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Beyond welfare reform: Reframing undocumented immigrants' entitlement to health care in the United States, a critical review

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ABSTRACT

This article addresses the main scholarly frames that supported the deservingness of unauthorized immigrants to health benefits in the United States (U.S.) following the passage of the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA), known as the Welfare Reform bill, in 1996. Based on a critical literature review, conducted between January 1997 and March 2011, this article begins with an analysis of the public health rhetorics that endorsed immigrants' inclusion into the U.S. health safety net. In this vein, the "cost-saving" and "the effortful immigrant" frames underscore immigrants' contributions to society vis-à-vis their low utilization of health services. These are complemented by a "surveillance" account that claims to protect the American public from communicable diseases. A "maternalistic" frame is also discussed as a tool to safeguard families, and particularly immigrant mothers, in their roles as bearers and caretakers of their American-born children.

The analyses of the "chilling" and the "injustice" frames are then introduced to underscore major anthropological contributions to the formulation of counter-mainstream discourses on immigrants' selective inclusion into the U.S. health care system. First, the "chilling effect," defined as the voluntary withdrawal from health benefits, is examined in light of unauthorized immigrants' internalized feelings of undeservingness. Second, an "injustice" narrative highlights both the contributions and the limitations of a social justice paradigm, which advocated for the restoration of government benefits to elderly immigrants and refugees after the passage of PRWORA. By analyzing the contradictions among all these diverse frames, this paper finally reflects on the conceptual challenges faced by medical anthropology, and the social sciences at large, in advancing health equity and human rights paradigms.

Introduction

The front page photo of a long line of elderly women standing outside the Immigration Office in New York City on a cold winter day, was one of those poignant images from the mid-1990s that told Americans that something was about to change. This snapshot, and many others taken at welfare offices, employment agencies, and community-health care centers, would become emblematic of the transformations that were to come. In August 1996, President Clinton signed into law the Personal Responsibility Work Opportunity Reconciliation Act or PRWORA (Public Law 104–193, 1996), a bill that symbolized the spirit of self-sufficiency and work ethic that should inspire both natives and the foreign-born. With the stroke of a pen, the 60-year-old federal cash assistance program, the Aid to Families with Dependent Children (AFDC) was terminated and replaced by a state-run competitive block-grant program (Cordero-Guzmán & Quiroz-Becerra, 2007; Marchevsky & Theoharis, 2006).

Until this point the U.S., like other industrialized nations, had held a long tradition of providing equal access to public assistance to both legal residents and citizens (Marchevsky & Theoharis, 2006). With PRWORA, the U.S. set a precedent for all other developed nations that guaranteed equal treatment to individuals in either category (Fix & Tumlin, 1997; Viladrich, 2011). Succinctly, the law divided all immigrants into two broad groups, qualified and nonqualified aliens, thus making citizenship a necessary condition for social and health entitlements. The timing of arrival also created a legal divide, allegedly designed to prevent immigrants from coming to the U.S. to take advantage of the country's welfare state system. Legal immigrants who arrived after August 1996 became ineligible for all means-tested federal benefits, including public health insurance and cash assistance, for the first five years of their

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residence in the U.S. (Okie, 2007). Consequently, many groups of legal immigrants qualified for as few welfare benefits as their undocumented peers with entitlement tied to date of arrival, length of residence, and the status of their progress to naturalization according to a cumbersome qualifying grid (Fix & Tumlin, 1997).

With the exception of emergency Medicaid, the law did not include provisions for undocumented immigrants. States that desired to grant benefits to this population not only would have to secure their own funding, but also pass their own laws to that end (Kaushal & Kaestner, 2005). Although undocumented immigrants had never been beneficiaries of means-tested programs prior to PRWORA, this bill clearly spelled out their ineligibility by making states, and not the federal government, explicitly accountable for the financial and logistic burden of providing services to them (Fix & Tumlin, 1997; Kullgren, 2003). In addition, the law significantly restricted the amount of uncompensated care available to the uninsured, including unauthorized immigrants (Kullgren, 2003). Finally, PRWORA removed a cash assistance program administered by local governments that had formerly served unauthorized immigrants (Angel, 2003).

