Routledge
Taylor & Francis Group

Journal of Ethnic and Migration Studies

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/cjms20

# Versatile brokerage: migrant-provider relationships in the third net of the U.S. Healthcare system

Erin Hoekstra & Anthony Michael Jimenez

**To cite this article:** Erin Hoekstra & Anthony Michael Jimenez (2023): Versatile brokerage: migrant-provider relationships in the third net of the U.S. Healthcare system, Journal of Ethnic and Migration Studies, DOI: 10.1080/1369183X.2022.2161494

**To link to this article:** https://doi.org/10.1080/1369183X.2022.2161494

Published online: 06 Jan 2023.

JOURNAL OF ETHNIC AND MIGRATION STUDIES
https://doi.org/10.1080/1369183X.2022.2161494



# Versatile brokerage: migrant-provider relationships in the third net of the U.S. Healthcare system

Erin Hoekstra [a] and Anthony Michael Jimenez [b]

[a]Department of Social and Cultural Sciences, Marquette University, Milwaukee, WI, USA; [b]Department of Sociology and Anthropology, Rochester Institute of Technology, Rochester, NY, USA

**ABSTRACT**

In studies of migrant healthcare, 'brokerage' is conceptualised as the process by which community health workers facilitate low-income migrants' access to the formal healthcare system, acting as both gatekeepers to healthcare and representatives advocating for patients. Building on these conceptualizations, we examine brokerage within what we call the 'Third Net' of the U.S. healthcare system, an informal health network comprised of mostly volunteer-run, community-based organisations and clinics that provide medical care to uninsured, undocumented migrants. Our study draws from 52 in-depth interviews with volunteers and a cumulative 23 months of ethnographic fieldwork with two migrant-serving organisations in Houston, Texas, and Phoenix, Arizona. We argue that brokerage roles and relationships within the Third Net are necessarily marked by versatility. This versatile brokerage in the Third Net (1) facilitates ad hoc access to the mainstream health system for uninsured, undocumented migrants; (2) challenges migrants' racialized disentitlement and discourses of migrant dependency; and (3) de-centers and expands broker roles. Contributing to migrant health and brokerage literature, this research illustrates that brokerage relationships are not always fixed and hierarchical; brokering care is not solely about access to an inequitable health system but can also involve creating new and more equitable configurations of care.

**ARTICLE HISTORY**
Received 9 February 2022
Accepted 29 November 2022

**KEYWORDS**
Migrant health; health disparities; immigration; undocumented; versatile brokerage

## Introduction

Since its passage in 2010, the Patient Protection and Affordable Care Act (ACA) has extended health insurance coverage to over 20 million people in the United States (Kaiser 2020). For these millions who were able to access health insurance under the ACA, individuals employed as 'Navigators' played a central role in helping those previously uninsured navigate the bureaucratic channels to enrol in coverage through the new health marketplaces. These Navigators and other Community Health Workers act as 'brokers' for low-income, marginalised people who had been unable to access health coverage and care prior to the ACA (López-Sanders 2017a). Acting as liaisons primarily

**CONTACT** Erin Hoekstra erin.hoekstra@marquette.edu
Authors have contributed equally to this article.

between uninsured migrant patients and the medical system, these healthcare brokers serve as both patient representatives and gatekeepers to medical resources, providing linguistic support, identifying insurance alternatives, and culling information from migrant networks (López-Sanders 2017a; Okie 2007; Shi et al. 2009; Viladrich 2005). In this way, they link newly-insurable patients with the healthcare safety net, or the 'second tier' of the U.S. health system (López-Sanders 2017a).

However, under the ACA, undocumented migrants (and legal permanent residents in the country for less than five years) remain ineligible for health coverage and care. Lacking access to non-emergency medical services in the mainstream health system, they are relegated to an ad hoc, informal, and sometimes underground healthcare system comprised of free clinics and community-based organisations, which we call the 'Third Net.'[1] Although scholars have examined brokerage processes in the formal healthcare system (Aptekar 2020; Fernandez and Gould 1994; Gould and Fernandez 1989; López-Sanders 2017b), less is known about brokerage within this Third Net.

Drawing on a cumulative 23 months of ethnographic fieldwork and interview-based research with two community-based migrant-serving organisations within the Third Net – Justicia y Paz (JyP) in Houston, Texas, and Community Clinic of Phoenix (CCP) in Phoenix, Arizona – we argue that brokers can negotiate new configurations of migrant healthcare. We find that, within the Third Net of care, brokerage involves (1) facilitating ad hoc access to the mainstream health system for uninsured, undocumented migrant patients; (2) challenging migrants' racialized disentitlement and discourses of migrant dependency; and (3) decentring and expanding broker roles through a more versatile form of brokerage. Contributing to the literature on migrant health and brokerage, this research illustrates that brokering care is not solely about facilitating access to an inequitable medical system for those who have been systematically excluded; it can also involve envisioning and creating more just configurations of care.

This research is important for multiple reasons. First, it explores brokerage processes in an important though underexamined context: the Third Net of the U.S. healthcare system. Prior to the ACA, most undocumented migrants sought care from the second tier: the healthcare safety net (Staiti, Hurley, and Katz 2006). Since the ACA's passing, however, the safety net received fewer federal reimbursements (Wallace et al. 2013) and, with few exceptions (see Marrow and Joseph 2015), has had to focus less on undocumented migrants and more on 'paying' (i.e. Medicaid-eligible) citizens in order to stay afloat (Andrulis and Siddiqui 2011). Federally excluded from the first tier of private medicine and squeezed out of the second tier of safety net provisions, undocumented migrants increasingly have nowhere to turn other than the informally-run, volunteer-based Third Net (Frey and Pardo 2017; Hoekstra 2021; Jimenez 2021). Second, this research sheds light on the undertheorized capacity of brokers to manifest new, albeit informal, configurations of care. Scholars have cast brokers as representatives, gatekeepers, liaisons, and the like (Gould and Fernandez 1989; López-Sanders 2017a, 2017b), various roles which seek to facilitate migrants' access to care in the mainstream health system. We extend this work to illustrate ways brokers in the informal Third Net attempt to establish alternative caregiving relationships that challenge, rather than sustain, conventional patient-provider brokerage relationships. Third, our research illustrates the versatility of the broker role. Versatile brokerage refers to the new roles and relationships of those who facilitate access to healthcare for uninsured, undocumented migrant patients. Within the Third Net, brokers also

critique the socio-structural conditions that make access to care so restrictive in the first place. Our research invites scholars, medical practitioners, and pro-migrant spaces to consider ways in which addressing migrant health disparities involves imagining new relationships and models of brokering care.

## Brokering migrant healthcare

This study contributes to research on the role of community organisations, health workers, and other individuals providing and facilitating access to healthcare through formal and informal channels for uninsured, undocumented migrants (Boehm 2005; Campbell-Montalvo et al. 2022; Campbell-Montalvo and Castañeda 2019; Fernández-Kelly and Portes 2012; Isaacs et al. 2013; Lamphere 2005; Marrow 2012). Asad and Clair (2018) argue for the importance of conceptualising migrant status as a 'racialized legal status' that foregrounds 'how the law serves as a fundamental mechanism of social stratification that produces racial/ethnic health disparities' (19). Shaped by processes of racialisation that impact migrants in the U.S., undocumented status has been used to justify the denial of healthcare and other social services. Uninsured, undocumented migrants in the U.S. have been systematically refused access to health coverage and disentitled of their right to healthcare. For these migrants, patterns and processes of racialisation, including anti-immigrant rhetoric and policies, have marked them as undeserving and burdensome on collective resources. These migrant patients are then relegated to the Third Net for healthcare, an informal safety net marked by inadequate and substandard healthcare provision. Within the Third Net, volunteer medical providers challenge this racialized disentitlement in part by bridging healthcare access for their patients through engaging in various roles and relationships known as brokerage. In this informal sphere, migrants also negotiate healthcare access for themselves and each other.

