"Putting Band-Aids on Things That Need Stitches": Immigration and the Landscape of Care in Rural America

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ABSTRACT Growing numbers of immigrants work and live in rural, geographically isolated areas throughout the United States, places without previously settled immigrant populations. Rapid immigration to such areas already struggling with poverty, weak public infrastructures, and high concentrations of uninsured residents has given way to an increasingly precarious landscape of care. The neoliberal logics of American health care and contentious debates over immigration reform shape this landscape and condition relations among providers, immigrants, and others. Through what I call "band-aid" care and the informal transactions that characterize it, such as rationing, bartering, hoarding, willful noncompliance, and goodwill, providers and immigrants counter these logics of exclusion and inequality by participating in the dynamic improvisation of care considered illicit and often prohibited under the market-based economic rationale of health-care provision. Social obligations and moral legitimacy benefit otherwise marginalized providers who engage in this landscape of care, while vulnerable immigrants gain entry and access to vital resources within this landscape through sociality and interdependence, which engender opportunities (however fraught) for living. Yet providers and immigrants understand band-aid care to be necessary, just, moral, and legitimate in response to precarity characterized by geographical isolation, economic scarcity, civic inequality, market-based health care, and exclusionary policies. [*immigration, health care, exclusion, social inequality, United States*]

RESUMEN Creciente número de inmigrantes trabajan y viven en áreas rurales, aisladas geográficamente alrededor de los Estados Unidos, lugares sin previas poblaciones inmigrantes asentadas. La inmigración rápida a tales áreas que ya están luchando con pobreza, infraestructuras públicas débiles, y altas concentraciones de residentes no asegurados le ha dado paso a un paisaje del cuidado crecientemente precario. Las lógicas neoliberales de la atención médica en los Estados Unidos y los debates contenciosos sobre la reforma migratoria determinan este paisaje y condicionan las relaciones entre proveedores, inmigrantes y otros. A través de lo que llamo la atención "con curitas" y las transacciones informales que la caracterizan, tales como el racionamiento, el trueque, el acaparamiento, el incumplimiento deliberado, y la buena voluntad, los proveedores y los inmigrantes oponen estas lógicas de exclusión y desigualdad a través de participar en la improvisación dinámica de la atención considerada ilícita y a menudo prohibida bajo la racionalidad económica basada en el mercado de la provisión de la atención médica. Las obligaciones sociales y la legitimidad moral benefician a proveedores que de otro modo serían marginados quienes se involucran en este paisaje de la atención, mientras inmigrantes vulnerables ganan entrada y acceso a recursos vitales dentro de este paisaje a través de la sociabilidad y la interdependencia, los cuales engendran oportunidades (sin embargo tensas) para vivir. No obstante, los proveedores e inmigrantes entienden la atención con curitas como

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necesaria, justa, moral y legítima en respuesta a la precariedad caracterizada por el aislamiento geográfico, la escasez económica, la desigualdad cívica, la atención médica basada en el mercado y las políticas excluyentes. [*inmigración, atención médica, exclusión, desigualdad social, Estados Unidos*]

On a hot and humid afternoon in early August 2014, I sat down with David, a local physician and community clinic director. I had heard that David was one of the few in the area who worked with temporary migrant workers and more permanently established immigrant families. It was difficult to get a hold of David during the summer months because it was peak harvest season, when many migrant workers traveled to the rural, isolated, and sparsely populated area of Maryland's Eastern Shore to work in the region's agricultural, poultry, and seafood industries. David's small community clinic was often full of activity on the days that I had visited. It felt strange to be there when it was quiet and still.

David was highly animated when we began to talk. I sensed he wanted to tell me something right away. Before I even had a chance to ask a question, he recounted an incident that had been ongoing for several weeks, something that he had still been working on right before I had arrived. "The nicest man came in one day," David explained. "He wasn't feeling well. He complained of being really tired but he was very thin, very active, and very healthy appearing." He continued, "I told him, 'Let me do some tests on you.'"

The test results surprised David, "He's just spilling sugar in his urine and I thought to myself, 'Oh my Lord, he's forty-two.' So I asked him, 'Have you ever been told that you're diabetic?'" When the man responded that he had never been given that diagnosis but that his father was diabetic, David decided to do additional tests. "I did the tests as best I could," he told me. "I get indigent rates from the lab company for certain tests, and I often eat the cost myself and don't even charge the patients. In his case, I told him he definitely has diabetes and that he had to be on insulin. I have a very good relationship with the insulin reps so I told them, 'I have this gentleman who is undocumented. He can't go through patient assistance.'"

He paused for a moment, surveying my face to see if I understood his patient's predicament, and continued, "There are patient assistance programs through the pharmaceutical company if you are poor but if you're undocumented, you're *nothing*. So I got the reps to give me the medicine for him." David went on, "He ended up in someone else's care and they called me and said, 'Why are you doing this to this man? He can't afford this medicine. He doesn't pay for it.' They said you can't continue to do this for him, and I said, 'Why not? There's nothing stopping me from continuing to do this for him.' I have an agreement when he runs low, he comes by."