PRWORA, along with other legal instruments (e.g., Proposition 187) marked a deep shift in the social portrayal of foreigners in the U.S., and raised the tenor of anti-immigrant rhetoric to the pinnacle of conventional wisdom (Newton, 2009). Proposition 187, a ballot initiative passed in California in 1994, denied unauthorized immigrants access to health and public education among other public services. Although this measure was found unconstitutional later on, it contributed to galvanize sentiments against unauthorized immigrants in the U.S.

Under the metaphor of the U.S. as a "welfare magnet," PRWORA aimed at discouraging immigrants from coming to this country for the purpose of taking advantage of America's tax dollars. Although the figure of the unworthy poor has had an infamous history in the U.S. welfare policy formulation, the notion of immigrants' undeservedness was now brought to fame with thousands of legal immigrants losing means-tested benefits (e.g., cash and housing assistance) and health coverage, including Medicaid. Unauthorized foreigners were then constructed as lawbreakers in both moral and judicial terms (see Cole, 2009). Not only were they now seen as entering the U.S. illegally but they were also given "criminal careers" framed on several grounds — their alleged counterfeiting of U.S. documentation (e.g., social security and resident cards), their working off-the-books and not paying taxes, and their use of government-funded programs and services, and thus unjustly benefiting from American taxpayers' contributions. The crystallization of this imagery sustained a neoliberal paradigm aimed at cutting services and at reducing the size of the government by transferring fiscal and administrative functions from the federal to the state level (Cordero-Guzmán & Quiroz-Becerra, 2007).

The study: background and main aims

A large body of anthropological and social science research has reckoned the impact of PRWORA in the overall retrenchment of the welfare state, amid the reign of neoliberalism in the developed world (see Coburn, 2000; Morgen & Maskosky, 2003; O'Connor, 2000). The welfare reform bill was passed at a time when corporate medicine sought to legitimate its hegemonic power via commercial contracts between the U.S. health system and those able to afford it (Rylko-Bauer & Farmer, 2002). The literature has examined pivotal issues concerning immigrants' health care in the post-welfare reform era — from the progressive loss in subsidized and primary care (Siddiqi, Zuberi, & Nguyen, 2009), to the worsened health of immigrant children (Kalil & Crosby, 2010) and immigrant women's increasing rates of depression (Jagannathan, Camasso, & Sambamoorthi, 2010), to rising levels of poverty among immigrant families (see Newman, 2001). Furthermore, an ample tradition in critical medical anthropology has addressed the role of political-economic forces in shaping the distribution, management and experiences of illness among immigrants and other vulnerable groups. This literature has underscored the increased risk for disease rooted in substandard living and exploitative labor conditions, inadequate nourishment and social stressors (Farmer, 1997; Ho, 2004).

This paper is drawn from a growing body of work in medical anthropology that reckons the complex meanings of "illegal" immigration within an interdisciplinary framework (see Castañeda, 2009; Chavez, 2004; Willen, 2007, 2011). Still, as noted by Willen (2012a) the theme of deservingness, although central to the constructions of illegality and rights, has remained an underinvestigated topic in the scholarly literature. Therefore, more research is needed on the scholarly deployment (and impact) of discursive frames that portray immigrants as either worthy or undeserving of health benefits in the U.S. The analysis that follows delves into one of this volume's key questions that inquires on the ways in which welfare state retrenchment, fed by neoliberal paradigms, has influenced scholarly and public discourses on deservingness. To that end, the main goal of this paper is to shed light on the scholarly narratives which, in the aftermath of welfare reform, promoted the inclusion of vulnerable immigrants (uninsured and unauthorized) into the government safety net. Although arguments supporting immigrants' exclusion are the most publicized consequence of this piece of legislation, much less is known about the social production of discursive frames that support, either wholly or selectively, unauthorized immigrants' inclusion into the health safety net, amid their rights for health care, in the U.S.

This article begins with the presentation of the study's methods, followed by a summary of framing theory as a conceptual tool for understanding the scholarly production on immigrants' deservingness reckoned in the aftermath of welfare reform. This is further developed through the examination of main public health frames that endorse unauthorized immigrants' access to health care in the U.S., based on "cost-saving," "effortfulness," "surveillance" and "maternalistic" tropes. The analysis of the "chilling" and the "injustice" frames are then introduced to underscore main anthropological contributions to the formulation of counter-mainstream narratives. Finally, the paper offers a reflection on the potential advantages of framing theory in medical anthropology vis-à-vis the challenges this discipline, and the social sciences at large, faces in advancing social justice and health equity paradigms.