Brokerage refers to a process 'by which intermediary actors facilitate transactions between other actors lacking access to or trust in one another' (Marsden 1982, 202). Gould and Fernandez identify five distinct brokerage types that demonstrate the various social roles that brokers occupy (Fernandez and Gould 1994; Gould and Fernandez 1989) (Figure 1). Within larger economic, political, and social systems, brokers play a

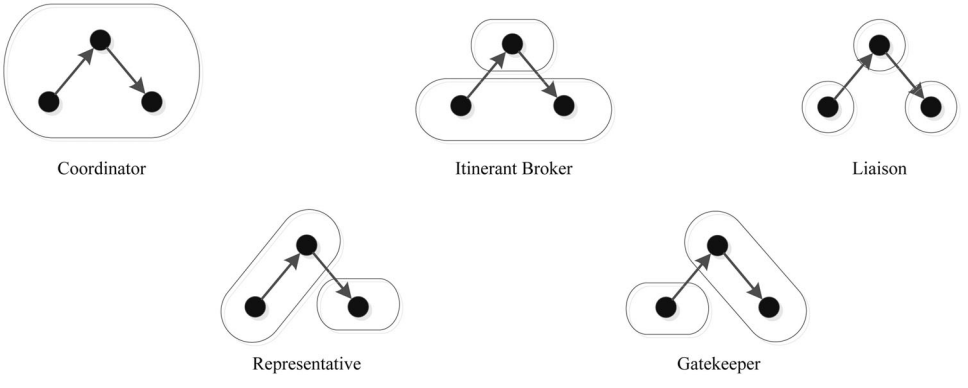


**Figure 1.** Gould and Fernandez (1989) 'mono-planar' brokerage typology.

key role in bridging gaps in social structure (or 'structural holes') (Burt 2000, 2005; Gould and Fernandez 1989; Marsden 1982; Obstfeld and Borgatti 2008; Small 2009; Stovel, Golub, and Milgrom 2011). In this way, brokers leverage their relationships with disparate parties to facilitate one or both parties' access to resources, ensuring the movement of 'goods, information, opportunities, or knowledge' (Stovel and Shaw 2012, 140; see also Burt 2004; Fernandez and Gould 1994; Gould and Fernandez 1989). Brokers can also be understood as 'street-level bureaucrats,' frontline workers who facilitate access to social services, knowledge, and robust social networks integral for attaining employment, healthcare, and even immigration status (Aptekar 2020; Belabas and Gerrits 2017; Borrelli 2019; Campbell-Montalvo et al. 2022; Campbell-Montalvo and Castañeda 2019; Edlins and Larrison 2020; Kelly 1994; Lamphere 2005; Lipsky 2010 [1980]; Maynard-Moody and Musheno 2000; Portes and Sensenbrenner 1993) .

A growing literature analyzes the increasing relevance of brokerage and importance of street-level bureaucrats in facilitating migrant access to healthcare as well as the varied roles and relationships of brokerage within the current health system (Cadzow et al. 2013; Campbell-Montalvo et al. 2022; Campbell-Montalvo and Castañeda 2019; Fernández-Kelly and Portes 2012; Isaacs et al. 2013; Jezewski 1990; Jezewski and Sotnik 2001; López-Sanders 2017b, 2017a; Marrow 2012). Drawing from Gould and Fernandez's typology of the various brokerage roles (Gould and Fernandez 1989; Fernandez and Gould 1994), more recent scholarship on healthcare for migrants and communities of colour emphasises the institutionalisation of brokerage relationships in healthcare access under the Affordable Care Act. In particular, Community Health Workers (CHWs) and Navigators operate as street-level bureaucrats within this brokerage relationship. Working to help members of their communities (often 'co-ethnics') access health coverage, CHWs and Navigators act as representatives connecting their community members to healthcare coverage (Joseph and Marrow 2017; López-Sanders 2017b; WestRasmus et al. 2012; Witmer et al. 1995). These representatives may also act as 'cultural brokers,' translating the medical and bureaucratic jargon of ACA requirements into culturally-appropriate and understandable terms (Cadzow et al. 2013; Dysart-Gale 2005; Lindsay et al. 2014). Although these brokers operate largely as representatives of their communities, they must also navigate the bureaucratic requirements of the formal health system. In this way, these frontline workers act as gatekeepers, in addition to representatives, and must balance the tensions of the gatekeeping role in facilitating access to formal healthcare coverage (López-Sanders 2017b, 2017a; Marrow 2012; Portes, Fernández-Kelly, and Light 2012; Weiner et al. 2004).

In discussing their brokerage typology, Gould and Fernandez (1989) assumed a mutual exclusivity of these various roles, yet Laura López-Sanders (2017a) has argued for the reality of brokerage roles and responsibilities that go beyond these 'mono-planar' assumptions. She argues: 'By simultaneously serving as representatives and as gatekeepers, brokers function in a bi-planar brokerage role, potentially dedicated to one group on one plane (e.g. as a health clinic employee) and dedicated to another group on different plane (e.g. as a co-ethnic immigrant group member)' (2017a, 48). Acknowledging this dual brokerage role, López-Sanders has coined the terms 'double-embedded liaison' to account for the multiplicity of roles and loyalties that these health workers must navigate (Figure 2).

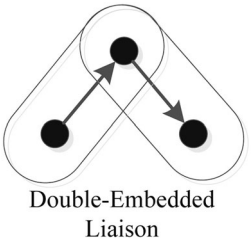


**Figure 2.** López-Sanders (2017) 'bi-planar' double-embedded liaison brokerage.

Building on López-Sanders' work, we examine brokerage processes and relationships in the Third Net, the informal, community-run spaces that increasingly serve as the last resort for migrants in need of care. Beyond the mono – and bi-planar forms of brokerage, we argue for the reality of brokerage as a 'multi-planar' relationship in which volunteer medical providers in the Third Net engage in more versatile forms of brokerage, acting as 'double-embedded liaisons' to use their networks to broker ad hoc access for their patients into the first and second tiers of healthcare while also working to actively de-centre themselves as brokers within the Third Net itself. Our analysis demonstrates ways in which brokers in the Third Net facilitate access to the formal healthcare system, often take on the role of healthcare practitioner, and establish new healthcare models more conducive to equitable distributions of power.

## About the cases: Third Net sites

Justicia y Paz. Situated in the middle of one of Harris County's rapidly-developing neighbourhoods, Justicia y Paz (JyP) is a faith-based non-governmental organisation in Houston, Texas, that provides free basic medical care, food, clothing and temporary shelter to hundreds of low-income undocumented migrants each year. Structurally, JyP is separated into a 'women's house' and 'men's house' – two buildings that sit back-to-back on the same neighbourhood block. Children, female volunteers, and migrant women reside in the former. Male volunteers and migrant men live in the latter. While the women's house is two stories tall and can house up to 40 people, the men's house is wide and can provide shelter for up to 65 people. Since its initiation in 1980, JyP has run exclusively on volunteer labour and donations from communities and parishes across the world, including the Vatican. It has never received government funding. Like other spaces inspired by the Catholic Worker Movement (Day 1952; Deines 2008; McKanan 2008; Morton and Saltmarsh 1997), JyP operates with the philosophy that the state is ill-equipped to meet the needs of the poor and serves as a 'house of hospitality' for the region's undocumented population. This means that JyP volunteers (referred to as 'Catholic Workers') treat every undocumented migrant who comes to its doors as a Christ-like figure whose needs should be actively attended to, regardless of how big or small these needs are.

