Local Government's Role in Health Care for Undocumented Immigrants: Three Counties in North Texas

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Local governments and local public hospitals are often responsible for the provision of health care to the medically indigent and uninsured. With rapidly increasing health care costs and sustained contention over how to respond to the needs of undocumented immigrants, local governments have struggled to provide services to low-income undocumented residents who are typically ineligible for public benefits. Three case studies from the Dallas, Texas metropolitan area (Dallas, Collin, and Ellis Counties) are presented to illustrate how local governments may collaborate with nonprofit service providers to serve the health care needs of the undocumented. Such collaborations may offer political, economic, and cultural advantages in comparison to health care provision by the public sector alone. Alternative circumstances and strategies involved in public-nonprofit collaboration are reviewed for these politically and fiscally varying localities.

With rapidly increasing health care costs, health care providers have struggled with the costs of serving low-income undocumented residents. Undocumented workers and their families are often among the working poor, and typically neither have access to employer-based health insurance nor qualify for public programs limited to legal residents. However, the undocumented are nevertheless entitled to emergency health services from hospital emergency departments under the federal Emergency Treatment and Active Labor Act of 1986 (EMTALA), and many public and private hospitals bear substantial costs in providing them with care that is ultimately uncompensated.

Responses by government to the health needs of the undocumented population or even to assist hospitals with the burden of providing care can be potentially controversial in the context of the highly charged public debate over the appropriate response to illegal immigration. This paper presents accounts of how three counties in North Texas have addressed the issue of health care provision to the undocumented population in order to examine the issues surrounding service provision to an underserved and often politically controversial group. In particular, these cases illustrate how collaborations between the public and non-governmental sectors have been used to manage this issue with varying degrees of success.

Background

Texas has one of the highest rates of medically uninsured individuals and families in the nation, and undocumented immigrants form a large part of the population without health insurance. Under the Texas Constitution and Texas law, it is county governments that are responsible for health care to the indigent, including the undocumented. In recent years, entities involved in the provision of care to undocumented immigrants, such as county-run health facilities, public hospitals, private hospitals, and non-profit community-based clinics have increasingly collaborated with each other to provide expanded services more effectively, more efficiently, and perhaps in a less politically controversial manner.

Hospitals are motivated by their desire to reduce unnecessary emergency room visits, and thereby reduce their short-term financial burden and resource strain. Health care providers seek to secure more comprehensive care than can be offered in either primary care clinics or in the emergency room alone. Collaboration may offer system-wide collective benefits, reducing costs in the long-term as a result of undocumented immigrants receiving appropriate care in a more timely manner.

The public administration literature is rich with comprehensive theories on inter-organizational networking and collaboration. For example, Gray (1985) utilizes a systems approach to describe the conditions that facilitate inter-organizational collaboration, especially in turbulent environments. This theory assumes that the process of establishing collaboration is a multi-stage sequential process involving problem-setting, direction-setting and structuring. The central tenet of this theory is that different factors influence the advancement of collaboration through these various stages. Literature on inter-organizational collaboration identifies predisposition of stakeholder characteristics, characteristics of existing relationships, organizational capacity, and programmatic capacity as some of the major factors that determine the success of collaborative efforts.

This study applies factors and processes identified in the literature on collaboration to study the process of collaboration amongst various stake-holders in the provision of health services to undocumented immigrants. It provides an opportunity to analyze both why and how county governments, hospitals and other health care providers collaborate with each other in an environment of fiscal crisis and political controversy.

The study draws on evidence from three counties in the Dallas, Texas metropolitan area (Collin, Dallas, and Ellis), drawing on ongoing research by the authors on collaborative arrangements between the public and nonprofit sectors in the provision of health care

services that serve the indigent and undocumented population. The three cases represent diverse approaches to the challenge of serving the undocumented, including an urban county with a well-established but over-burdened public hospital and a number of public and non-profit primary care clinics; an affluent suburban county with a modest public program and a complex relationship with nonprofit providers that has been affected by the politics of immigration and public services; and a county encompassing both suburban and rural sectors that has limited resources but strong collaboration between local government and non-profit providers. Conclusions are presented about alternative circumstances and strategies involved in public-nonprofit collaboration in politically and fiscally varying localities.