Methods

This study is based on a qualitative analysis of the social science and the public health literature on the effect of the U. S. Welfare Reform (PRWORA) on immigrants' health care after 1996. Literature searches, from January 1997 to March 2011, were conducted via the National Library of Medicine (PubMed and Medline Plus) databases maintained by Hunter College and Queens College, and the broader City University of New York (CUNY) online libraries. The selection criteria focused on articles that either directly dealt with the impact of welfare reform on immigrants' health status and outcomes, or that indirectly addressed its effects (e.g., changes in Medicaid eligibility).

The search was conducted on major medical and social sciences databases including (in alphabetical order): Anthropological Index Online, Anthrosource, CINAHL, CUNY databases, JSTOR, Medline, Social Sciences Citation Index, Social Sciences Full Text, and Sociological Abstracts. The following key terms were utilized:

"access to health care," "deservingness," "expenditures," "framing," "health rights," "health services," "immigrants," "legal status," "managed care," "Medicaid," "PRWORA," "undocumented," "welfare reform." These terms were combined with others that emerged during the search (e.g., "Hispanics/Latinos," "minorities," "prenatal care") leading to new literature findings.

A broad search led to more than 2000 citations, between public health and social sciences journals. In cases when the title and/or abstract were related to the topic of interest, a full version was obtained for further review. The analysis of a total preliminary list of 216 articles led a further exclusion of articles, either because no further expansion on the topic appeared in them, or no specific frames were derived from their content. A total of 96 articles from the public health literature and 68 articles from the social sciences literature were retained for the analysis, for a total of 164 articles that met the inclusion criteria.

About half of the 68 articles drawn from social sciences sources conveyed an anthropological focus (i.e., *Social Sciences & Medicine*, *Medical Anthropology Quarterly, American Anthropologist*; *Culture, Medicine, and Psychiatry*), while the other half was distributed evenly among migration journals (e.g., *International Migration Review*, *Journal of Immigrant & Refugee Studies*) and policy sources (e.g., *Journal of Poverty, Aging and Social policy*).

About half of the articles from the public health literature were drawn from three sources (*The American Journal of Public Health*, *Health Affairs* and the *Journal of Immigrant and Minority Health*), while the other half came from several health journals and health policy reports (e.g., *the Urban Institute*). Approximately one-third of these articles were devoted to vulnerable immigrant families, particularly pregnant women and their children, a fact that is reflected on the salience of the "maternalistic" frame in the literature.

All selected papers were read in full for the purpose of identifying the frames to which the main arguments were conveyed. The frames that emerged from the analysis were drawn from the open assessment of the main topics summarized above. Contrary to prescriptive content analysis, which relies on pre-coded sets of close parameters, open analysis examines the dominant messages and subject matter within the text (McKeone, 1995). The analysis was done manually by recording the manifest content (e.g., quotations) and the implications drawn from the articles' findings. With the exception of the "maternalistic" frame, which has received ample scholarly attention and gained considerable public visibility during the period studied, the remaining frames seemed to be evenly distributed in the literature. Given the nature of this review project, no authorization was required from the Institutional Review Board of the Queens College of the City University of New York, which sponsored the study.

From framing to counter-framing

The term framing was first coined by sociologist Erving Goffman (1986), and then popularized by linguistic and cognitive scientists, to define conceptual structures that organize discourses and assemble narratives amid patterns of selection and valuation (Chong & Druckman, 2007; Lakoff & Ferguson, 2006). Framing takes places in three states beginning with frame building, which creates specific definitions and positions on a particular topic; frame setting (or agenda setting) that involves the selection and dissemination of specific frames; and framing effect, or the impact on segmented audiences (Scheufele, 1999).