Conceptualising care in both medical and non-medical terms, JyP facilitates a range of free activities/services including but not limited to: (1) recruiting volunteer doctors from Houston's medical district to provide primary healthcare services to nearly 300

undocumented migrants each month; (2) offering financial support to over 100 migrant families in need of home care assistance; (3) helping migrants navigate formal medical bureaucracies; and (4) providing temporary gender-segregated shelter. Additional services include coordination with other community organisations, weekly food and clothing distributions, daily delivery of brown-bagged lunches to day-laborers and the homeless, and bi-weekly ESL courses for the organisation's migrant guests. In line with the Catholic Worker Movement (Day 1952; Deines 2008; McKanan 2008; Morton and Saltmarsh 1997), the combination of these activities are intended to synergize charity and social justice frameworks to accomplish two goals: (1) meet migrants' needs and (2) challenge the underlying global political-economic forces that catalyze migrants' displacement in the first place.

**Community Clinic of Phoenix**. Located in a small, nondescript house on a busy corner in central Phoenix, Community Clinic of Phoenix (CCP) is a free clinic for uninsured patients, the majority of whom are undocumented Latinx migrants. The clinic provides free medical care to about five hundred patients with treatable chronic health issues that have usually gone undiagnosed and untreated for years such as high blood pressure, high cholesterol, and/or diabetes. Offering limited primary, naturopathic, and holistic healthcare, the clinic is open two days a week: Thursday's clinic includes appointments for general nursing, women's health and midwifery, naturopathic and holistic care (including appointments with a curandera who does healing work with crystals and feathers), and limited mental health support, while Saturday's clinic focuses on appointments with physician assistants and, once a month, with a physical therapist. Volunteers also make house calls to patients throughout the week, monitoring the health of the most acute patients and those with transportation issues that keep them from the clinic. Operating without government or grant funding, CCP is funded solely by individual donations and the proceeds generated from selling clinic-branded merchandise and hosting fundraising events like art auctions and pig roasts.

The clinic relies on hundreds of volunteers to provide a variety of primary and specialist care, fundraise, clean the clinic, restock medical supplies, and generally keep the organisation running. The volunteers include an interesting mix of people: members of a collective of street medics who provide healthcare at migrant rights protests and founded the clinic; doctors, nurses, and physician assistants working in local hospitals and doctor offices; curanderas and other spiritual healers who are themselves migrants; and younger, affluent white suburbanites who are aspiring medical students looking for experience with 'underserved populations.' Unlike JyP, CCP is not a faith-based organisation, although many volunteers adhere to different faith traditions. The driving force behind the organisation's mission is a strong sense of justice around healthcare as a human right for all, especially for uninsured, undocumented migrants. The clinic founders assert that CCP has always been 'unapologetically activist' in its approach to healthcare for those who they describe in their official mission as the 'medically-marginalized.'

These two organisations operate within the Third Net with different missions (one secular and the other faith-based), scopes of service (one focused primarily on the provision of healthcare and the other more expansive in its services offered), and geographic locations. Additionally, JyP and CCP work within two states that have differing approaches to immigration and health policy and immigration enforcement. Though contrasting in many respects, these two organisations, their volunteers, and patients

provide a clear picture of the brokerage work undertaken in the Third Net. At both sites, brokerage involves facilitating access and promoting change.

## Methods

Our IRB-approved study analyzes brokerage relationships in the Third Net of the U.S. healthcare system and the implications of these relationships for our understandings of brokerage generally. We separately volunteered and conducted ethnographic research with two Third Net organisations for approximately one year (JyP, September 2015-October 2016; CCP, June 2015-June 2016). Through our fieldwork, we participated in a range of organisational activities, including medical intakes, (in)formal meetings, recreational outings, volunteer orientations, training workshops, and fundraising events. During these activities, we observed volunteer-migrant interactions, points of contention among volunteers, and migrants' medical experiences. After developing rapport, we used a snowball sampling approach to recruit potential interviewees. We obtained written/verbal consent prior to data collection.

Across the two organisations, we conducted 52 in-depth, semi-structured interviews with volunteers (JyP, 18; CCP, 34) who worked in multiple capacities (e.g. health practitioners, interpreters, social workers, etc.). Ethnography's immersive strength (Hammersley 2018) allowed us to observe how volunteers and migrants broker care, while interviews (Lamont and Swidler 2014) helped us understand the deeper, less visible meanings/significance of brokerage processes. Together, these methods enabled a more holistic understanding of brokerage processes and their variable meanings. During our fieldwork, we engaged in a deliberate, iterative data collection process, in which interviews enabled us to test emerging theories and further explore initial findings with informants. In this way, interviews provided a point of confirmation or contestation of the themes we observed during fieldwork and enabled us to triangulate the themes discussed in this paper. All themes were first evidenced in ethnographic observation and then discussed further in interviews with informants in our fieldsites.

The multi-sited nature of this research was analytically valuable because it allowed us to compare and contrast brokerage processes in two geographically, philosophically, and politically different contexts and identify interconnections between the organisations and the broader healthcare system, a key benefit of multi-sited ethnography noted in previous research (Molloy, Walker, and Lakeman 2017). Interview topics slightly varied depending on the interviewee but generally included: (1) biography and/or motivation for volunteering; (2) interactions with other volunteers; (3) migrants' medical needs/challenges; (4) impacts of immigration and healthcare policies; (5) organisation history, mission, and activities; and (6) reflections about their role(s) within the organisation. The length (30–90 min), location (i.e. onsite/offsite), and notetaking format (written/audio-recorded) of the interviews were based on interviewees' preferences. All interviews were transcribed prior to analysis.

We conducted a reflexive thematic analysis (Braun, Clarke, and Hayfield 2022; Braun and Clarke 2019) of ethnographic and interview data. By reflexive thematic analysis, we mean that analytic themes were not predefined prior to the coding process nor prescribed through the use of a codebook; rather, analytic themes developed around the core organising concept of brokerage through a reflexive coding process. The two main analytic

themes that emerged included evidence of brokerage relationships among the organisations' volunteers and patients and how brokerage enables access to healthcare for uninsured, undocumented migrants. Themes were created and evolved co-constitutively in conversations between the authors about the data, specifically about observations and interview-based examples of volunteers negotiating healthcare access for their patients (and migrants negotiating access for themselves and each other) in ways that differed dramatically from mainstream health and safety net institutions. From volunteers' and migrants' experiences, we infer that brokers in the informal Third Net can go beyond facilitating migrants' access to mainstream systems of care and challenge the structural conditions that make these mainstream systems prohibitive in the first place.

## Results

Our findings (see Table 1) demonstrate that brokerage within the Third Net is predominantly marked by a versatility of roles and relationships that differs from brokerage within the mainstream health system. On one hand, Third Net brokers (i.e. volunteers) continue to work through formal and informal channels to facilitate migrants' access to the mainstream health system, adopting Lopez-Sanders' representative and gatekeeper roles. At the same time, however, the informality of the Third Net both forces and enables a radical shift in the discourse and practice of brokerage, ultimately destabilising power hierarchies where migrants, volunteers, and health practitioners can all adopt the broker role (Figure 3). In this way, examinations of brokerage in the Third Net demonstrate the multi-planar and versatile nature of brokering migrant healthcare in this largely informal tier.