Demographic and Health Profile of the Undocumented

Texas, as a border state, had over 2.9 million immigrants in 2005, accounting for thirteen percent of the state's population, in contrast to seven percent for the rest of the country. (Passel et al., 2004) While no accurate measures of undocumented immigrants exist, extrapolations based on children enrolled in schools, with identification other than a Social Security number, estimate this population to have been one million people in 2000 (U.S. Census Bureau, 2003), increasing by fifty-four percent to 1.7 million people by 2007. (Hoefer and Baker, 2008) Thirty-one percent of undocumented families have at least one family member, usually a child, who is a citizen. Most undocumented immigrants are relatively younger than the larger population, with over ninety percent of the undocumented less than 44 years old. (Pew Hispanic Center, 2006)

People of Hispanic ethnicity account for a large proportion of legal residents among the immigrant population, as well as of the undocumented in Texas. About thirty-eight percent of the 23.5 million people in Texas are of Hispanic ethnicity (U.S. Census Bureau, 2008), compared to fifteen percent in the United States.

According to the Pew Hispanic Center, most undocumented immigrants in the United States are employed in the service industry (31%), followed by construction (19%), production (15%), and farming (4%). (Pew Hispanic Center, 2006). Given their immigration status and their employment concentration in the service sectors, most undocumented immigrants earn close to minimum wage income, thereby falling below the federal poverty line. The average family income in 2003 was $11,300 to $12,600. Twenty-seven percent of adults and thirty-nine percent of children belonged to households with incomes below the federal poverty line. (Pew Hispanic Center, 2006)

Undocumented immigrants are relatively younger and healthier than the general population. This is partly due to the process of selection that takes place as the result of the hardships one has to overcome to cross the border. However, the undocumented population tends to have higher prevalence of communicable diseases such as tuberculosis (Achkar et al., 2008). and chronic illnesses such as diabetes (Eldridge, 2002). Beyond anecdotal evidence, the health profile of this sub-population is largely unknown.

Health Care Services Available to the Undocumented

Implementation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 led to de-coupling of social welfare benefits from health insurance

safety-net programs such as Medicaid. Among the many changes were complex restrictions on social welfare and health insurance benefits to legal immigrants. PRWORA instituted a five year waiting period for legal immigrants entering the United States before they could gain access to many social safety-net services. Prior to passage of PRWORA, undocumented and 'unqualified' immigrants such as temporary non-resident aliens were excluded from receiving services of federal entitlement programs. PRWORA further strengthened existing laws limiting undocumented immigrants' access to federal entitlement programs.

State and local governments are required to screen for immigration status when people apply for programs designated as a `federal public benefit.' Undocumented immigrants, unqualified immigrants, and qualified immigrants yet to complete the five year waiting period are disqualified from receiving services from programs designated as a Federal public benefit. However, certain core services must be available to all persons regardless of immigration status, the program's federal public benefit status, or funding source. Such services include emergency Medicaid, immunizations, and diagnosis and treatment of communicable diseases. State and local governments are prohibited from screening applicants for programs that are deemed federal public benefits. Programs providing Maternal and Child Health services (Title V of the Social Security Act), Family Planning services (Title X of the Social Security Act), Federally Qualified Health Centers (FQHCs), and programs receiving Primary Care Block Grants fall outside the category of federal public benefits, and hence are accessible to the undocumented. Prenatal and maternal care services are covered because children born in the U.S to undocumented immigrants are U.S citizens and thus are eligible for most services. However, most undocumented immigrant parents who have children of U.S citizenship avoid applying for eligible benefits for fear of being identified and deported (Eldridge, 2002).

Children of undocumented immigrants born outside of the U.S face similar hurdles to health care access as their parents. They are denied access to health insurance coverage through the State Children's Health Insurance Program (SCHIP) due to their immigration status. Federal laws do allow states to provide certain health services to certain populations such as migrant farm workers without screening for citizenship (Eldridge, 2002). Texas provides coverage to qualified children of immigrants who do not qualify for Medicaid due to the five year wait period. However, no provisions are made for children of undocumented immigrants.

