

# Immigrant Sanctuary or Danger

## Health Care and Hospitals in the United States

*Beatrix Hoffman*

■ **ABSTRACT:** Hospitals have for centuries been considered safe havens for immigrants and people on the move. However, immigrants and migrants who seek health care have also been targeted for exclusion and deportation. This article discusses the history of how hospitals and health care facilities in the United States have acted both as sanctuaries and as sites of immigration enforcement. This debate came to a head in California in the 1970s, when conservatives began attacking local public health facilities' informal sanctuary practices. Following the California battles, which culminated in Proposition 187 in 1994, immigrant rights movements have increasingly connected calls for sanctuary with demands for a right to health care.

■ **KEYWORDS:** activism, health care, hospitals, Proposition 187, sanctuary, undocumented

On 24 October 2017, ten-year-old Rosa Maria Hernandez, who suffers from cerebral palsy, was detained by Border Patrol officers as she recovered from surgery in a Texas hospital. Her case attracted intense media attention and a lawsuit from the American Civil Liberties Union, not only because of her youth and her medical condition, but also because US immigration authorities had previously avoided detaining individuals in hospitals and health facilities (N. Rodriguez 2017). Since the Trump regime began its immigration crackdown, ICE (Immigrations and Customs Enforcement) and CBP (Customs and Border Protection) agents had increasingly approached or entered areas previously designated “sensitive locations” or “safe zones,” including hospitals.

In response to this and other cases in which undocumented immigrants were detained while seeking health care, two physicians and an ACLU attorney published a piece in the *Journal of the American Medical Association* calling for “sanctuary hospitals.” The authors argued that hospitals should do more “to protect the rights of immigrant patients,” including establishing clear policies on privacy and to what extent the hospital will cooperate with immigration authorities. They wrote: “There has always been a sense among many health care professionals that medicine represents a higher calling, with a commitment to serve those who are underserved, protect those who are less fortunate, and provide care, particularly emergency services, regardless of the ability of an individual to pay for those services or their immigration status” (Saadi et al. 2017).

What is the US hospital for immigrants—a sanctuary from persecution or a place where a child recovering from surgery may be targeted, handcuffed, and separated from her parents? Throughout the past century and a half, US hospitals and other health facilities have served as both: as refuges and as locations for immigration enforcement. The idea that health professionals' “higher calling” compels them to protect immigrants has repeatedly been in tension with the



notion that immigrants seeking health care should be identified and removed as threats to the US welfare state and health system.

This article begins by sketching the history of US health care facilities' roles in both sanctuary and in immigration enforcement. The ethical obligations of hospitals and clinics to provide care have sometimes led them to ignore immigration status and even to refuse to cooperate with immigration authorities. But health facilities have also flagged immigrant patients as "public charges" and reported them for repatriation and deportation. Providers that ignore immigration status have mostly done so on an ad hoc basis, and such informal sanctuary protections could crumble under pressure from governments to identify and exclude "undeserving" immigrants, particularly at times of intensified economic anxiety and nativism.

Hospital practices of treating or reporting immigrants did not come to national attention until the 1970s, when US health care costs exploded at the same time that undocumented immigration was increasing. Some politicians sought to link these two phenomena by blaming immigrants for burdening local health and welfare services. In Los Angeles, California, the county's informal policies of providing care without questioning immigration status were forced into the open by a conservative backlash that culminated in the 1994 campaign for Proposition 187, a state anti-immigrant law that intended to ban education, health, and social services to the undocumented. This article shows how the volatile debates in California on immigrant health care utilization between 1970 and 1995 forced providers and activists to explicitly defend hospitals and clinics as sites of sanctuary. As challenges to immigrant health access continued in the 2000s, from state-level restrictions to the Affordable Care Act's exclusion of undocumented people, social movements have increasingly argued that sanctuary protections are inseparable from a right to health care for immigrants.

### Some Thoughts on the Origins of Immigrant Sanctuary in Hospitals

The first hospitals in the Western world were associated with people on the move. Monks founded these institutions in early Christian Europe both to heal the sick and, as the word *hospital* itself shows, to provide hospitality to travelers. (The words *hostel* and *hotel* also share the same root, the Latin *hospes* meaning guest or host.) The special emphasis on welcoming traveling people stemmed from biblical calls to take in the stranger (such as Matthew 25:35). When Saint Benedict called for the founding of hospitals in the sixth century CE, he instructed, "let all guests who arrive be received like Christ for He is going to say 'I came as a guest and you received me'"<sup>1</sup> (Cilliers 2002). According to historian Guenther Risse, mobile populations further spurred the growth of the hospital system: social and economic upheavals in late eleventh- and twelfth-century Europe led to "the presence of thousands of refugees crowding the new cities" and encouraged the establishment of lay hospitals alongside the traditional monasteries (Risse 1999: 99, 109).