### *Bridging beyond the third net: brokering care into the mainstream system*

Under the Affordable Care Act, undocumented migrants remain ineligible for healthcare coverage on a federal level, except for in a life-threatening emergency or in labour and

**Table 1.** Findings about Versatile Brokerage in the Third Net.

| Main Finding | Examples from JyP data | Examples from CCP data |
|---|---|---|
| Brokering access to care in the formal healthcare system | Providing proof of income and residency so migrants can access free healthcare through formal channels under the *Gold Card* | Informal, ad hoc negotiation for pro bono procedures and specialist care with sympathetic medical providers in the formal healthcare system |
| Challenging negative characterisations of migrants | Critiquing 'illegality,' asserting migrant's humanity through a faith-based perspective | Asserting migrants as 'patients;' systemic critique that shifts the 'burden' from migrants to the larger healthcare system |
| Framing a right to healthcare | Healthcare and other social service provision as mandated by the 'Law of the Gospels' | Strong emphasis on the fundamental right to healthcare for everyone, including uninsured, undocumented migrants |
| De-centering traditional forms of brokerage | Volunteers, especially white citizen volunteers, resisting the centrality of their role as broker; shifting focus to migrant patients | Considerable time and effort expended on educating new volunteers about immigration policy and health justice to challenge traditional systems of brokerage |
| Asserting migrants as brokers | Migrant residents occupying leadership and brokerage roles within the organisation; migrants residents advocating for each other's health needs, ensuring care | Migrants as 'neighbors' in the same health community, as volunteer medical providers and spiritual healers within the organisation |

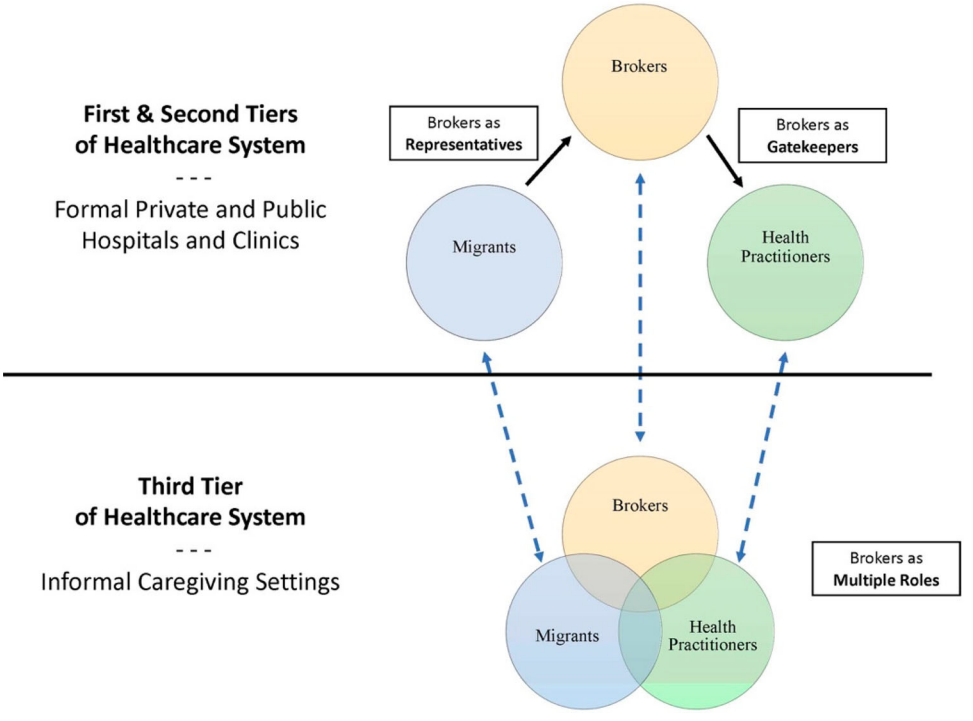


**Figure 3.** Versatile Brokerage: 'Multi-planar' brokerage model.

delivery. However, we find that volunteers (especially volunteer medical professionals) in the Third Net work through both formal and informal channels to negotiate access for their patients to care in the mainstream health system. In localities like Houston, formal initiatives like the annually-renewable Harris Health financial assistance programme – known as the Gold Card – offer up to 100% coverage for medical expenses incurred within the Harris Health System (Harris Health Gold Card, 2000). To qualify, individuals must present proof of income, residency, and identity; legal status is not a concern. Accordingly, JyP volunteers do everything they can to help migrants obtain these proofs and become eligible for the Gold Card. Margaret, JyP's Co-Director, explains:

> I don't know what we would do without our own clinics and … connections with the hospitals, which are very supportive in the sense that if we sign forms for people that live here, then [HHS will accept that as] proof of residency and income … All they need is a good ID, which is problematic because some people don't have it.

Though ID requirements can create significant challenges (Jimenez 2021), JyP's ability to represent and vouch for migrants' residency and income is significant. Assuming migrants have some form of identification, JyP can help undocumented migrants become formally eligible for health coverage otherwise federally denied to them, effectively facilitating their way into the first and second tiers of the healthcare system.

In the absence of formal initiatives like the Gold Card, Third Net practitioners use their knowledge of the health system and their social and professional networks to

broker care informally. This is the case in Phoenix, where there are virtually no formal avenues for uninsured, undocumented migrants to access non-emergency care in the mainstream health system. Additionally, anti-immigrant rhetoric and legislation have translated into punitive immigration enforcement that dampens migrants' health-seeking behaviour. However, in this inhospitable environment for migrants, CCP volunteers use their expertise and prestige as medical professionals (who largely work in formal healthcare settings for their day jobs) and their networks of colleagues to broker care for their patients through informal channels into the mainstream health system. For instance, CCP volunteers use their networks to negotiate pro bono specialist care for some of their patients in need of more complex medical procedures, from biopsies to heart surgery. In other examples, CCP organises crowd-funding campaigns for patients in need of costly procedures and care that the clinic cannot provide. For example, they raised over forty thousand dollars to pay for surgery for Yolie, a single mom with young children, when she crushed her arm falling off a ladder. After the pins were removed from her arm post-surgery, she was able to get the rehabilitation she needed at no cost from CCP's volunteer physical therapist. As important as this informal or semi-formal brokerage is for individual patients, this model of brokerage for all 500 of CCP's patients would be unsustainable and unrealistic. As a result, brokerage into the mainstream health system negotiated by CCP volunteers only occurs on an individualised, ad hoc, and case-by-case basis, using their networks both in the mainstream health system and in their communities to broker care through sometimes unorthodox ways between the Third Net and the mainstream health system.

Together, these examples demonstrate the semi-formal brokerage role that volunteers in the Third Net play in brokering care for their uninsured, undocumented patients. In this role, they act as a different kind of 'double-embedded liaison' facilitating (often ad hoc) access into the mainstream health system. Depending on the variabilities of local policies and programmes, both JyP and CCP work to navigate formal and informal healthcare access for their patients.

### *Challenging racialized disentitlement through shifting discourses of migrant dependency*

In addition to the semi-formal brokerage between the Third Net and the mainstream health system, more versatile forms of brokerage exist within the Third Net, which reflect a radically different discourse and practice of brokering care for migrant patients. This versatile brokerage destabilises the power hierarchies of more traditional brokerage relationships. For both organisations, versatile brokerage involves a shift in discourse, challenging the racialized disentitlement and constructed dependency of their patients.

For CCP, a key part of enabling migrants' access to healthcare is challenging migrants' racialized disentitlement. Donna, one of the main clinic founders and core organisers, asserts:

> Around the country, but particularly in Arizona, we see anti-immigrant rhetoric that portrays immigrants as burdens. This is especially true in discussions about healthcare, as if immigrants don't deserve to go to the doctor. This rhetoric shows up in harsh immigration policies like SB1070 [the infamous Arizona legislation that allows local police to check the immigration status of anyone they arrest or detain] … but it's important to recognize that

> it's not immigrants that are the burden. It's the denial of healthcare, not uninsured immigrants, that is a burden on society as a whole.

In this discussion, Donna challenges the anti-immigrant rhetoric that frames migrants as 'burdensome non-patients' and promotes a framework which sees migrants as 'patients within a burdensome system.' Adopting a larger structural critique, Donna emphasises the ways that policies like SB1070 create situations in which migrants are racialized as 'illegal' and burdensome. Healthcare legislation that denies migrants access to health coverage and care plays a significant role in the construction of migrants as encumbering the system, emphasising the costs that they incur rather than their contributions to society. CCP works to frame migrants at the clinic first and foremost as patients, emphasising their right to healthcare access and provision. The problem then for CCP is with a larger system that refuses to recognise the patient status of uninsured migrants and actively works to deny them healthcare.