Federal laws allow states to extend certain Medicaid services to other needy sections of the population. However, states bear a substantial portion of the additional costs. It is up to the states to decide if potential applicants are to be screened for immigration status in order to receive these additional services. Texas does not provide any additional services that do not require screening for immigration status. Texas' Medicaid program covers only the federally mandated emergency services. Emergency Medicaid generally covers pregnancy and child birth, and any other life threatening conditions (Texas Health and Human Services Commission, 2004). Based on annual expenditures, emergency Medicaid accounts for the largest component of all health services that are available to undocumented immigrants (Strayhorn, 2006).

Other state programs that benefit undocumented immigrants include Maternal and Child Health services, state mental health services, immunizations, Women and Children's

health services, public health, and emergency medical services. Maternal and Child Health services cover children with special health needs in schools. Immunization and public health programs provide treatment for communicable diseases such as HIV-AIDS and especially tuberculosis regardless of immigration status to ensure the health of the larger population. State mental health service programs treat undocumented immigrants only in case of mental health emergencies since it is mandated by EMTALA. While the state does provide a variety of services to the undocumented, the services are fragmented and the programs are woefully under-funded. Most state services are funded by Federal block grants whose federal contribution has remained flat over several years.

In Texas, local governments and private entities incur the largest share of expenses related to providing primary and emergency health care services (Strayhorn, 2006). The Texas Indigent Healthcare and Treatment Act requires counties to act as the 'safety net of last resort.' These programs are meant to cover individuals who do not qualify for any of the state and federal government healthcare programs. Under the Act, counties are allowed to provide services either through hospital districts, public hospitals, or County Indigent Health Care Programs (CIHCP). The difference between hospital districts and public hospitals lies in the method of funding and the level of matching funds available to counties from federal and state governments. One hundred and forty four of the two hundred and fifty eight counties in Texas operate hospital districts. Counties offering CIHCP offer coverage for preventive and emergency healthcare services. One hundred fifty Texas counties offer some version of a CIHCP.

Hospitals and other private entities also bear a substantial portion of the costs associated with providing healthcare services to Texas' indigent and undocumented. According to the Indigent Care Collaboration, an alliance of indigent care providers, undocumented immigrants accounted for 14% of all uncompensated care provided in hospital out-patient settings and 25% of all uncompensated care provided in emergency departments. The total cost of uncompensated care provided to undocumented immigrants is estimated to be around $1.3 billion (Strayhorn, 2006).

The existing distribution of resources and responsibilities across various levels of government and private entities in the provision healthcare services to the indigent, and especially the undocumented, has led to unfavorable outcomes for almost everyone involved. The undocumented immigrants face huge hurdles and risks to receiving timely care. The fragmented and incomplete nature of available healthcare services provides inadequate care to indigents and undocumented immigrants with chronic illnesses. Local and city governments face large financial burdens as federal and state governments shift responsibility by imposing under-funded mandates. Healthcare providers such as hospitals are forced to bear high costs resulting from uncompensated emergency room care. Non-profits and charities struggle to find appropriate ways to spend their resources optimally in an increasingly fragmented system.

In addition to economic inefficiencies and inequities, the provision of social services to the undocumented has become a politically charged issue. The larger national debate about immigration reform has made provision of services to undocumented immigrants a politically charged issue at the county and local government level. In addition to the wider

debate on immigration reform, the then Texas attorney general in 2001 expressed his opinion that hospital districts providing healthcare services to the undocumented would be violating federal laws, such as PRWORA, since Texas had not explicitly re-authorized that counties provide basic healthcare services to all indigents regardless of immigration status. This further complicated and constrained county officials from effectively providing or expanding services to the undocumented.

The economic and political crisis surrounding the provision of healthcare service to the undocumented has increased the likelihood of collaboration amongst stakeholders. While collaboration can be defined in numerous ways depending on the environment, participating entities and nature of the relationship, for the purposes of this study, Gray's (1985) definition of "pooling of appreciations and/or tangible resources, by two or more stakeholders, to solve a set of problems that neither can solve individually." However, existence of a crisis by itself is not enough to initiate, build, and sustain collaborative efforts. The problem arising from the crisis needs to have certain characteristics to necessitate collaboration. These characteristics include solutions that are indivisible in nature amongst potential stakeholders, organizational forms that are insufficient to address the problem, and a setting in which stakeholders acting independently would cause unanticipated and dissonant consequences (Aldrich, 1976).