But a tension between hospitals' welcome and rejection of the stranger developed early on. In the Middle Ages, communities responded to the spread of leprosy and plague by establishing mechanisms for exclusion, segregation, and confinement of people suspected of carrying disease, especially traveling merchants and sailors. In Venice during the plague epidemic of 1348, public health officials designated an island off the city as a detention center for "potentially infected goods, ships, and persons." The word *lazaretto*, as the new quarantine stations were called, came from *nazaretto*, meaning a place for pilgrims (Risse 1999: 220, 202). The close relation of these two words captures how strangers and travelers could be seen as both especially deserving of welcome and care, and as dangerous threats to the public health.

As urbanization and economic change in the early modern era led to uprooted populations and structural poverty, distinctions arose between the so-called “deserving” and “undeserving” poor. In religious doctrine and government policy, the undesirable vagrant and tramp replaced the worthy stranger, and transient people became objects of scorn rather than welcome. These transformed attitudes were reflected in the Elizabethan Poor Law (1601), which institutionalized residency requirements so that newcomers would not be eligible for local relief (Risse 1999: 216–217; Wickenden 1956). Poor law notions shaped the early welfare system in colonial America, where towns and villages could expel travelers or new arrivals attempting to utilize public relief, including medical services.

## Hospitals and Immigrants in the United States

Hospitals in the early United States were viewed as a place of last resort; affluent and “respectable” people would not go near them and were instead visited by physicians in their own homes for medical treatment. In large US cities, hospitals became associated with poor immigrants, especially the Irish. By the mid-nineteenth century, historian Charles Rosenberg notes, “the rapidly growing number of poverty-stricken immigrants created something approaching a crisis in American hospitals” (Rosenberg 1987: 41–42).

The presence of large numbers of immigrant patients worsened the hospitals’ unsavory reputation. In perhaps the most dramatic example, in 1858 angry citizens burned down the marine hospital on Staten Island that housed new immigrants with contagious diseases (Hirota 2017: 126). However, there is some evidence that immigrants may also have found sanctuary in hospitals. In 1913, officials at Bellevue Hospital in New York City complained that large numbers of patients were being admitted “a day or less” after their arrival in the United States, “meaning their illness had been overlooked” by immigration authorities, at both their original ports of embarkation and the Ellis Island medical inspection station. Such immigrants were supposed to be expelled from the country, but, despite the complaints, Bellevue only cooperated in deporting seven patients that entire year (Oshinsky 2016: 187).

Immigrants may have been segregated and stigmatized, but urban hospitals were still mostly institutions of inclusion for many European immigrants entering via East Coast ports. The story was very different in the western United States, where hospitals completely excluded Chinese immigrants and Chinese Americans due to their race. This exclusion was particularly egregious because immigrants arriving from China were required to pay a head tax to support public hospitals in California—hospitals that they were not allowed to use. When Chinese residents of San Francisco in 1888 petitioned to build their own hospital outside the city limits, their application was refused, according to historian Nayan Shah, “on the grounds that the Chinese intended to use ‘objectionable Chinese systems of medical treatment,’ which would make a Chinese Hospital a grave ‘nuisance’ to the rest of the city” (Shah 2001: 71). Finally, in 1925, the nation’s first Chinese Hospital opened in San Francisco’s Chinatown, an emblem of community resilience but also of continuing segregation and discrimination (Hom 2014).

Immigrants seeking health care were stigmatized for their supposed tendency to disease and for racial difference, but also for economic reasons. The notion that immigrants “likely to become a public charge” or dependent on welfare, relief, and other public services should be refused admission or deported dates back to the colonial era. In the 1830s, historian Hidetaka Hirota has found, it became a deportable offense at the state level, as New York and Massachusetts tried to reduce the influx of Irish immigrants. What became known as “public charge doctrine” was then incorporated into federal law in the Immigration Act of 1882 (Hirota 2017).

Public charge doctrine linked immigration to welfare and health policy by utilizing exclusion and deportation as avenues for minimizing public expenditures.