CCP's goal, however, is not to simply reify conventional patient-provider relationships. Part of the organisation's vision is to manifest a larger CCP community where patients fight for their own rights to healthcare. Their understanding of migrants as patients is a far cry from many clinics, in which patients are solely on the receiving end of services. First and foremost, CCP emphasises the fact that the clinic's patients are members of the same larger community, and the language most often used regarding patients at the clinic is that of 'neighbor.' Consistently across fundraising appeals and social media posts, this image of a community of neighbours is central, emphasising a mutuality, rather than a hierarchical relationship, between patients and providers, citizens and noncitizens. This vision is emphasised in one of CCP's funding letters, saying, 'Together, we really can build a better world, where all our neighbours, regardless of immigration status, know that their lives and health are valued.' In this way, CCP challenges anti-immigrant rhetoric of dependency by highlighting migrants' right to belonging and health as neighbours, while indicting the U.S. health system for denying migrants' right to healthcare.

JyP volunteers also challenge migrants' racialized disentitlement. Whereas CCP promotes migrants' patient status and challenges the connotations of immigration and healthcare law, JyP asserts that entitlement to care is actually based on a higher-level spiritual law that recognises migrants' humanity. According to Margaret, one of JyP's co-directors, this sentiment reflects the Bible's 'Sermon on the Mount' in Matthew 25 where Jesus Christ instructs people to care for the poor as they would care for him: 'What you do for the least of the brethren you do for me.' Every volunteer references this verse when explaining their motivation for joining JyP, and according to Margaret, Matthew 25 captures the whole essence of JyP's mission and aims. Laurie, a volunteer, shares that whenever anyone asks Margaret how they can ever repay JyP for its support, Margaret always makes some reference to the passage or simply responds 'Matthew 25,' suggesting that people can repay JyP by providing whatever support they can to others. For JyP volunteers (i.e. Catholic Workers), this directive supersedes healthcare and immigration laws that might limit or prevent practitioners from providing care to low-income undocumented migrants. In an article published six years into JyP's ongoing 40-year existence, Larry (JyP's co-director) explained:

> At Justicia y Paz, we don't worry about breaking the law. In fact, we are totally distracted by trying to keep the law, the Law of the Gospels that says that we must love our neighbors as ourselves. Rejecting homeless people, refugees, mothers and children because they don't have an ID is like rejecting Jesus. True, we may be too fundamentalist or literal in our interpretation of Matthew 25, but then we are stuck with being Catholic Workers.

Several volunteers echo Larry's sentiment and conclude that rejecting 'the poor' is like rejecting Christ himself. Rather than concern themselves with immigration and healthcare laws, Catholic Workers focus solely on upholding the 'Law of the Gospels.' Conventionally, migrants and citizens who seek services in formal medical settings must furnish legal documents (an ID; proof of insurance) in order to become eligible for care (Cervantes and Menjívar 2020; Van Natta 2019; Jimenez 2021). At JyP, however, such legal documentation is unnecessary.

Catholic Workers also regard illegality (i.e. undocumented status) as irrelevant when it comes to eligibility for care. Larry succinctly captures this in a description of JyP's beneficiaries: 'We haven't met an illegal alien in our six years as Justicia y Paz. We have met a lot of people, though.' Here, illegality signifies racialized disentitlement and less-than-human status. In replacing the notion of 'illegal aliens' with 'people,' Larry and other Catholic Workers challenge the prohibitive and dehumanising connotations of illegality and emphasise migrants' humanity. Expressions of humanity like this are important to and common among JyP volunteers. For example, when Consuelo, a volunteer, was asked what she hopes migrants will remember from their time at JyP, she responded: 'That in [Justicia y Paz], they were treated like human beings.'

In short, both organisations challenge migrants' racialized disentitlement on the basis of two different ideologies: for CCP, immigration and healthcare laws are inherently problematic, and for JyP, these laws are inferior to the 'Law of the Gospels.' Despite being oriented by different ideologies, practitioners within both organisations recognise the structural constraints of the healthcare system and seek to do more than simply facilitate migrants' access into it. For volunteers in both spaces, brokerage also involves status-shifting. CCP volunteers attempt to shift migrants' status from 'burdensome non-patients' to 'patients within a burdensome system,' and JyP volunteers try to shift migrants' status from 'illegal aliens' to 'human beings' with real needs and capabilities. Both sets of novel statuses challenge migrants' racialized disentitlement.

## *Versatile brokerage: envisioning new possibilities for brokering care in the Third Net*

In addition to disrupting the racialized disentitlement of non-citizens, Third Net practitioners attempt to de-centre and expand the broker role, creating a versatile type of brokerage where the distinctions among patients, brokers, and providers are blurred and power is actively negotiated. In short, volunteers from both organisations do not explicitly consider themselves brokers and actively work to contest traditional brokerage relationships wherein migrants have to go through volunteers (i.e. brokers) for care.

At Justicia y Paz (JyP), volunteers do what they can to decentre their role as brokers, but this can be challenging. Victoria, a volunteer, provides an example, explaining a moment when she took a migrant woman named Brenda to an appointment in Houston's medical district:

> When you're with someone [at a hospital] and it's about them and their life and their situation, and then the professional talks to [me], I'm like Brenda's right here, and she understands you; speaks English … It's not me. It's not my medical problem [or] legal problem. It's not my anything. Like, I just drove Brenda here … I'm not her social worker.

Victoria expresses frustration with becoming the centre of attention among health practitioners and emphasises that the clinic visit is about Brenda. In doing so, Victoria tries to decentre the broker role and re-centre Brenda in the healthcare interaction. Victoria also emphasises that she is not Brenda's social worker. She rejects the conventional liaison role of healthcare brokers and expresses desire for a relationship where she is peripheral, rather than central, to Brenda's healthcare needs.

This was a common experience among a predominately white base of volunteers at JyP. Health practitioners routinely asked volunteers questions about migrants' health even though these migrants were sitting in the same room, perfectly capable of articulating their own needs. Victoria reflects on these experiences:

> I feel weird about it. I don't know what it is. Is it the language? Is it race? Is it both those things? I don't know, but it does frustrate me, and I struggle a lot with the idea of the white savior complex and [whether or not] I'm perpetuating it by being here.

Here, Victoria shares frustration with possibly reifying the white saviour role. Brokerage processes are generally understood in practical 'means-to-an-end' terms (i.e. the job of the broker is to facilitate access to care), but here, Victoria illustrates deeper considerations about what it means to be a broker. In this Third Net context, brokerage also means challenging the conditions that make brokering care necessary in the first place. In other words, Victoria and other volunteers want to make themselves (i.e. the broker role) unnecessary or irrelevant. Doing so, however, requires critical evaluation of the healthcare and immigration policies that structure migrants' experiences of exclusion and reaffirm hierarchal brokerage relations. Relative to JyP, CCP is more intentional about evaluating these policies.

CCP recognises that not all new volunteers fully understand the relationship between the organisation's anti-racist and health justice aims. Clinic volunteers represent a diversity across spectrums of age, race, immigration status, citizenship, and socioeconomic status. This diversity of volunteers comes with a particular set of challenges around fostering the mission of the organisation, including providing equitable healthcare with cultural humility and establishing a non-hierarchical, collaborative environment. The early clinic volunteers came largely from within the immigrant rights movement in Phoenix and already had a robust knowledge of the anti-immigrant sentiment and structural challenges faced by the clinic's patients. However, as the clinic became more established, it attracted a cohort of volunteers – mostly white, affluent young adults hoping to get experience working with 'underserved communities' to strengthen their applications to medical school. Lorena, one of the original founders of the clinic, discussed this influx of new volunteers who lacked knowledge about the clinic's history and the larger context of immigration and health policy, saying:

> We end up getting a lot of white, suburban kids as volunteers who want to go into medicine. With PA school being so competitive, their applications are more likely to get a look with them having volunteered with 'underserved' communities. But they come to us without the knowledge of immigrant rights or health justice, and this means that we have to go through a

> process of educating them about what our patients are up against. Otherwise, we end up replicating the power inequalities of patient-provider relationships … and, in this context, that looks a lot like white saviorism.