Some of these characteristics are reflected in the provision of healthcare services to the indigent and undocumented. The existing structure of indigent healthcare services leads to hospitals bearing a substantial financial burden and emergency room overcrowding. Private and non-profit clinics, while having the will to extend healthcare services to the undocumented, are often short on resources, and appropriate coordination is hampered by the fragmented nature of healthcare services available to indigents and the undocumented. Further, the political situation has made it extremely difficult for counties to institute any reforms by themselves. The shortcomings in the existing configuration of services, distribution of resources, and responsibilities created an environment where collaboration could lead to potential economic gains for hospitals, more resources for non-profit entities, better value for counties, and continuity of care for advocates of the undocumented.

Beyond the characteristics of the problem, other factors that affect collaborative capacity include the characteristics of the stakeholders, the quality of relationships, the quality of the collaborative efforts' organizational structure, and the programmatic quality of the service being provided (Foster-Fishman et al, 2001). Important characteristics that stakeholders need to be predisposed with include knowledge and skills necessary to perform the tasks entailed in collaborative efforts (Knoke and Wood, 1981) and attitudes and motivation of the stakeholders (Wandersman et al., 1994).

Quality of existing inter-organizational relationships determines whether such relationships can evolve in a positive manner (Lin, 1999) into viable (Gottlieb et al., 1993) and sustainable (Chavis, 1995) collaborative efforts. Quality of inter-organizational relationships depends on the quality of the internal working climate (U.S. Census Bureau, 2008), the ability of stakeholders to unite under a share vision of goals and solutions (McCann and Gray, 1986), and the ability of the stakeholders to facilitate fair distribution of resource and responsibilities (Armbruster et al, 1999).

The quality of the organizational structure that the collaborating stakeholders decide to build determines whether or not they can sustain their effort and engagements. (Wandersman et al., 1994), Characteristics that enhance organizational capacity include leadership skills, formalized processes and procedures, a well developed internal communication system that encourages information sharing, necessary human and financial resources (Wandersman et al., 1994), the ability to continuously learn and adapt by responding to feedback, and engagement in continuous evaluation (Armbruster et al., 1999) and a well developed framework of accountability (Foster-Fishman et al., 2001).

Programmatic capacity is the coalition's capacity to design and implement the program or service effectively (Foster-Fishman et al., 2001). The coalition should collectively be able to identify the community's needs, design innovative solutions, and mobilize community support for the new program or service (Barton et al., 1997). Good program design is characterized by the stakeholders' efforts to use resources efficiently by utilizing community strengths and resources, possessing realistic goals, delineating roles and responsibilities clearly, targeting services, fitting the ecological context, and displaying culturally sensitivity (Foster-Fishman et al., 2001). These attributes may be more likely to be found in arrangements that include community-based partners.

Dallas County

Dallas County is the second largest county in Texas, and contains the city of Dallas, the ninth largest city in the United States. In 2007, Dallas County's population was an estimated 2,366,511, a 6.7 percent increase since 2000. The County population included 20.3 percent African Americans and 37.1 percent of Hispanic origin. An estimated 24.0 percent of Dallas County's residents were foreign born, and 39.4 percent of those over the age of five spoke a language other than English at home. The estimated median family income for the county in 2007 was $52,071, with 16.9 percent of residents and 25.5 percent of children under 18 having incomes below the federal poverty line. The U.S. Census Bureau estimated that in 2005, 29.1 percent of non-elderly Dallas County residents did not have public or private health insurance (2009).

Dallas County established a public hospital, now the Parkland Health and Hospital System, in 1894. The hospital has an operating budget of over $1 billion and in FY 2007 experienced 42,788 admissions, 136,264 emergency room visits, and 849,098 clinic visits. In 1987, Parkland created a network of Community Oriented Primary Care (COPC) clinics that currently includes 11 community health centers, 11 school-based clinics, and eight women's clinics, as well as numerous outreach programs. The hospital is partially funded through a Dallas County Hospital District property tax, and also accepts public and private health insurance. In FY 2007, Parkland provided more than $512 million in uncompensated care. The hospital uses an income eligibility standard of 200 percent of the federal poverty guideline for subsidized services, but will serve anyone seeking care and then seek to bill for care for those above its standard.