In recent years, there has been a burgeoning of social science research interested in the connections between the production of frames (or frame building) and changes in public policy and the welfare state. When it comes to immigration reform, framing has helped build and strengthen public stereotypes and prejudices regarding foreigners' contributions vis-à-vis their alleged misbehaviors in recipient societies (Beutin et al., 2007). In this vein, anthropological work has addressed the context-specific construction and subjective experiences of deservingness among different groups of immigrants and refugees (Becker, Beyene, & Ken, 2000; Fujiwara, 2005; Horton, 2004; Morgen & Maskosky, 2003; Yoo, 2008). Recent framing research has underscored the importance of competing discourses in producing alternative frames (Chong & Druckman, 2007; Sniderman & Theriault, 2004). Nevertheless, while conservatives have been successful in shaping the immigration debate by relying on frames such as "illegal immigrant," "illegal alien," and "undocumented immigrants" — all suggesting foreigners' unlawful behavior and their violation of rules — progressives have fallen short in fostering alternative explanations.

Key witnesses and experts (including scholars) play a central role in framing and counter-framing efforts, particularly regarding the ways in which particular groups are constructed as deserving of government's aid. For example, as noted by Yoo (2008) policy hearings in Congress at the time PRWORA was passed were pivotal in gathering support to overhaul some of the law's most restrictive clauses. Concomitantly, the media impact of alternative frames, which underscored the needs of vulnerable elderly immigrants, was at the heart of many of the benefit restorations that were introduced after the PRWORA's enactment (Fujiwara, 2005; Yoo, 2001). Since both content and sources are relevant in shaping public opinion, the importance of academic framing becomes even more conspicuous given the relevance of source credibility in framing effects, particularly regarding the role of scholars in influencing the direction of what the public believes concerning immigrant communities in the US (see Hirsch, 2003). Therefore, the analysis of scholarly constructions of deservingness offers a unique window of opportunity to gain a better understanding of both the actual and potential influence of academic discourse in public policy.

Discourses of deservingness: the "cost-saving" and the "effortful immigrant" frames

The public health literature has consistently supported an overarching framing narrative aimed at portraying immigrants as deserving of health benefits on the basis of their contributions to society, based on the hard living and working conditions they face on American soil. Under the subtle motto of "protecting outsiders" this narrative has been developed in several discursive ways. First, an accountable argument ("cost-saving frame") stresses the fact that undocumented immigrants' poor health, in the medium and long-run, will have a negative spillover effect on the larger society with their ultimate need for emergency services mostly paid by tax dollars and non-reimbursable services. Consequently, providing time-efficient preventive health services, such as immunizations and early screening, is seen as a cost-effective strategy (Berk, Schur, Chavez, & Frankel, 2000; Goldman, Smith, & Sood, 2006; Ku, 2009; Mohanty et al., 2005; Muennig, Fahs, & Davis, 2002; Okie, 2007). According to this rationale, it is precisely the non-citizen alien and the undocumented poor (portrayed as "effortful immigrants") the ones that contribute the most but receive the least although they pay taxes, earn below-poverty incomes, and endure insalubrious working and living conditions. Therefore, denying immigrants' access to health care until an emergency situation arises is seen as myopic public policy which, in the end, leads to increased costs for the society at large (Okie, 2007).

Second, the "effortful immigrant" frame is drawn from reports that show that immigrants under-utilize health services and are

responsible for lower health expenditures than the native-born. Contrary to the myth of undocumented foreigners' use (and abuse) of the U.S. health care system, this body of work shows that immigrants, regardless of nationality and legal status, tend to report less use of health care services in the U.S. compared with their US-born peers (Muennig et al., 2002; Ortega et al., 2007). Foreigners have lower health expenditures than native-born Americans and contribute more to the economy, both in productivity and in taxes, than the public services they may receive (Goldman et al., 2006). While the "cost-saving" and "the effortful immigrant" frames are devoted to assuage Americans' fear and apprehension of outsiders, the next section focuses on yet another frame invoked to explicitly protect American insiders.

National security and public health culprits

In line with seminal work in medical anthropology that underscores the deployment of surveillance narratives as artifacts for political control (i.e., the metaphor of the "body politic," see Scheper-Hughes & Lock, 1987), this review draws attention to a policing frame aimed at shielding insiders (meaning the U.S. native population) from foreign dangers. Based on the idea that immigrants represent a public hazard to others, the "national security" frame highlights the fact that they bring a "disproportionate burden of undiagnosed illness — including communicable diseases such as tuberculosis and HIV, and that they frequently lack basic preventive care and immunizations." (Kullgren, 2003:1630). Undocumented workers often get jobs in dangerous conditions and are not immunized against serious diseases. Therefore, they presumably pose a serious threat as they may be carriers of highly communicable pathogens that can be transmitted to the U.S. population at large (Sonfield, 2007).