Destabilising the brokerage role within the larger racial dynamics and power inequalities of patient-provider interactions demands vigilance and intentionality from clinic organisers and core volunteers to ensure that new volunteers share the clinic's vision. As a core activity of the clinic, regular volunteer orientations and trainings on things like immigration policy and health justice educate new volunteers to understand the larger social and political context in which the clinic's patients must survive. This education also involves training non-Spanish-speaking volunteers in etiquette for working with an interpreter, including the directive to always maintain eye contact and speak directly to the patient themselves, rarely looking at the interpreter during appointments. In this way, this education also involves, at least implicitly, a challenge to traditional systems of brokerage and hierarchies of patient-provider relationships.

In the Third Net, the broker role can also be expanded. At both JyP and CCP, migrants also provide direct care to others. One Catholic Worker, Carolina, is a migrant herself and conducts medical intake at JyP's clinic every week. Her family received medical care from JyP several years prior to her arrival in the country, and now she has been providing this care herself for about six years: 'It's so funny. In the beginning, Margaret didn't even want me to touch the computer. She was like, 'don't touch anything; just watch!' And now I'm like in charge of the clinic [she laughs].' Studying to be a Physician's Assistant, Carolina occupies a leadership role in the clinic. When other volunteers have questions about clinic protocol, they commonly turn to Carolina.

In many cases, migrants join volunteers at JyP in a range of activities including weekly food distributions, cooking/cleaning, and caregiving. In turn, they too become brokers of care. Like volunteers, migrants help one another fill out Gold Card applications, share information about reliable clinics, and provide linguistic assistance during medical visits. This is particularly important for migrants like 46-year-old Joseph, who suffered a debilitating car accident and speaks in low mumbles. Elias, a 75-year-old Mexican man, is among a select few who are able to understand Joseph. Accordingly, Elias makes sure Joseph takes his medicine every day and routinely accompanies Joseph to medical appointments outside of JyP in order to literally speak on his behalf. Thus, volunteers are not the only ones responsible for brokering care; the Third Net's informality allows for a renegotiation of roles such that Joseph, a migrant who also needs care (conventionally the 'patient'), can act as both caregiver (health practitioner) and care facilitator (broker).

Migrants at CCP also play an active role in organisational activities. In addition to understanding patients and volunteers as 'neighbors' in the same larger community, CCP volunteers recognise patients not as passive recipients of healthcare or other social services but, rather, as active organisers working to claim their own rights. For instance, in a volunteer training on the clinic's mission and vision, Michael, a nurse and CCP volunteer, said to the new volunteers in attendance:

> What you have to know is that our patients are part of a very strong and very organized immigrant community in this state. They are by no means drains on the system, and at

> the same time, they are by no means victims that are taking this sitting down. They are gutsy and smart organizers fighting for their own rights.

By describing patients as both neighbours within a larger health community and organisers fighting for their own rights, CCP volunteers explicitly recognise migrants' active role in facilitating migrant healthcare. This recognition disrupts traditional patient-provider configurations which figure patients as a passive receivers of care and opens possibilities for migrants to serve as brokers themselves.

At CCP, migrants are not only among the patients, but also volunteer as medical professionals and caregivers at the clinic. For example, Octavia, a migrant herself, provides patients talk therapy and mindfulness training to help alleviate stress and anxiety. Javiera, a migrant woman and volunteer from the Hispanic Nurses' Association, not only provides care at CCP but also uses the space to educate current and future medical professionals about the challenges faced by uninsured, undocumented migrants in the U.S., like her parents and brother: 'Before coming to CCP, I didn't know that clinics like this existed. Now I can't see myself ever not working in a clinic like CCP.' Given the centrality of migrants as both patients and providers at JyP and CCP, both organisations challenge conventional broker roles. When volunteers broker care, they do not simply act as gatekeepers of medical resources and representatives of migrant interests. They also act as enablers of different configurations of care whereby migrants can act as brokers themselves.

## Discussion and conclusion

Building on scholarship that examines brokerage processes in the first and second tiers of the U.S. healthcare system (Gould and Fernandez 1989; López-Sanders 2017b, 2017a), we employed ethnography and interviews to explore the modes and meanings of brokerage in what we call the Third Net, a loose network of volunteer-run community-based organisations and clinics that provide informal health services to low-income undocumented migrants. We found that brokerage within the Third Net involves (1) facilitating access to the formal tiers of the healthcare system; (2) challenging migrants' racialized disentitlement and discourses of migrant dependency; and (3) manifesting a more versatile form of brokerage. Our research highlights the potential for brokers within the Third Net to not only enable healthcare access but also challenge the existing legal parameters of migrants' healthcare exclusion.

Our two Third Net sites – Justicia y Paz (JyP) and Community Clinic of Phoenix (CCP) – differ in geography, contexts of state and local policy, and philosophies of care. However, in their approach to brokering migrant healthcare, JyP and CCP share a couple of important commonalities, illustrating characteristics potentially salient across other Third Net spaces. First, volunteers in both organisations reframe migrants in ways that challenge dominant anti-immigrant rhetoric. JyP rejects the notion that undocumented migrants are undeserving by virtue of their 'illegality,' and CCP challenges the idea that migrants are a 'burden' on healthcare resources. In doing so, both sites contest migrants' racialized disentitlement and emphasise the deficiencies of the healthcare system in its current state. Moreover, volunteers within both organisations recognise migrants not as passive recipients of care but, rather, as active caregivers

and collaborators. Relatedly, a second commonality between the two organisations is that they both actively work to reconfigure conventional brokerage relationships, and in doing so, challenge the racialized power dynamics of migrant healthcare access and provision that can often fall into patterns and pitfalls of white saviorism. At both JyP and CCP, this work involves the incorporation of migrants as leaders, organisers, and healthcare practitioners within the organisations. Through the work of these organisations, we find that brokerage processes within the Third Net can vary greatly from conventional brokerage relationships in the first and second tier.

Adding to the literature on migrant health and brokerage (Campbell-Montalvo et al. 2022; López-Sanders 2017b, 2017a) our research illuminates the potential versatility of brokerage relationships. At the beginning of our paper, we discussed several theoretical models of brokerage for migrant healthcare, in which organisations and individuals act as gatekeepers and/or representatives to broker healthcare access for uninsured, undocumented migrants within the first and second tiers of care (Gould and Fernandez 1989; López-Sanders 2017b, 2017a). (See Figures 1 and 2). Consistent across these models is the implication that brokerage relationships are primarily unidirectional (e.g. migrants go through brokers to access health practitioners and other resources) and static (i.e. the categories of migrant patient, medical broker, and health practitioner are fixed and mutually exclusive). Advancing these models of brokerage, our cases reveal the potential for versatility in brokerage relationships, where social, economic, and medical resources are allocated multi-directionally and the broker role can shift from person to person (see Figure 3). Thus, at a theoretical level, our research illustrates that brokerage can involve both stabilisation and destabilisation. Consistent with previous work (Aptekar 2020; Campbell-Montalvo et al. 2022; Campbell-Montalvo and Castañeda 2019), both medical (CCP) and non-medical (JyP) entities broker semi-formal access to mainstream healthcare services and essentially stabilise otherwise disconnected patient-provider relationships. Adding to this literature, our cases also demonstrate ways in which multiple groups (i.e. migrants, health practitioners, organisation volunteers) can manifest new configurations of healthcare and share the broker role, ultimately destabilising traditional patient-provider relationships.