Besides Parkland, there are a number of other sources in Dallas County for health care to the medically indigent. All of the hospitals provide the mandated access to emergency room services, and several (particularly non-profits) offer subsidized care to non-

emergency patients as well. The County also had more than 20 medical free clinics and several dental free clinics in 2008, many affiliated with faith-based organizations providing a variety of health care services.

Despite its comprehensive array of services, Parkland collaborates with a number of nonprofit agencies and community groups. The hospital operates the Dallas site for the federal Healthy Start program, working on outreach projects with a variety of community-based groups to improve maternal and child health. Parkland also is involved with an extensive network that includes community-based free clinics, local nonprofit and for-profit hospitals, private physicians, and faith-based organizations. The Dallas County Medical Society arranges for donated specialty care to uninsured individuals being served through community providers, while HOMES, a partnership between the City of Dallas and several nonprofit agencies serving homeless individuals and families, operates two mobile units that offer acute and preventive medical care and social work services at various community sites. Other community and inter-agency collaborations include work with local Federally Qualified Health Clinics and special networks for HIV/AIDS, rape crisis and victim intervention, perinatal care, community immunization, health screening, trauma, disaster planning, and response efforts.

For Parkland Hospital and Dallas County, collaborations with community nonprofits have been undertaken for a variety of reasons. Because the hospital has chosen to take a very proactive position with regard to public health, generating a half-billion dollars in uncompensated care, its resource needs are substantial. Partnering with community actors promotes community health both by diverting patients to other sources of care and by maintaining health in ways that lessen the overall demand on the county's hospital system for emergency and acute care, thus reducing costs. Further, the hospital operates in a politically conservative and fiscally uncertain environment, and the political benefits of these collaborations help to build political and social capital, thus promoting legitimacy and garnering support.

One of the most politically sensitive issues for Parkland Hospital has been provision of services for undocumented people. Nearly half of Parkland's patients, 47.3 percent, are of Hispanic origin, with a higher proportion in labor and delivery and other critical areas. Many of these patients are undocumented, and the hospital has a policy of providing treatment regardless of citizenship or immigration status. For some elected officials and voters, this commitment is troubling, and while there has been no serious challenge to Parkland's commitment to open access, it is an issue that raises potential problems from advocates critical of undocumented immigration and of the provision of public services to the undocumented. Community partnerships help to address the problem of providing care to this large segment of the community whose members often have only episodic contacts with the health care system.

One potentially promising new collaboration may be the establishment of a "three-share" program in Dallas County. Such programs involve the development of health benefit programs to low wage workers in small businesses who typically receive no employer-provided health benefits. Contributions from the employer and the employee are supplemented with a subsidy that keeps rates affordable in comparison to most other health insurance programs. The proposed Dallas County initiative would be operated as a non-

profit entity, drawing on funding from the federal and state governments and from Parkland Hospital. Similar programs have been adopted in several localities around the country, the most prominent of which is in Muskegon, Michigan. (Browning, 2009) A Dallas County three-share program was initiated in the summer of 2010, although its status and impact remain unclear at this writing.

Collin County

Collin County is a rapidly growing area north of Dallas County that includes affluent and recently developed suburbs, as well as some rural areas and small towns. Collin County's estimated population in 2007 was 730,690, an increase of 48.6% since 2000. The County's residents are 7.2 percent African American and 13.5 percent of Hispanic origin. In 2007, an estimated 16.5 percent of County residents were foreign born, and 23.3 percent of the County's population over the age of five spoke a language other than English at home. The estimated 2007 median family income was $91,881, and 6.2 percent of County residents and 7.6 percent of children under 18 lived in households with incomes below the federal poverty line. The Census Bureau estimated that in 2005, 16.4 percent of non-elderly Collin County residents did not have public or private health insurance.

While the County has a number of modern private hospitals and numerous medical providers, the public health infrastructure in Collin County is far less developed. The County's antiquated public hospital was sold in the early 1980s, with the proceeds used to create a health care trust fund that supports a modest indigent care program that has served fewer than 400 individuals annually, and fewer than 200 persons annually from 2003-2006. The program raised its eligibility income standard from 25 percent of the federal poverty guideline to 50 percent in 2004, and again to 100 percent in 2007; however, stringent asset tests have limited the ability of many indigent persons to qualify. While under the Texas homestead statute, houses are not considered, nonelderly nondisabled adults must have less than $2000 in other assets, except for motor vehicles which can have values up to $4650. Anyone holding assets greater than these limits is not eligible for County-subsidized health services.