Certain groups of immigrants may also be involved with risk-taking behaviors (e.g., having multiple sexual partners, abusing drugs and alcohol) and are more exposed to infectious diseases (such as rubella), as in the case of some Latino groups in the U.S. (Moua, Guerra, Moore, & Valdiserri, 2002). In line with this narrative, treating immigrants who are potentially vectors of pathogens and endemic diseases will be beneficial for the entire population (Nandi, Loue, & Galea, 2009). By denying undocumented immigrants the right to health care, this frame further blames the government for ultimately hurting its American citizens. A case in point is the resurgence of tuberculosis, a nonemergency but highly contagious condition with a greater incidence among newcomers, particularly those arriving from Latin American and Southern Asia. As noted by Quill, Aday, Hacker, and Reagan (1999), undocumented immigrants do not receive either screening or treatment for this disease and may later become a threat to the broader population. Excerpts from the articles by Moua et al., (2002) and Kullgren (2003) further illustrate the "national security" trope:

> "The United States population needs to grow in its realization that providing for basic public health safeguards for this at-risk population is not merely a humanitarian gesture but also enlightened self-interest." (Moua et al., 2002:194).

> "The 300,000 to 500,000 undocumented immigrants that enter the United States each year arrive bearing a disproportionate burden of undiagnosed illness including communicable diseases such as tuberculosis and HIV and frequently lack basic preventive care and immunizations." (Kullgren, 2003:1630).

The "security/terrorism frame" (see Lakoff & Ferguson, 2006) that became pervasive after September 11, 2001, paradoxically provided extra validation to the endorsement of immigrants' access to health services on the basis of their potential role as disease-carriers — the occurrence of SARS is a case in point (Eichelberger, 2007). Although the metaphor of immigrants as vectors of disease is far from new (see Fairchild, 2003; Kraut, 1995), what is novel here is that the health science literature has refurbished it to actually justify immigrants' access to health care in the U.S. According to this body of work, by providing timely and comprehensive health care to both legal and unauthorized immigrants, the U.S. will protect the health of its own (native) population in two main ways. First, it will save a significant amount of resources, mostly money but also institutional and human capital; and second, it will successfully prevent contagion of transmissible diseases (e.g., tuberculosis and HIV).

Nevertheless, the idea of immigrants as deserving contributors to American society, on the basis of their hard work ethic and payment of taxes, is discordant with their representation as being a risk to others or presumed vectors of transmissible diseases. Both depictions are merged into an overarching public health rhetoric that, not without contradictions, helps build discursive support for immigrants' inclusion into the U.S. government-sponsored health system. Finally, framing works selectively to support health coverage for certain groups of immigrants. In fact, while universal access focuses on covering all immigrants on the basis of either their general contributions or their potential risks to American society, "selective frames" emphasize the need to protect specific groups of immigrants — pregnant women, the elderly, and immigrant children.

The "maternalistic frame": policing damage control and protecting the nation's future

The enactment of PRWORA helped solidify in public opinion the frame of the state-dependent woman who uses her reproductive capacity to take advantage of U.S. resources (Chavez, 2004; Viladrich, 2011). The media has been key in instilling and promoting such fears, particularly regarding Latin Americans' untamed reproductive ability along with their alleged overuse of medical and social services. Facing the decreasing participation of Latina immigrants in Medicaid rolls, the public health literature invested a great deal in documenting and justifying pregnant women's prerogative to health care services (Kaushal & Kaestner, 2005; Loue, Cooper, & Lloyd, 2005; Marshall, Urrutia-Rojas, Mas, & Coggin, 2005). In this context, a framing narrative, inspired by a "maternalistic" approach, was concocted to protect immigrant mothers in their roles as bearers and caretakers of American children. In other words, given a mainstream rhetoric that blames immigrants (particularly Latinas) for depleting public funds, their role as "carriers" of unborn Americans was devised to endorse their right to health care. If the children of immigrants are the nation's future, supporting their mothers (even undocumented ones) becomes an imperative.