Sickness could be a justification for deportation, as in the Bellevue example above, but “likely to become a public charge” was a much more frequent reason that hospitals became involved in immigration enforcement in the twentieth century. In the early 1900s, public hospitals were supposed to identify “alien” dependent patients who could not prove that they had been healthy when they arrived in the United States or whose “presence in a hospital may tend to show that [they were] likely to become a public charge at time of entry” (Wickersham Commission 1931).

But not all hospitals followed this policy. A 1931 federal report found uneven enforcement of the reporting requirement: hospitals “may or may not report the alien to immigration authorities. Some are anxious to have aliens taken off their hands, or are compelled by law to make reports, but the cooperation here is even less uniform than that of State and local penal institutions,” which were also required to report public charge cases. The report also noted that private hospitals were even less likely than public ones to report “alien” long-term patients (Wickersham Commission 1931: 53).

In her monumental study *Three Worlds of Relief*, the sociologist Cybelle Fox found regional differences in welfare authorities’ willingness to enforce the public charge doctrine before the 1930s. In San Diego and Los Angeles, private charities, public health departments, and hospitals often “cooperated with the local immigration inspector in locating deportable aliens,” but the story was different in Cook County, Illinois: some immigrant patients were reported by the long-term care facilities in Oak Forest, but “practically none from the Cook County Hospital.” Indeed, Cook County provided a graded hospital fee scale so that aliens who sought public medical care but did not want to risk deportation as a public charge “may pay their way if able” (Fox 2012: 135–136).

From her analysis of hospital cooperation with immigration authorities in the 1920s, Fox surmises that resistance to cooperation—what we might call sanctuary—was regional; it was more common in the Midwest and Northeast than in California, where it was almost unheard of. Utilizing national statistics on deportation, Fox goes on to show that people of Mexican origin were far more often deported as public charges than any other single nationality (Fox 2012: 153). She concludes that California health authorities so willingly joined in the immigration regime because their immigrant “problem” was Mexican, not European.

Mexico was not included in the numerical caps imposed on immigration in the 1924 Immigration Act. This was not because restrictionists reviled Mexicans less than other nationalities, but because of the continuing need of Southwestern agriculture and industry for Mexican labor. Crucially, Mexicans were seen as both a desirable labor force and also as eminently “deportable”—easy to access in times of need and easy to get rid of in times of scarcity (Molina 2014; Ngai 2003).

During the mass deportation and repatriation drives of the Great Depression, in which an estimated one million people of Mexican origin (nearly half of whom were citizens) were forced to leave the United States, hospitals and health officials played a central role. The historians Emily Abel and Natalia Molina have demonstrated how public health authorities in Los Angeles targeted Mexicans for repatriation both because they were accused of having contagious diseases, and because they attempted to utilize public health services for themselves or their families. Both historians describe long-time Mexican residents of Los Angeles forced onto repatriation trains or driven to Mexico in cars for allegedly suffering from tuberculosis and venereal disease. Mexican-origin residents were also targeted for public charge violations when they sought medical care for any condition. Molina found that Los Angeles welfare authorities actually positioned deportation officials in the county hospital to pounce on families waiting for care (Abel 2004; Molina 2006: 136).

When immigrants and Mexican-origin residents and citizens sought health care during the Great Depression, they became deportable as public charges. When the United States joined World War II and the unemployment crisis was replaced by a massive labor shortage, Mexican workers again became desirable. The “bracero” guest worker agreement between Mexico and the United States brought 4 million Mexicans to work in industry and especially agriculture from 1942 to 1964. Braceros (as these workers were known) received medical examinations and some health care coverage as part of their labor contracts (Wiest 1966).

Although braceros had a right to medical care on paper, their attempts to claim that right could also lead to deportation. In a 1945 incident discussed by the historian Chantel Rodriguez, a bracero named Felix Tapia Montana was injured while working for the Pennsylvania Railroad and then received a large bill for his hospital care. Montana went on a one-man strike and began to organize other workers to protest egregious deductions for medical care from their paychecks—care that was supposed to be covered by bracero health insurance they had already paid for. When the protest was reported in New York newspapers and came to the attention of the Senate Committee on Education and Labor, the Pennsylvania Railroad unilaterally ended Montana’s contract, and he was repatriated to Mexico shortly afterward. Such incidents indicate that labor organizing and health rights activism have been included alongside contagion and being a public charge as grounds for deportation/repatriation related to health care (Molina 2014; C. Rodriguez 2018).