In addition to the County indigent program, there are several nonprofit clinics providing primary health care in Collin County, although only one of these serves adults, and that clinic is open only one night per week. A number of Collin County residents seek care from Parkland Hospital in neighboring Dallas County, some openly and some with falsified Dallas County addresses. These individuals are not turned away, but Parkland seeks to recover funding from Collin and other adjacent counties for services provided to medically indigent. While these people may meet Dallas County's eligibility standard of 200 percent of poverty but not the standards used by the other outlying counties, such attempts to get payment are generally rebuffed.

In 2003, the Collin County commissioners voted to expand the use of the health care trust fund resources to provide grants to several nonprofit clinics within their county. Lump sum payments of $50,000 were given to two clinics in FY2003, a total of $147,425 was awarded to six clinics in FY2004, $194,000 to nine clinics in FY2005, $215,000 to eight clinics in FY2006, and $299,988 to nine clinics in FY 2007.

In 2007, after the election of more politically conservative county commissioners, new restrictions were placed on the nonprofit grant program, although the level of funding offered was maintained at approximately $300,000. One new mandate was that information on the individuals served with County funds be provided to County officials for verification of their (County) residency status. While clinics were also admonished to limit the use of County funds to legal U.S. residents, the County did not actually verify the status of patients whose services were subsidized. Three nonprofit providers declined to accept the grants with these restrictions, while another nine providers accepted the grants. In addition to the agencies withdrawing, some recipient agencies failed to spend their entire allotment, with the result that only $218,913 of the $300,000 authorized was actually spent. For FY2009, funding for the grant program was reduced by 33% to just under $200,000, with nine non-profits receiving grants.

At the same time as imposing these restrictions, however, a new program was established that provided County subsidies to services offered to the medically indigent through the urgent care facilities operated by the Primacare chain. In FY2008, the County paid for 2,357 patient visits with a total of $269,727. Not only has this arrangement expanded the points of access to health care, but anecdotal evidence suggests that it has reduced demand for emergency room services in area hospitals. As with the nonprofit grants, while County residence is verified, the program has not screened for citizenship status, allowing far greater access to undocumented residents than had previously been in effect.

However, the issue of public funds being used for services to undocumented individuals is never far from the surface in the very conservative context of Collin County politics. State and local elected officials from the county are often challenged to declare their opposition to such funding, and few are willing to stand up to such challenges. When a County-appointed task force on indigent health care recommended expansion of publicly funded services in 2006, a political uproar ensued from conservative activists who insisted that Collin County was being overrun by "illegal aliens" who threatened local security, the local economy, and the local government. Those activists maintained that increased funding for indigent health care would create a massive bureaucracy (the creation of one full-time position was recommended) and serve as a magnet that would attract undocumented "freeloaders" to the County. In 2009, the requirements for nonprofit health providers' participation in the County's grant program were revisited, and funding for the program has subsequently been reduced substantially, as financial austerity resulting from falling property values and tax revenues has resulted in reductions in many local government programs.

Ellis County

Ellis County is immediately south of Dallas County, and includes a number of bedroom suburbs while retaining rural and small town communities. The county's estimated population in 2007 was 143,488, a 29 percent increase since 2000. The county's residents were 9.2 percent African Americans and 21.9 percent people of Hispanic origin. In 2007, an estimated 7.4 percent of county residents were foreign born, and 18.4 percent of those over the age of five spoke a language other than English at home. The estimated 2007 median family income was $64,050, and about 10.7 percent of county residents and 15.6 percent of

children under 18 lived in households with incomes below the federal poverty line. The Census Bureau estimated that in 2005, 26.3 percent of non-elderly Ellis County residents did not have public or private health insurance. (2009)

Like Collin County, Ellis County does not have a public hospital or hospital district. The county has two major private hospitals in its major population centers of Ennis and Waxahachie, but has no County-operated health clinics. While some county residents may seek care at Parkland Hospital, the U.S. Veterans Affairs Hospital in Dallas, or in Dallas-based indigent health clinics, the major source of indigent medical care in Ellis County is Hope Clinic, located in the County seat of Waxahachie.

