could improve quality of care?
- The term "patient-centered care" has become popular these days. How would you describe your approach to patient-centered care?
  - What has worked well for you? What has not?
  - Some definitions include incorporating patient perspectives and cultural norms into care delivery, and treating patients as partners. What do you think of this approach? Do you have examples of when this approach works, or does not work?
  - *Definition: (1) considering patients' needs, wants, perspectives and individual experiences; (2) offering patients opportunities to provide input into and*

participate in their care; and (3) enhancing partnership and understanding in the
patient–physician relationship

- Do you think Crownsville serves any non-medical needs of your patients?
    - In what ways does Crownsville serve people beyond medical care?
- Do you personally help patients with non-medical needs?
- What are the main barriers to health for your patients?

Job Experiences:

- What do you like most about working at Crownsville? What do you like least?
- Have you had any particularly positive experiences working at Crownsville? What about any particularly negative experiences?
- What are the biggest challenges for your job?
- Do you feel like you have the time and resources to do your job well?
- How would you say Crownsville compares with other primary care settings? Urgent care clinics? Private physicians?

Program Awareness:

- How would you describe the mission of Crownsville?
- Can you tell me what you know about the history of Crownsville?
- What's the reputation of Crownsville in your community?
- What's your understanding of Crownsville's connection with the federal government?
- Crownsville is a Federally Qualified Health Center. Do you know what that means?
    - If **NO/UNSURE**: Federally Qualified Health Centers like Crownsville are part of a nationwide, federal program that funds health care services for people living in medically underserved areas.
    - **ALL**: What do you think about government-funded medical care programs, like this one?
- How do you think Federally Qualified Health Centers compare with other primary care providers?
- Do you think your patients are aware that Crownsville receives funding from the federal government? About what percentage?

- Do you think other people in your community are aware Crownsville is government funded? Why/why not?
- Do you think people see Crownsville as a program for poor people? Why/why not?
- How do you feel about government assistance?
    - o Who do you think deserves help from the government? What about for medical care specifically?
    - o How do you think Crownsville compares with other government-funded programs?
- What more could Crownsville do to meet the needs of your community?
- What more could policymakers do to meet the needs of your community?

<u>Cool Down:</u>

We're almost done, I just have a few more questions for you about your background.

- Would you mind sharing with me your age?
- What's the highest level of education you have completed?
- How would you describe your race and ethnicity?
- Would you identify as religious? If so, what religion?
- Politically, would you say that you lean more conservative or liberal? Do you tend to vote for one political party more than others?
- What is your marital status?
- Do you have children?
- How much longer do you anticipate working at Crownsville?

<u>Conclusion:</u> Is there anything else that you would like to add that we didn't talk about?

- Now that the interview is over, how was that experience for you?
- Is it okay to get in touch with you if I need to ask a quick clarifying or follow up question? I want to make sure I got everything right. (Verbal Consent)

Feel free to reach out to me in the future, my contact information is on the consent form. Thank you again for your time!