### **From “Don’t Ask; Don’t Tell” to Undocumented Health Rights: California, 1970s–1990s**

The 1965 Immigration and Nationality Act ended the admissions quota system based on national origin. The law was intended as a civil rights measure, but by imposing numerical caps on legal immigration from Mexico and other major sending countries, it ushered in a new era of mass undocumented immigration, primarily from Latin America and Asia (Ngai 2003). By the 1970s, a permanent class of undocumented people was growing in many regions of the United States.

This was especially evident in Los Angeles, California. Although most undocumented communities throughout the country remained in the shadows, their numerical significance in southern California, as well as the region’s large population of long-term residents and citizens of Mexican origin, made Los Angeles a flashpoint for more explicit debates over immigrant rights. One of the most public discussions of a right to health care for undocumented immigrants and of the role of public health institutions in immigration enforcement emerged in Los Angeles County. The county, which had been the site of hospital-based repatriations in the 1930s, became a center of medical provision to the undocumented in the 1970s and 1980s.

California was also the birthplace of a burgeoning conservative movement against local taxation (McGirr 2002). In 1976, complaints began to emerge about Los Angeles County directing benefits to “illegal aliens” and that this practice was becoming a burden on taxpayers. County Supervisor Pete Schabarum led the charge by releasing a statement that “the county was providing \$10.8 million in health services to illegals [*sic*].” The elected Board of Supervisors, which governed Los Angeles’s public health facilities, was divided on this issue. In a memo to Supervisor Edmund Edelman, an aide argued that Schabarum’s figure was only an estimate and an inaccurate one, since the \$10.8 million did not include funds recovered by the county for providing the services, whether through individual payment or other means. The aide also noted that “illegal” immigrants both paid taxes and generally avoided using health services “because they fear detection and deportation” (Jesus 1976). Although this was an argument that the undocu-

mented were not a burden on local health services, it was not yet a justification for deliberately providing care to this population. Over the next two decades, continuing attacks from anti-immigrant politicians would force county officials to more openly defend their policy choices.

Although patients did have to undergo interviews for eligibility, Los Angeles County health facilities did not require any information about their immigration status. County hospitals and clinics did not advertise their openness to noncitizens, but in practicing what amounted to a “don’t ask; don’t tell” policy, they served as de facto havens for immigrants needing health care. But in 1979, Los Angeles Chief Administrative Officer Harry Hufford pushed for a new rule that would require all uninsured patients to apply for Medi-Cal (California Medicaid, the state-federal health insurance program for the poor) before receiving care at a county facility. Since the Medi-Cal application included verifying citizenship or immigration status via an “Alien Status Verification Form,” this measure was clearly directed at undocumented immigrants.

For the first time, county officials were forced to publicly acknowledge and defend immigrant inclusion. Supervisor Edmund Edelman, a progressive who represented heavily Latino parts of East Los Angeles, attacked Hufford’s proposal as a “back door attempt to deny care.” Community groups, the Los Angeles County Bar Association, and even the local branch of the Red Cross spoke out against the measure. Still, a newly elected county board with a conservative majority implemented the new requirement in 1980 (Cox 1985).

Local reactions to this reflected the increasingly polarized debate about immigration and public services in California. A Los Angeles woman wrote to the Board of Supervisors that “illegal alien people . . . are not entitled to these services for which we *Americans* are paying through our taxes. These aliens pay no taxes, do no work.” A North Hollywood couple sent Pete Schabaram their “heartfelt gratitude” for “the board’s action to cut off medical treatment for illegal aliens.” “This is a good beginning in reducing the tax burden,” noted a couple from Encino, and “will also discourage the influx of the illegals” (A. Hoffman 1981; Sego 1981; Hammer 1981).

But Angelenos also wrote to the Board opposing the Medi-Cal application requirement. The most frequent comment in these letters emphasized the public health considerations of denying health services to immigrants: “The attitude of your fellow Councilmen is outrageous. Don’t they realize the danger of neglecting the poor and the sick? Epidemics start that way!” “Your support of the poor will help contain and protect the whole population against dreaded, contagious diseases.” Letter writers noted that not asking about immigration status served the public health interest: “These unfortunate workers fear being deported—hence will not seek free care.” “The health of everyone in Los Angeles is in jeopardy if we scare any group out of seeking medical attention when it is necessary.” Some argued that immigrants deserve care because they are “hard working people, respectable.” And, a few referred to broader human rights grounds: “These people . . . are human beings subject to the ills that befall us.” “I hope that you will still be able to stay the slaughter of innocents” (Gorin 1981; Kagan 1981; Sperling 1981; Moore 1981).