As illustrated in Figure 3, brokers within the Third Net can do more than simply facilitate access to healthcare because they operate on a different informal plane than brokers within the formal first and second tiers of care. Traditional examinations of brokerage relationships have been critiqued as 'mono-planar' with more recent scholarship recognising the potential for brokerage relationships to be 'bi-planar' (López-Sanders 2017a). In these bi-planar brokerage relationships, Navigators and other street-level bureaucrats operate as both representatives and gatekeepers simultaneously, balancing migrants' healthcare needs and hospital/clinic administrators' profit-driven demands. Our research contributes to this literature by shedding light on the reality of brokerage as a 'multi-planar' relationship. Migrant patients, brokers, and health practitioners continue to navigate brokerage relationships within the first and second tiers. At the same time, however, the three groups coalesce on a different informal plane (i.e. Third Net sites like JyP and CCP) where neither the patient 'representative' nor 'gatekeeper' modality of brokerage is necessary; it is a plane where migrants can represent their own healthcare needs and rights and healthcare practitioners can circumvent the hyper-profit pressures of private medicine. Thus, in practical terms, brokerage within the Third Net takes seriously

migrants' agency and allows for an active re-imagining and reconfiguration of immigrant healthcare in the U.S. Although the informality of the Third Net presents practitioners and migrants with notable challenges (e.g. steady funding and labour power), it also presents opportunities for everyone involved to advocate for a more just healthcare system. Future research should explore if, how, and why versatile brokerage manifests in other Third Net contexts.

## Note

1. Although López-Sanders and others refer to the healthcare system's different sectors as 'tiers,' we use the term 'net' to remain consistent with our other work. In a forthcoming book, we describe this third tier as the 'Third Net' to signal its relationship to the healthcare safety net.

## Acknowledgements

The authors would like to thank the anonymous reviewers, the editorial team, and Lisa Sun-Hee Park for their constructive feedback and suggestions on the manuscript at various stages of the process. We would also like to thank our respective significant others for their support and the communities in which we worked for their tireless efforts toward migrant justice.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

This work was supported by Ford Foundation; Anna Welsch Bright Memorial Fund.

## ORCID

*Erin Hoekstra* http://orcid.org/0000-0002-4509-7542
*Anthony Michael Jimenez* http://orcid.org/0000-0003-3550-3145

## References

Andrulis, D. P., and N. J. Siddiqui. 2011. "Health Reform Holds Both Risks and Rewards For Safety-Net Providers And Racially And Ethnically Diverse Patients." *Health Affairs* 30 (10): 1830–1836. doi:10.1377/hlthaff.2011.0661

Aptekar, S. 2020. "Doctors as Migration Brokers in the Mandatory Medical Screenings of Immigrants to the United States." *Journal of Ethnic and Migration Studies* 46 (9): 1865–1885. doi:10.1080/1369183X.2018.1494545

Asad, A. L., and M. Clair. 2018. "Racialized Legal Status as a Social Determinant of Health." *Social Science & Medicine* 199: 19–28. doi:10.1016/j.socscimed.2017.03.010

Belabas, W., and L. Gerrits. 2017. "Going the Extra Mile? How Street-Level Bureaucrats Deal with the Integration of Immigrants." *Social Policy & Administration* 51 (1): 133–150. doi:10.1111/spol.12184

Boehm, D. A. 2005. "The Safety net of the Safety net: How Federally Qualified Health Centers "Subsidize" Medicaid Managed Care." *Medical Anthropology Quarterly* 19 (1): 47–63. doi:10.1525/maq.2005.19.1.047

Borrelli, L. M. 2019. "The Border Inside–Organizational Socialization of Street-Level Bureaucrats in the European Migration Regime." *Journal of Borderlands Studies*, 1–20. doi:10.1080/08865655.2019.1676815.

Braun, V., and V. Clarke. 2019. "Reflecting on Reflexive Thematic Analysis." *Qualitative Research in Sport, Exercise and Health* 11 (4): 589–597. doi:10.1080/2159676X.2019.1628806

Braun, V., V. Clarke, and N. Hayfield. 2022. "'A Starting Point for Your Journey, not a Map': Nikki Hayfield in Conversation with Virginia Braun and Victoria Clarke About Thematic Analysis." *Qualitative Research in Psychology* 19 (2): 424–445. doi:10.1080/14780887.2019.1670765

Burt, R. S. 2000. "The Network Structure of Social Capital." *Research in Organizational Behavior* 22: 345–423. doi:10.1016/S0191-3085(00)22009-1

Burt, R. S. 2004. "Structural Holes and Good Ideas." *American Journal of Sociology* 110 (2): 349–399. doi:10.1086/421787

Burt, R. S. 2005. *Brokerage and Closure: An Introduction to Social Capital*. Oxford: Oxford University Press.

Cadzow, R. B., M. Craig, J. Rowe, and L. S. Kahn. 2013. "Transforming Community Members Into Diabetes Cultural Health Brokers: The Neighborhood Health Talker Project." *The Diabetes Educator* 39 (1): 100–108. doi:10.1177/0145721712465342

Campbell-Montalvo, R., and H. Castañeda. 2019. "School Employees as Health Care Brokers for Multiply-Marginalized Migrant Families." *Medical Anthropology* 38 (8): 733–746. doi:10.1080/01459740.2019.1570190

Campbell-Montalvo, R., O. Sidorova, M. Valdovinos, X. Cong, and R. Lucas. 2022. "Health Care Access Brokerage by School Employees for Immigrant Mexican and Indigenous Guatemalan Farmworking Families in a Connecticut Elementary School." *AERA Open* 8: 23328584211068070. doi:10.1177/23328584211068071

Cervantes, A. G., and C. Menjívar. 2020. "Legal Violence, Health and Access to Care: Latina Immigrants in Rural and Urban Kansas." *Journal of Health and Social Behavior*, 1–17. https://doi.org/0022146520945048.

Day, D. 1952. *The Long Loneliness*. San Francisco: Harper & Row.

Deines, H. 2008. "The Catholic Worker Movement: Communities of Personal Hospitality and Justice." *Social Work and Christianity* 35 (4): 429–448.

Dysart-Gale, D. 2005. "Communication Models, Professionalization, and the Work of Medical Interpreters." *Health Communication* 17 (1): 91–103. doi:10.1207/s15327027hc1701_6

Edlins, M., and J. Larrison. 2020. "Street-level Bureaucrats and the Governance of Unaccompanied Migrant Children." *Public Policy and Administration* 35 (4): 403–423. doi:10.1177/0952076718811438

Fernández-Kelly, P., and A. Portes. 2012. "Health Care and Immigration: Understanding the Connections." *Ethnic and Racial Studies* 35 (1): 1–2.

Fernandez, R. M., and R. V. Gould. 1994. "A Dilemma of State Power: Brokerage and Influence in the National Health Policy Domain." *American Journal of Sociology* 99 (6): 1455–1491. doi:10.1086/230451

Frey, B., and A. M. Pardo. 2017. "Filling the Migrant Rights Gap: Localized Protections of International Economic and Social Rights." *Public Integrity* 19 (2): 136–150. doi:10.1080/10999922.2016.1221304

Gould, R. V., and R. M. Fernandez. 1989. "Structures of Mediation: A Formal Approach to Brokerage in Transaction Networks." *Sociological Methodology*, 89–126. doi:10.2307/270949

Hammersley, M. 2018. "What is Ethnography? Can it Survive? Should it?" *Ethnography and Education* 13 (1): 1–17. doi:10.1080/17457823.2017.1298458

Harris County Hospital District Financial Assistance Program. 2000. Harris Health System. https://www.harrishealth.org/SiteCollectionDocuments/eligibility/policies/financial-assistance-program-policy-5.02.pdf.