Through a framing twist, the attention on the woman was then switched to her offspring. For example, in an article on immigrant children' barriers to health care, Shin (2006: 387) chose the header "Prenatal Health Care for Immigrant Children" (note the emphasis on *children* rather than on *immigrant women*) to point out that: "Children who do not receive prenatal health care are affected even before they are born." Accordingly, frames based on need highlight the dangers faced by un-cared-for pregnant women and their unborn children, and the consequent potential costs that the increased need for postpartum services bring to municipalities and states (Berk et al., 2000). Pregnant immigrant women are more at risk of health and delivery complications, including having low-birth weight children with birth defects, if not treated early. Other adverse outcomes include maternal mortality and morbidity derived from complications of pregnancy (Adams, Gavin, Manning,

& Handler, 2005; Rosenberg, Handler, Rankin, Zimbeck, & Adams, 2007). As Minkoff (1997:705) noted:

> "Because illnesses in the perinatal period can affect two generations, the prohibitions [of welfare reform] may have unique consequences for pregnant women and their newborns, such as the denial of zidovudine [antiretroviral] treatment during pregnancy and of immunization during infancy."

A decade after Minkoff's article was published, Sonfield (2007:10) argued:

> "Is it really in the national interest to deny prenatal and postpartum caring to immigrant women whose babies will be U.S. citizens? Who benefits from withholding voluntary family planning services from immigrant women who themselves do not want to become pregnant?"

In sum, framing the issue of unauthorized women as being "carriers" of unborn American children provides discursive support for their entitlement to government-sponsored health care. In the end, the ultimate power of this narrative rests on the idea that it is everybody's best interest to have American children that are born (and remain) healthy. Not surprisingly, in the years following welfare reform many states, including New York and California, opted for protecting women as "baby carriers" and for providing all children with health insurance, regardless of their immigrant status.

(Un) deserving grids and the "chilling effect" frame

Welfare reform created a complex grid of categories among the poor by distinguishing among those who qualify for government aid and those who should comply with market rules. The reform's complex system of "inclusions" and "exclusions" encouraged bureaucratic barriers, confusion and misinformation regarding immigrants' entitlement to health and social benefits. For instance, Horton (2004) reveals how a public hospital set up differential health care rules of inclusion into the safety net, based on the alleged "moral worth" of different groups of immigrants (i.e., by constructing images of commendable Cubans versus undeserving Mexicans). In a similar vein, Choi (2009) showed how the Marshallese in Hawaii had better access to health care, than both Filipinos and Koreans, due to a favorable state policy that granted them health insurance. The new welfare system also benefited those suffering from "commodified conditions," as in the case of patients diagnosed with HIV/AIDS who had full access to welfare benefits that were denied to others (Crane, Quirk, & Van der Straten, 2002).

The phenomenon popularly known as the "chilling effect" (also called "voluntary withdrawal") refers to the situation of immigrants who, although potentially eligible for health and social benefits, actually refrain from using them (Hagan, Capps, & Kabiri, 2003; Kaushal & Kaestner, 2005). Both the health and the social sciences literature have delved into understanding the underlying causes of this phenomenon — from behavioral models on barriers to health care to welfare critiques. Nevertheless, one that has hardly been addressed is immigrants' internalized sense of illegitimacy (Fassin, 2004). Surely, the analysis of the moral economy of health care (Fassin, 2004; Watters, 2007) provides interesting scaffolding in this direction by narrowing the differences between *de jure* and *de facto* deservingness. In other words, legal entitlement to health benefits does not necessarily mean that immigrants internalize them as such. And this is because the allocation of health goods is not just based on economic grounds but on the specific moral and ethical values attributed to different actors. Therefore, the "chilling effect" can actually be interpreted as a symptom of immigrants' internalized feelings of undeservingness, which actually rose in the years following the passage of welfare reform.

The anthropological literature has provided meaningful conceptual tools to our understanding of the multi-faceted ways in which both discourses and practices undermine the health claims of vulnerable immigrant groups. For instance, a special volume (edited by Lamphere, 2005) reckoned the dramatic declines in Medicaid welfare caseloads in the post-welfare managed era supported by discourses on financial accountability, fiscal austerity and medical necessity. This line of work also shows the complex ways though which the welfare system disenfranchised providers' ability to serve their clients, ultimately burdening primary safety-net organizations that assist the uninsured population (Horton, 2006). As shown by several papers in this issue, welfare and health agencies often become the main disciplinary gatekeepers that capitalize from both subtle and open institutional mandates aimed at discouraging immigrants, even when eligible for public benefits, from using their programs and services.