These letters arrived in Supervisor Kenneth Hahn’s office in a bundle, indicating coordination among opponents. In fact, the supervisors’ action was backfiring: the new Medi-Cal requirement was sparking a local movement on behalf of immigrants’ right to access medical care. Los Angeles community organizations, including free clinics, legal aid attorneys, service workers and teachers unions, and Latino civil rights groups, were banding together in a coalition called the County Health Alliance (CHA) (Muller and Ventriess 1985: 83).

The CHA, led by community activist Carol Jacques, made several arguments in opposition to the Board of Supervisor’s policy. They tried to refute claims that services to the undocumented were a major burden on county budgets. The CHA circulated a statement from the Director of LA County Health Services that “it is unlikely that any overall savings would be achieved by eliminating non-emergency care for undocumented aliens and in fact such a prohibition could

increase total costs significantly” because “the county would still have to care for the patients when their conditions become emergent and much more expensive to treat” (Jacques 1981). “[T]he Alliance believes it is unconscionable for the government or people of Los Angeles County to use undocumented immigrants as a scapegoat for the economic problems faced by the Department of Health Services,” the group announced in a press release. “The assumption that these people are a drain on public resources is a malicious myth” (County Health Alliance 1981).

The CHA also argued that the Medi-Cal proposal would hurt both public health and individuals’ right to care. One member organization, the Mexican American Bar Association, announced: “Access to health care is a fundamental human right in our society. The proposed changes, which entail reporting of a person’s status to the Immigration Service prior to rendering service, would serve to deny this right through intimidation” (Valadez 1981). According to the *LA Times*, the CHA position was that, if forced to report their status, “many sick immigrants will be too frightened to seek health care.” Because of this double-barreled threat, “We’re turning to the courts,” CHA attorney Katharine Krause told the *Times* (Merl and Merina 1981).

In June of 1981, the County Health Alliance brought a lawsuit against the Board of Supervisors for their new Medi-Cal policy. Superior Court Judge Richard Schaur immediately issued an injunction blocking the county from “implementing or administering a requirement or policy that undocumented aliens complete an Alien Status Verification Form (‘CA-6 form’) or otherwise provide information to the United States Immigration and Naturalization Service as a condition of receiving health care services at hospitals or clinics operated by the County of Los Angeles” (Gates 1984). The judge’s reasoning rested not on public health grounds, but on the CHA’s additional argument that California’s state legal code required counties to serve as the provider of last resort for all “indigent residents” (Cox 1985). In the judge’s interpretation, income, not immigration status, was the requirement for provision of public medical care.

The injunction went into effect right away, barring health facilities from requiring patients to fill out the form. The legal case itself carried on for another four years, until the Board of Supervisors agreed in 1985 on a settlement that promised the county would continue to provide care at hospitals and clinics without asking about immigration status. But Schabarum, the conservative supervisor, told a journalist, “This is not the end of it” (Cox 1985).

The County Health Alliance’s victory reflected Los Angeles’s position as a center of increasingly effective immigrant rights activism. It represented a convergence of the liberal municipal politics that had given the city its first black mayor a decade earlier—and brought progressives onto the county Board—with a vibrant Chicano movement, which ranged from mainstream civil rights organizations like the Mexican American Legal Defense and Educational Fund to more militant student and youth groups. As historian David Gutierrez has shown, the Chicano politics of the 1960s, which was based in non-immigrant Mexican-American communities, by the 1980s increasingly adopted immigrant rights as central to its efforts against racial discrimination (Gutierrez 1995: 189–199).

Nor was Los Angeles new to the notion of sanctuary; its police had been banned from asking about immigration status since 1979 (Felker-Kantor 2018). Los Angeles in the 1980s was also a major destination for refugees and asylum seekers from Central America and a hotbed of the church-based sanctuary movement. The Salvadoran Sanctuary group *El Rescate* opened its own neighborhood health clinic, *Clinica Oscar Romero*, in 1983. But the rhetoric of sanctuary groups initially focused on the vulnerability of refugees fleeing US-sponsored violence, more than on promoting access to services for the overall undocumented population (Chinchilla et al. 2009).