Figure B1. Proportion Of Total Population Group With At Least One Community Health Center Within County of Residence
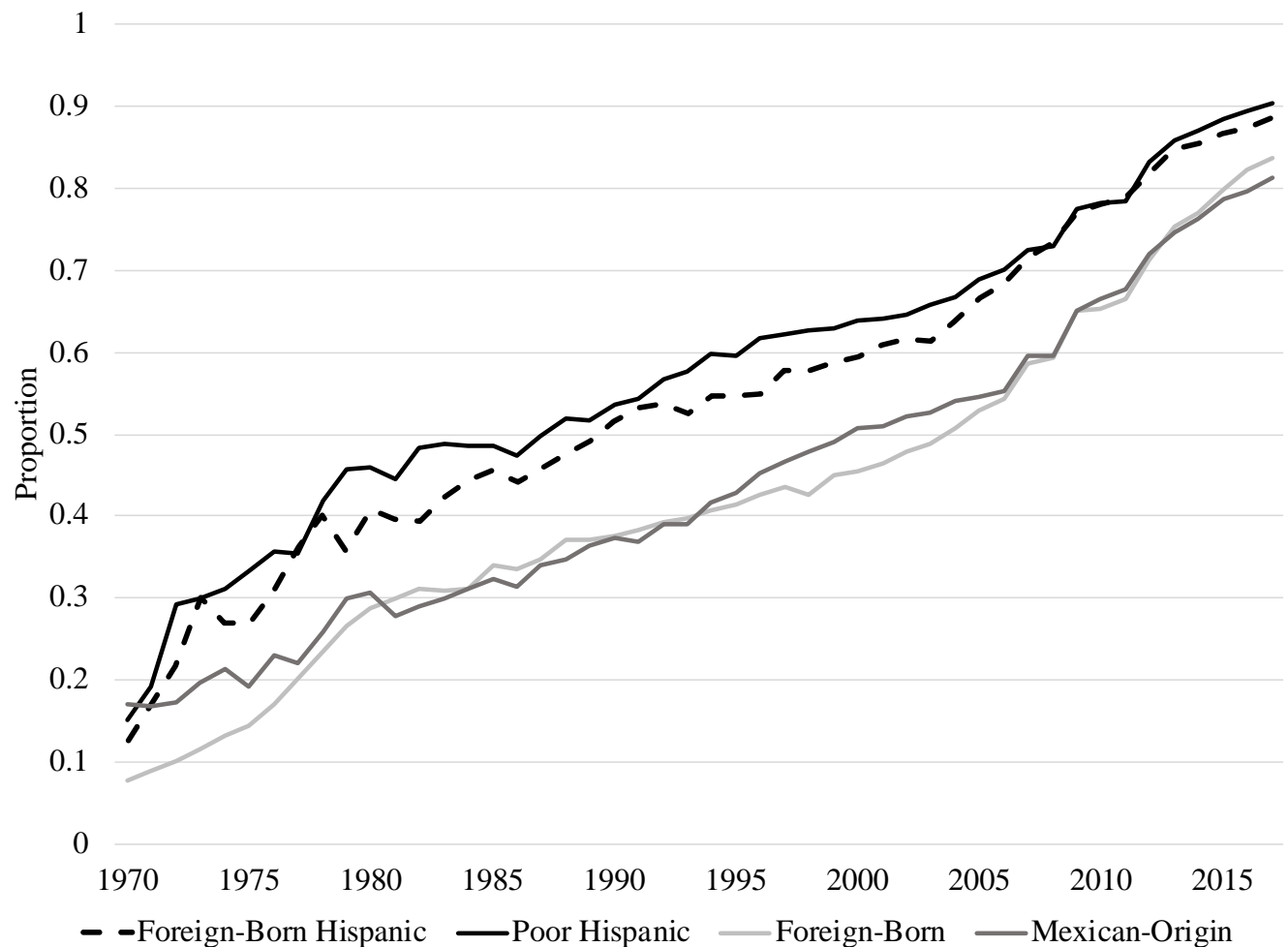
Source. Author's calculations using HRSA administrative records, Census, and ACS data.
Notes. Data on foreign-born Hispanics from NHGIS time-series (Manson et al. 2018). Data on poor Hispanics, Mexican-origin, and foreign-born are aggregated from the tract-level to counties for comparison (using Logan et al. 2014).

Table B1. Proportion Population With Access to CHCs, By Distance Threshold (Miles)

Year	<1 mile	<2 miles	<5 miles	<10 miles
Poor Hispanic[a]				
1970	0.05	0.10	0.22	0.30
1980	0.11	0.21	0.41	0.55
1990	0.17	0.31	0.54	0.69
2000	0.20	0.36	0.60	0.75
2010	0.26	0.46	0.71	0.84
2017	0.34	0.57	0.83	0.93
Poor White[a]				
1970	0.01	0.03	0.08	0.12
1980	0.03	0.07	0.16	0.26
1990	0.05	0.11	0.23	0.36
2000	0.06	0.13	0.28	0.43
2010	0.09	0.20	0.42	0.61
2017	0.15	0.31	0.58	0.79
Mexican-Origin[a]				
1970	0.01	0.02	0.06	0.16
1980	0.04	0.09	0.27	0.45
1990	0.07	0.18	0.44	0.63
2000	0.11	0.25	0.52	0.70
2010	0.19	0.38	0.66	0.82
2017	0.27	0.51	0.80	0.92
Foreign-Born[a]				
1970	0.02	0.07	0.21	0.35
1980	0.05	0.13	0.33	0.55
1990	0.10	0.22	0.47	0.69
2000	0.14	0.28	0.54	0.74
2010	0.20	0.39	0.67	0.84
2017	0.29	0.52	0.81	0.95
Foreign-Born Hispanic[b]				
2000	0.16	0.31	0.57	0.76
2005	0.19	0.37	0.63	0.81

2010	0.24	0.44	0.70	0.85
2016	0.33	0.56	0.83	0.94
		US-Born Hispanic[b]		
2000	0.14	0.28	0.52	0.70
2005	0.17	0.33	0.60	0.77
2010	0.19	0.37	0.65	0.82
2016	0.26	0.48	0.78	0.92

Notes. Estimates produced using population counts of every census tract and the distance from tract each centroid to its nearest Community Health Center.

[a] Data source is the Longitudinal Tract Database, using 2000 and 2010 Censuses and American Community Survey data.

[b] Data source is the NHGIS using 2000 Census data, and merged 2005-2018 American Community Survey data.