Hope Clinic was established in August 2000 with a $200,000 grant from Ellis County that allocated funds received from the state tobacco liability settlement. Additional funding was secured from local civic groups, churches, and individual donors and volunteers. Baylor Hospital, whose emergency room visits experienced a large reduction with the opening of Hope Clinic, also supports the clinic with an annual $40,000 grant, and additional support is received from the Ellis County United Way.

Since the 1980s, Ellis County has had a modest indigent health care program as mandated by the State of Texas, with eligibility set at the lowest level allowed by the state, 21 percent of the federal poverty guideline, along with the same asset limit as in Colin County. In 2003, the program spent approximately $700,000 on fewer than 75 beneficiaries. Hope Clinic offered to take over primary care for the county program for $275,000 a year while raising the eligibility standard to 150 percent of the federal poverty guideline, a proposal accepted by the County Commissioners Court and implemented in 2004. This arrangement has continued, with county funding gradually increasing along with the range of services offered by the clinic, and in 2009, Hope Clinic was designated as a Federally Qualified Health Center, which has resulted in additional operating subsidies provided by the federal government, as well as an expanded scope of health care services provided.

Unlike the other two counties discussed in this paper, the provision of health care services to undocumented persons has not been a significant issue in Ellis County. According to Dr. Mackie Owens, the clinic director, elected officials in the county have not raised any objections to Hope Clinic's acceptance of patients, screening only for income and County residency, but not for citizenship status.

Discussion

Much of the literature summarized above addresses the formation of coalitions including governmental and nongovernmental agencies to achieve ends that individual actors cannot adequately pursue on their own due to limits in organizational and technical capacity. (for example, Gray, 1985) In each of the three counties discussed in this paper, collaboration between local governments and nonprofit service providers has offered an effective mechanism for health care service delivery in a setting that can leverage volunteer time and donations, provide services in a cost-effective manner, and often build on the trust and cultural competence of community-based organizations. Local governments benefit when such collaborations reduce the need for costly hospital-based care while operating in settings that may be more inviting and culturally attuned to uninsured and underinsured people in need of a med-

ical home than are more bureaucratic and frequently impersonal public service providers. These attributes may be of particular benefit to people who are undocumented immigrants. Such immigrants are often among the working poor who lack health insurance or the income to purchase health care at market rates, and they are at risk for health problems that may be alleviated by ready access to culturally competent primary and preventive care.

As discussed above, the provision of health care to undocumented individuals is a critical issue in many parts of the United States, including the State of Texas. While the national health care reform program enacted in 2010 would broadly expand access to health services for many poor and uninsured Americans if it survives legal and political challenges, undocumented individuals have been expressly excluded from coverage in the legislation, and there is limited political support for changing that in the foreseeable future. Local governments and local public hospitals will continue to bear much of the burden of providing care to those who are not legal residents, while facing political pressures to exclude undocumented people from services.

Although Aldrich (1976) and others have predicted that collaborations may develop when independent action may lead to dissonant consequences, none of the literature reviewed explicitly emphasizes that collaboration may in some cases also be pursued out of political necessity, for the purpose of blurring accountability for potentially unpopular actions. When public entities can contract out for unpopular services, or for otherwise acceptable services to unpopular community beneficiaries, they may partially alleviate pressure to discontinue such services. The cases of Dallas and Collin Counties presented here may be examples of such a desire to depoliticize the provision of health care to undocumented county residents.

Conclusion

Collaboration between local governments and community-based nonprofit agencies to provide health care to undocumented residents was found to work effectively in three disparate localities in the North Texas Region. One advantage of such collaboration is that nonprofits may have flexibility, cultural competence, and social capital beyond that of local governments (and in the case of Dallas, the large bureaucratic public hospital system), improving the capacity to effectively address health care needs of the undocumented in these disparate communities. Contracting out provision of health care services to undocumented people may also reduce, although not eliminate, some of the political baggage associated with providing services to undocumented immigrants. As communities cope with the persistent limitations of the American health care system, the value of public-private collaborations in health care should be considered, and perhaps enhanced, in any redesign of local service delivery.

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