Throughout the 1980s, the undocumented population in the United States continued to grow, with California becoming home to half of the nation’s undocumented people (an estimated

1.3 million), many of whom found work in the state's large number of low-wage service jobs (Public Policy Institute 1996; Ramos 2017). In 1986, the new federal immigration law known as IRCA (Immigration Reform and Control Act) criminalized the hiring of undocumented workers, while also creating an amnesty program for some immigrants. The volatile politics of immigration converged in California in 1994, when Republican Governor Pete Wilson backed a statewide anti-immigrant referendum known as Proposition 187. The battle over Proposition 187 would prove to be a turning point in the immigrant rights movement in general and the immigrant health rights movement in particular.

Proposition 187, also known as the "Save Our State" initiative, was the brainchild of long-time conservative activists and state legislators who argued that benefits to the undocumented were bankrupting California. Proposition 187 intended to deny all state-funded public services, particularly education and health care, to undocumented immigrants. It would ban public health agencies from providing any type of non-emergency care to the undocumented, and also require hospitals and clinics to report immigrants seeking care.

Proposition 187 received a majority of public support in polls, but also led to an outcry over its draconian approach. Opponents of Proposition 187 focused primarily on the denial of public education to immigrant children, but the initiative's direct attack on access to health care also forced providers to take a more public stand than ever before, and some for the first time. The indomitable Los Angeles County health officials were now joined by major medical, nursing, and public health organizations, as well as existing immigrant and civil rights groups, in condemning the proposition. Among the medical groups registering their opposition were the California Medical Association, California Nurses Association, California Association of Hospital and Health Systems, and the California chapter of the American College of Emergency Physicians (Green 1994).

Health care providers' most frequent objections to Proposition 187 were on public health grounds. Dr. Thomas Peters, Chairman of Bay Area Health Officials, declared, "The initiative would have us turn patients away from clinics treating tuberculosis, HIV/AIDS, sexually transmitted diseases, and other communicable conditions." In their appeals to public health, Proposition 187 opponents did not emphasize immigrants' rights to access, but rather the threat to the general public posed by undiagnosed and untreated disease. The same pamphlet also noted that immigrants "handle the food supply," so denying them immunizations and health care could "spread costly and preventable communicable diseases across California" ("Vote No" n.d.).

Medical providers also objected to being required to identify undocumented immigrants. Opponents cried that Proposition 187 "put[s] Californians in service of Big Brother" and "turns doctors, nurses and teachers into INS (Immigration and Naturalization Service) agents." According to an editorial in the *Sacramento Bee*, "every teacher, social worker and nurse, the very people whose work depends so much on trust, would become a government snoop" (Schrag 1994; "Vote No" n.d.).

As massive street protests against the proposition erupted, some opposition language began to acknowledge health care and other public benefits as a right of immigrants themselves. The leaders of a 150,000-person march in downtown Los Angeles wrote of Proposition 187, "this fundamentally unjust measure, aim[s] to deprive families of the most critical services that help to achieve and sustain a higher quality of life: education and health care" (Cedillo and Gutierrez 1999). Protest signs reading "Protest Prop 187-It Kills" drew attention to the potentially dire consequences of the denial of medical care (Protest Photo n.d.). Residents of Las Vegas, New Mexico, signed a petition declaring "We, the undersigned, are opposed to Proposition 187 in California because it denies the basic rights of health care and education to immigrants" (New Mexicans Against Proposition 187 n.d.). The battle over Proposition 187 became the first



nationwide social movement to explicitly defend access to health care for the undocumented as a human right.

Despite the protests, some of which were the largest in California since the Vietnam War, Proposition 187 passed in a statewide referendum with 59 percent of the vote on 8 November 1994. The law was immediately challenged in court, but California public health agencies were concerned that patients would start to avoid clinics and hospitals out of fear. In the absence of immediate implementation, some local health authorities declared that they would continue providing care as before. Just days after the law passed, the City and County of San Francisco issued an announcement that “The Department of Public Health is not enforcing Proposition 187 at this time,” and urged patients to “PLEASE ATTEND YOUR REGULARLY SCHEDULED CLINIC APPOINTMENTS” (Department of Public Health 1994).

Providers seized the uncertainty about Proposition 187’s implementation as an opportunity to continue providing health care. They were further emboldened when temporary court injunctions stopped enforcement of the education, health, and social services provisions of the law (Coalition for Immigrant and Refugee Rights 1994). Finally, in March 1998, most of Proposition 187 was ruled unconstitutional by a US District Court on the grounds that immigration legislation was a federal, not a state matter. But this was only a partial victory for rights advocates. The 1996 federal welfare reform law implemented several measures curtailing rights to social and medical services, including a five-year ban on legal immigrants’ access to public health insurance. And subsequent state-level initiatives would similarly try to restrict medical and other services available to immigrants, including in Arizona in 2010 and Alabama in 2011.