Although not all the literature provides conclusive evidence on the occurrence of the "chilling effect" (see Potocky-Tripodi, 2004), its conceptualization has become a strategic tool to advocate for vulnerable immigrants' inclusion into the safety-net (see Kretsedemas, 2003). In other words, the "chilling effect" frame has served as a counter-argument to show that rather than overutilizing services, many eligible immigrants are actually staying away from them (Swingle, 2000). Mixed-status families are a case in point. Unauthorized immigrants, although not qualified for public assistance, often have children that are eligible for it (Singer, 2001). According to this rationale, by denying health care and public benefits to the undocumented, the system is likely to affect their children since unauthorized immigrants are often reluctant to bring their offspring to routine health check ups (Fix & Zimmerman, 1999; Hagan et al., 2003; Kim, 2001; Kretsedemas, 2003). We now turn to the examination of a social justice paradigm that successfully advanced a counter-framing trope in support of restoring benefits to the elderly after the passage of PRWORA.

Advancing the "injustice frame": protecting the vulnerable elderly

Early on after the passage of PRWORA the human rights movement denounced the violation of social rights resulting from the law's draconian clauses, in particular regarding the cuts of benefits for the elderly and other susceptible groups (Yoo, 2001). In her analysis of social discourses on welfare beneficiaries, Fujiwara (2005) examined the counter-narratives deployed by community organizations with the aim of restoring benefits to elderly immigrants. These counter-frames invoked the victimization of immigrants along with the moral obligation of policy makers to ease the tribulations experienced by poor aging and disabled immigrants (Fujiwara, 2005; Yoo, 2008). Through ethnographic dexterity, the late anthropologist Gay Becker et al. provided a unique contribution to the social justice framework, by describing the sorrows experienced by Cambodian refugees who, in the aftermath of the reform, fell into despair and hopelessness (Becker et al., 2000:156):

> "The survivors of the Khmer rouge Regime, primarily illiterate, rural-dwelling people who had endured terrible hardships, were poorly equipped to deal with the complexities of life in the US (…) The majority of Cambodian refugees were thus consigned to a life of enforced idleness and poverty."

The mental health plights of refugees, many suffering from depression and anxiety, have actually been the object of several studies that link their sorrows to financial strains (see the review by Lindert, von Ehrenstein, Priebe, Mielck, & Brähler, 2009). Several

Hmong individuals took their own lives as they were cut off from welfare, some leaving behind messages detailing their inability to survive without government support. The case of Chia Yang is paradigmatic. Feeling overwhelmed, she did not know how to respond to the letter she had recently received informing of the termination of her public and health benefits, including food stamps. She looped a cord around her throat, tied it to an overhead beam, and jumped off the trunk of her husband's car. The media morbidly provided detailed accounts of desperate refugees whose inadequate means for survival led them to severe depression, self-inflicted violence and even suicide, as a distressing enunciation of the law's mortal effect on the most vulnerable of all (see Eljera, 1997). Foreigners like Chia Yang fell into a literal abyss while trying to figure out how they would be able to provide for their families.

As noted by Fujiwara (2005) the idea of poor and feeble older immigrants taking their own lives played into issues of guilt and moral obligation. Counter-narratives invoked the victimization of immigrants along with the moral obligation of policy makers to ease the tribulations experienced by poor elderly and disabled immigrants. Aging, disability and frailty among the elderly were then used as an "injustice frame" that turned the government into the victimizer. Following the passage of PRWORA, and as a result of public outcry on elderly refugees' living conditions and endemic poverty, the media began disseminating benign representations of Asian refugees, including the Hmong. Politicians' fears of being seen as inhumane and responsible for the loss of lives led to public support for changes in some of the PRWORA's harshest clauses (Yoo, 2001).

Nevertheless, the "injustice frame" mostly advocated for a selected group of immigrants (e.g., vulnerable elders). In the meantime, mainstream media still demonized certain categories of immigrants, particularly undocumented individuals and single mothers — the later depicted in accordance with the old "welfare queen" stereotype, which has also been used to represent other public assistance recipients. Just as Asians had been inaccurately portrayed as a "model minority" not needing health care and other safety net services, Latina immigrants were now publicly framed as sexually promiscuous and biologically driven to procreation.