Hoekstra, E. 2021. ""Not a Free Version of a Broken System:" Medical Humanitarianism and Immigrant Health Justice in the United States." *Social Science & Medicine* 285: 114287. doi:10.1016/j.socscimed.2021.114287

Isaacs, S., R. Valaitis, K. B. Newbold, M. Black, and J. Sargeant. 2013. "Brokering for the Primary Healthcare Needs of Recent Immigrant Families in Atlantic, Canada." *Primary Health Care Research & Development* 14 (1): 63–79. doi:10.1017/S1463423612000229

Jezewski, M. A. 1990. "Culture Brokering in Migrant Farmworker Health Care." *Western Journal of Nursing Research* 12 (4): 497–513. doi:10.1177/019394599001200406

Jezewski, M. A., and P. Sotnik. 2001. "Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign-Born Persons." *Center for International Rehabilitation Research Information and Exchange*. http://cirrie-sphhp.webapps.buffalo.edu/culture/monographs/cb.php

Jimenez, A. M. 2021. "The Legal Violence of Care: Navigating the US Health Care System While Undocumented and Illegible." *Social Science & Medicine*, https://doi.org/113676.

Joseph, T. D., and H. B. Marrow. 2017. "Health Care, Immmigrants, and Minorities: Lessons from the Affordable Care Act in the U.S." *Journal of Ethnic and Migration Studies* 12: 1965–1984. doi:10.1080/1369183X.2017.1323446

Kaiser. 2020. Health Coverage of Immigrants. Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

Kelly, M. 1994. "Theories of Justice and Street-Level Discretion." *Journal of Public Administration Research and Theory* 4 (2): 119–140. doi:10.1093/oxfordjournals.jpart.a037201.

Lamont, M., and A. Swidler. 2014. "Methodological Pluralism and the Possibilities and Limits of Interviewing." *Qualitative Sociology* 37 (2): 153–171. doi:10.1007/s11133-014-9274-z

Lamphere, L. 2005. "Providers and Staff Respond to Medicaid Managed Care: The Unintended Consequences of Reform in New Mexico." *Medical Anthropology Quarterly* 19 (1): 3–25. doi:10.1525/maq.2005.19.1.003

Lindsay, S., S. Tétrault, C. Desmaris, G. King, and G. Piérart. 2014. "Social Workers as "Cultural Brokers" in Providing Culturally Sensitive Care to Immigrant Families Raising a Child with a Physical Disability." *Health & Social Work* 39 (2): e10–e20. doi:10.1093/hsw/hlu009

Lipsky, M. 2010 [1980]. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Service*. New York: Russell Sage Foundation.

López-Sanders, L. 2017a. "Changing the Navigator's Course: How the Increasing Rationalization of Healthcare Influences Access for Undocumented Immigrants Under the Affordable Care Act." *Social Science & Medicine* 178: 46–54. doi:10.1016/j.socscimed.2017.01.066

López-Sanders, L. 2017b. "Navigating Health Care: Brokerage and Access for Undocumented Latino Immigrants Under the 2010 Affordable Care Act." *Journal of Ethnic and Migration Studies* 43 (12): 2072–2088. doi:10.1080/1369183X.2017.1323452

Marrow, H. B. 2012. "Deserving to a Point: Unauthorized Immigrants in San Francisco's Universal Access Healthcare Model." *Social Science & Medicine* 74 (6): 846–854. doi:10.1016/j.socscimed.2011.08.001

Marrow, H. B., and T. D. Joseph. 2015. "Excluded and Frozen Out: Unauthorised Immigrants' (Non)Access to Care After US Health Care Reform." *Journal of Ethnic and Migration Studies; Abingdon* 41 (14): 2253–2273. doi:10.1080/1369183X.2015.1051465.

Marsden, P. 1982. "Brokerage Behavior in Restricted Exchange Networks." Pp. 201-218 in *Social Structure and Network Analysis,* edited by P. Marsden and N. Lin. Beverly Hills: Sage.

Maynard-Moody, S., and M. Musheno. 2000. "State Agent or Citizen Agent: Two Narratives of Discretion." *Journal of Public Administration Research and Theory* 10 (2): 329–358. doi:10.1093/oxfordjournals.jpart.a024272

McKanan, D. 2008. *The Catholic Worker After Dorothy: Practicing the Works of Mercy in a New Generation*. Collegeville, Minnesota: Liturgical Press.

Molloy, L. J., K. Walker, and R. Lakeman. 2017. "Shared Worlds: Multi-Sited Ethnography and Nursing Research." *Nurse Researcher* 24 (4): 22–26. doi:10.7748/nr.2017.e1506

Morton, K., and J. Saltmarsh. 1997. "Addams, Day, and Dewey: The Emergence of Community Service in American Culture." *Michigan Journal of Community Service Learning* 4 (1): 137–149. http://hdl.handle.net/2027/spo.3239521.0004.117.

Obstfeld, D., and S. Borgatti. 2008. Brokerage is a Process, not a Structure: A Clarification of Social Network Language. Meeting of International Sunbelt Social Network, Florida.

Okie, S. 2007. "Immigrants and Health Care-at the Intersection of two Broken Systems." *New England Journal of Medicine* 357 (6): 525. doi:10.1056/NEJMp078113

Portes, A., P. Fernández-Kelly, and D. Light. 2012. "Life on the Edge: Immigrants Confront the American Health System." *Ethnic and Racial Studies* 35 (1): 3–22. doi:10.1080/01419870.2011.594173

Portes, A., and J. Sensenbrenner. 1993. "Embeddedness and Immigration: Notes on the Social Determinants of Economic Action." *American Journal of Sociology* 98 (6): 1320–1350. doi:10.1086/230191

Shi, L., J. Tsai, P. C. Higgins, and L. A. Lebrun. 2009. "Racial/Ethnic and Socioeconomic Disparities in Access to Care and Quality of Care for US Health Center Patients Compared with non–Health Center Patients." *The Journal of Ambulatory Care Management* 32 (4): 342–350. doi:10.1097/JAC.0b013e3181ba6fd8

Small, M. L. 2009. *Unanticipated Gains: Origins of Network Inequality in Everyday Life*. Oxford: Oxford University Press.

Staiti, A. B., R. E. Hurley, and A. Katz. 2006. "Stretching the Safety net to Serve Undocumented Immigrants: Community Responses to Health Needs." *Issue Brief (Center for Studying Health System Change)* 104 (1): 1–4.

Stovel, K., B. Golub, and E. M. M. Milgrom. 2011. "Stabilizing Brokerage." *Proceedings of the National Academy of Sciences* 108 (Supplement 4): 21326–21332. doi:10.1073/pnas.1100920108

Stovel, K., and L. Shaw. 2012. "Brokerage." *Annual Review of Sociology* 38: 139–158. doi:10.1146/annurev-soc-081309-150054

Van Natta, M. 2019. "First do No Harm: Medical Legal Violence and Immigrant Health in Coral County, USA." *Social Science & Medicine* 235: 112411. doi:10.1016/j.socscimed.2019.112411

Viladrich, A. 2005. "Tango Immigrants in New York City: The Value of Social Reciprocities." *Journal of Contemporary Ethnography* 34 (5): 533–559. doi:10.1177/0891241605279019

Wallace, S. P., J. M. Torres, T. Z. Nobari, and N. Pourat. 2013. Undocumented and Uninsured: Barriers to Affordable Care for Immigrant Populations. UCLA Center for Health Care Policy Research. https://escholarship.org/uc/item/8ds5h7k3.

Weiner, S. J., M. Laporte, R. I. Abrams, A. Moswin, and R. Warnecke. 2004. "Rationing Access to Care to the Medically Uninsured: The Role of Bureaucratic Front-Line Discretion at Large Healthcare Institutions." *Medical Care*, 306–312. doi:10.1097/01.mlr.0000118706.49341.49

WestRasmus, E. K., F. Pineda-Reyes, M. Tamez, and J. M. Westfall. 2012. "Promotores de Salud and Community Health Workers: An Annotated Bibliography." *Family & Community Health* 35 (2): 172–182. doi:10.1097/FCH.0b013e31824991d2

Witmer, A., S. D. Seifer, L. Finocchio, J. Leslie, and E. H. O'Neil. 1995. "Community Health Workers: Integral Members of the Health Care Work Force." *American Journal of Public Health* 85 (8_Pt_1). doi:10.2105/AJPH.85.8_Pt_1.1055