## Hospitals as Sensitive Locations and as Deportation Stations

As the undocumented population continued to increase in the 1990s, immigrants’ use of health care continued to be a point of contention. The right to emergency room access in the United States had become law in 1986 with the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA). Although not explicitly created to include noncitizens, the law specified that the right to emergency care applied to “all” (Hoffman 2006). The legal valorization of the right to emergency care helps explain why state-level anti-immigrant laws, even Proposition 187, exempted this type of care.

While there is little evidence that EMTALA encouraged increased use of hospital emergency care—US emergency rooms had served as an unintended safety net for the poor and uninsured since the 1960s—anti-immigrant groups and politicians argued that immigrants’ use of emergency rooms was creating an economic crisis for hospitals and even forcing some to shut down. Municipalities, counties, and private hospitals, especially in border areas, jumped on this bandwagon as a way of demanding federal compensation for health care they provided to immigrants. The issue came to the attention of Congress, which responded by creating new programs within Medicare and Medicaid to reimburse hospitals that provided a “disproportionate share” of care to the indigent, including the undocumented, as well as a program called Emergency Medicaid for the same purpose (Gusmano and Thompson 2012).

By the early 2000s, hospitals had become aware that undocumented people could not legally be turned away from emergency rooms. Immigrants could also legally receive care in federally-funded health clinics. Despite these small avenues for access and the new programs for provider reimbursement, some US hospitals engaged in an egregious practice known variously as patient dumping, hospital deportation, or medical repatriation. In one 2012 example, a construction worker fell off a roof in Chicago and sustained catastrophic injuries and was taken to

nearby Advocate Hospital. Realizing he required long-term, expensive care, the hospital chartered a private plane to fly him back to Mexico, where he died. Some cases such as these received public and media attention, including a *New York Times* exposé of hospital deportations in 2008. There is even a private company known as Mexcare, founded in 2001, that contracts with US hospitals to repatriate sick or injured immigrants back to their home countries, often against their will. But, as immigration attorney Lori Nessel notes, “Because the practice of medical repatriation takes place in the shadows without any governmental regulation, it is impossible to know how many patients are unwillingly deported by U.S. hospitals” (Nessel 2012; Sontag 2008).

Hospitals came to public attention as potential sites of immigration enforcement not due primarily to medical repatriations, however, but during the fallout from stalled immigration reform during the Obama administration. In 2010, a Senate filibuster killed the DREAM Act (Development, Relief, and Education for Alien Minors Act), a decade-old proposal that would have provided a path to citizenship for undocumented immigrants who had entered the country as minors. Obama had supported the DREAM Act but also pursued a vigorous enforcement policy, earning him the moniker “deporter in chief.” Ahead of the 2012 elections, Obama increasingly responded to pressure from immigrant rights and youth organizations and began pursuing stopgap measures that could be implemented via federal agencies and executive orders, bypassing the recalcitrant Congress (Johnson 2011). These measures, which culminated in DACA (Deferred Action for Childhood Arrivals), included a new policy on “sensitive locations” for immigration enforcement.

On 24 October 2011, US Immigrations and Customs Enforcement (ICE) issued a memorandum to its field office directors and agents entitled “Enforcement Actions at or Focused on Sensitive Locations.” The memorandum advised that ICE enforcement actions should avoid “sensitive locations,” including schools, churches, and hospitals. (It did not mention clinics or other health care facilities.) ICE agents could enter such locations for enforcement activities under “extraordinary circumstances” only. The memo provided two somewhat different rationales for the policy: immigration enforcement might disrupt the operation of these institutions, and these institutions assisted groups requiring special care or assistance, specifically children, people with disabilities, pregnant women, or victims of crime or abuse. A similar memo was issued to agents of US Customs and Border Protection in 2013.

These were internal memoranda, more advisory than enforceable, so it is not surprising that when Trump came into office, enforcement actions that violated the sensitive location policy began almost immediately. In February 2017, several undocumented men were taken into custody at a winter warming center run by a church near Washington, DC, and ICE agents removed Sara Beltran-Hernandez, a 24-year-old asylum seeker from El Salvador, from a Texas hospital where she was receiving treatment for a brain tumor and returned her to immigration detention (Gass 2017).<sup>2</sup> Rosamaria Hernandez’s detention took place a few months later. The pendulum had swung away from recognizing hospitals as sanctuaries, and immigrant rights activists prepared for another round of battle.