Conclusions: the challenges ahead

The analysis of framing narratives in this article has followed an interdisciplinary social science approach to reflect on conceptualizations of immigrants' deservingness in the context of global migration and state entrenchment. At first glance, a language of merit (the "effortful immigrant") appears to contradict a dual frame that portrays immigrants as "carriers" of either American children, in the case of pregnant women, or of communicable diseases. And although the specific directions of these frames differ, they all fit into an overarching neoliberal paradigm that rewards individual responsibility and self-sufficiency. Under the premise that denying health care to vulnerable immigrants would lead to deleterious consequences for Americans at large, what is common to this body of work is not just its distance from the notion of health as a human right, but its focus on the imperative of "justified need."

In vivid *déja vu*, these public health frames were again deployed to counter anti-immigrant sentiment during the recent public hearings on health reform (Public Law 111–152, 2010). In the midst of this debate, well-worn cost-saving arguments were revamped to contest the bill's exclusionary clauses against unauthorized immigrants. More importantly, these stressed the advantages of counting on an insured, although undocumented, immigrant labor force that would lead to major savings in uncompensated and emergency care as well as in lowering insurance pool risks (Ku, 2009).

The social sciences' contributions to reframing efforts, as examined in this paper, also present limitations particularly regarding immigrants' disparate positions on the un-deservingness continuum. Specifically, the "chilling effect" and the "injustice" frames discussed earlier, although somehow conforming to social justice and humanitarian paradigms, privilege selected groups of immigrants at the expense of framing health care as a universal human right (see Willen, 2011). As noted earlier, selective frameworks determined to gain progressive expansion of rights, by advocating for special groups of immigrants can actually be more successful in drawing public support, as in the case of choosing children or frail people as the target population (see Ruiz-Casares, Rousseau, Derluyn, Watters, & Crépeau, 2010). Surely the restoration of benefits to elderly immigrants after the passage of welfare reform rested on a successful framing shift — from their image as "abusers" of the system to the one as "victims," which was accomplished by targeting this particular group in public opinion. Nevertheless, proposals towards progressive inclusion, which are based on additive notions of rights, are in clear contradiction with the principle of health as universal human rights.

As argued by human rights scholars the validation of the right to health care not only should be entrenched in ethical demands for health equity, amidst concomitant legal enforcing instruments, but also in the public internalization of moral values that conceive health as human right for all (see Gruskin, Grodin, Annas, & Marks, 2005; Schrecker, Chapman, Labonté, & De Vogli, 2010; Watters, 2007). In recent years, the field of medical anthropology has moved a step forward in advancing scholarly agendas into public discussions of "illegality" with regard to unauthorized immigrants' rights to health care (see Castañeda, 2009; Willen, 2007, 2012a,b). In a sense, the development of alternative framings that challenge the overarching vilification of unauthorized immigrants is a step forward in that direction. Nevertheless, as several papers in this issue suggest, this discipline still has unexplored territory to cover in the realm of interdisciplinary discussions on health inequalities and unauthorized immigration. Salient to this are anthropological contributions to "frame building" which could lead us to question, reformulate, and publicize counter-narratives on immigrants' (un) deservingness, and thereby echo the struggles of public advocates and social movements working to foster policy change.

Equally, there is a dearth of critical theoretical reflection on the effect of mainstream (and counter) frames on the everyday (unauthorized and uninsured) immigrants' lives. In this vein, counter-framing should allow the stories of immigrants to be heard in what Hirsch (2003) calls a sort of "liberation anthropology" which, in turn, should leas us to shape public health messages that respect immigrants' subjectivity and cultural values (see also Hirsch et al., 2010; Pavlish, Noor, & Brandt, 2010). In conclusion, this paper has advanced the argument that framing theory is a meaningful conceptual and methodological tool for anthropologists interested in the project of supporting a paradigm of health as a human right. At the same time, systematic ethnographic research is needed to inform and humanize discourses of deservingness. Anthropologists' efforts to press forward counter-framing agendas, in tune with immigrants' cultural values and subjective experiences of resilience and pain, will be a positive step forward to strengthening our role as public intellectuals.

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