## Activism for Health Care Sanctuaries and Immigrant Health Rights

Starting with the opposition in the 1980s and 1990s to anti-immigrant proposals in California, hospital sanctuary transformed from an informal, hidden practice to a social movement demand and sometimes an explicit policy. Since 1985, over five hundred US municipalities have declared themselves Sanctuary Cities, in which city employees, including health care workers,

are enjoined from acting as immigration enforcers (Aboii 2016; Mancina 2019). In more conservative regions, when legislators have passed state immigration laws including requirements that health providers inquire about citizenship, challenges from immigrant rights groups have been able to weaken or invalidate such laws (National Conference of State Legislatures 2012).

Health care sanctuary in the United States is complicated by the context of the health system in which no one, including citizens, has an enforceable right to medical care beyond emergency stabilization. By insisting on a right to care for immigrants, sanctuary activism necessarily includes a critique of the exclusionary healthcare system. This was especially evident after passage of the Patient Protection and Affordable Care Act (ACA or Obamacare) in 2010. Under pressure from Republicans and Conservative Democrats, President Barack Obama agreed to exclude undocumented immigrants from buying into the new subsidized insurance plans created by the law. Latino civil rights organizations protested this new exclusion and, in some states, activists pushed for local expansions of the ACA to the undocumented.

In Chicago, for example, immigrant rights groups have pursued a two-pronged strategy to address health and sanctuary protections for the city's large population of undocumented people. The Illinois Coalition for Immigrant and Refugee Rights partnered with providers in 2017 to successfully pressure Cook County to create a new program, Healthy Communities, that provides basic health coverage, a "medical home," and a health ID card to low-income patients regardless of immigration status (hearkening back to "don't ask; don't tell" by subsuming the category of undocumented within the category of low-income county resident). But Chicago health activism is going beyond silence to noncompliance and open advocacy of sanctuary. Rights groups have developed programs to train hospital staff to turn away ICE agents who do not show a warrant and advertise their welcoming policies to immigrant patients. Nurses with the National Nurses Organizing Committee went door to door in Chicago neighborhoods to inform families that county health facilities were "safe for all individuals to attend." In early 2018 advocates formed the Illinois Alliance for Welcoming Healthcare, bringing together hospitals, clinics, and public health agencies with immigrant rights, disability, and civil rights groups to enforce Chicago's sanctuary city protections in health care institutions (Beese 2017; Illinois Alliance 2018).

All these activities rest on the notion that sanctuary protections and health rights are inextricably connected. The COVID-19 pandemic has further laid bare how draconian immigrant enforcement practices become threats to individual and public health. US immigrant detention facilities have long been targets of activists for denying appropriate medical care. In 2020, these facilities are now epicenters of COVID infection and preventable deaths. The United States has deported infected immigrants, furthering the spread of the pandemic in Central America and elsewhere (Kerwin 2020). A recognition that sanctuary protections and immigrant rights help protect public health, as activist movements have argued since the 1980s, could have prevented some of this appalling tragedy.

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■ **BEATRIX HOFFMAN** is Professor of History at Northern Illinois University and the author of *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (2001) and *Health Care for Some: Rights and Rationing in the United States since 1930* (2012) and co-editor with Rachel Grob, Mark Schlesinger, and Nancy Tomes of *Patients as Policy Actors* (2011). Her current research project is a history of access to health care for immigrants and migrants in the United States. E-mail: beatrix@niu.edu

## NOTES

1. There are also numerous references to exile, welcoming the stranger, and refugees in the Old Testament; for one list, see United Church of Christ, “Biblical References to Immigrants and Refugees,” [https://www.ucc.org/justice\\_immigration\\_worship\\_biblical-references-to/](https://www.ucc.org/justice_immigration_worship_biblical-references-to/).
2. Beltran-Hernandez survived and was granted a temporary stay of deportation (CBS New York. “Brain Cancer Patient Facing Deportation Granted Temporary Stay.” 17 September 2017. <https://newyork.cbslocal.com/2017/09/19/cancer-patient-temporary-stay/>). Her case was also taken up by Amnesty International; “USA: Detained Asylum Seeker Needs Medical Care,” 24 February 2017. <https://www.amnesty.org/en/documents/AMR51/5781/2017/en/>

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