When I inquired about what "they" wanted David to do, he responded matter of factly, "Put him on regular insulin, which he would have to do every four hours. I have him on a pen that costs about $400 that he can do once a day and he's actually doing really well. He doesn't have the ability to test his sugar before he eats and do a sliding scale of insulin because he's in the field!" Shaking his head, David uttered, "Insulin has to be refrigerated. Hello? What are you supposed to do? Have a little fanny pack of ice with him as he's going through the chicken houses that are 110 degrees? So you have to be creative about the environment that they exist in. It's difficult at best, but it's difficult for everybody."

Referring back to those who chastised him, he declared, "But the hardest problem for them to deal with is that I give him free care and the point is that they have to purchase medication or services." He paused for what seemed like a long moment, looking past me out the window, and said quietly, "No matter what I do, I feel like I'm just putting band-aids on things that need stitches."

Drawing on the interviews I gathered and the observations I made while conducting ethnographic research on Maryland's Eastern Shore, in what follows I bring together three analytical threads to examine the everyday work and struggles enacted by immigrants and providers within what David calls "band-aid" care. These elements include anthropological studies of therapeutic itineraries, an analysis of recent transformations related to health care and immigration reform and long-standing issues of precarity among rural health systems, and theories of the political and moral economy of health. My aim is to better understand the broader landscape of care in places like Maryland's Eastern Shore, where spatial and temporal configurations of unequal access, moral and material exchanges, cultures of relatedness, and the politics of exclusion characterize everyday experiences of health and health-care provision.

By considering landscape as both a framing device and a local practice to understand the precariousness of care (Milligan and Wiles 2010), I demonstrate that moral and material circulations of caregiving and care seeking both mediate and are intensified by the logics of exclusion and inequality of health-care and immigration policies. In many ways, the metaphor used by David and other interlocutors in my fieldsite of a band-aid signals temporary, provisional measures undertaken to care for individuals who need more sustained attention and long-term treatment yet are left out of health care because of their legal or economic status. While acknowledging my interlocutors' use of band-aid as a means to illustrate the critical inadequacy of the systems in place to treat immigrants and the working poor in rural America, I argue that the care enacted on the Eastern Shore is far more extensive than the insufficient, modest form of

FIGURE 1. *Watermelon harvest. (Photograph by Emilia Guevara) [This figure appears in color in the online issue]*

care associated with band-aids. I seek to reorient the notion of band-aid as a means to underscore the lived ways that people create mutuality and care in the face of precarious economic conditions and a hostile political climate. I maintain that such modes of improvised care increasingly have become the standard of health- and social-care provision in many places, including the United States. Peter Redfield (2017), in his analysis of small technological fixes to large, complex issues, contends, "In their small and flawed utility, little devices can at least open larger questions that otherwise might remain foreclosed." I maintain that attending to band-aid care requires simultaneously examining the impersonal and self-interested logic of formal health-care access and a deeper analytical engagement with the interpersonal, relational, and reciprocal nature of health-care delivery.

BAND-AID CARE IN THE FIELD

I began ethnographic fieldwork on the Eastern Shore in 2013, after reading gray literature on the steep rise in immigration in this rural, isolated region of Maryland (Figure 1). I soon found that there was no information on immigration to this area, and much of my work initially consisted of documenting the rise in immigration from Mexico, Central America, and Haiti, and detailing the various immigrant groups working and settling in the region.[1] During the time I spent conducting interviews with local researchers, academics, medical- and social-service providers, and immigrants, and observing interactions in community health facilities, service organizations, homes, and immigrant housing, I began to hear and witness the challenges experienced within rural health-care systems, particularly in regard to the implementation of cost-saving and profit-motivated measures, which had been ongoing since the 1990s (Ricketts 2000).

Providers and administrators discussed the daily struggles of operating with already limited resources while serving populations with high levels of mortality and morbidity. They noted that, over the years, the region had experienced a drastic reduction in hospitals, lowered Medicare reimbursement rates for providers, and a rise in the consolidation of health-care delivery through the formation of care alliances and networks. My interlocutors, especially providers, understood that under the Patient Protection and Affordable Care Act (ACA), new funding had been earmarked for rural health centers and reimbursements for primary care physicians were supposed to increase.[2] But they worried that shortages of physicians and nonphysician providers and specialists; high rates of un- and underinsured, elderly, or poor residents who often require additional health care; and limited public resources allocated to health care would continue to plague rural health systems despite the promises of the ACA (Ricketts 2000; Rosenbaum et al. 2017).[3]

Even though I was interested in immigration, the challenges of rural health care became a frequent topic of conversation in my fieldsite. For many, immigration could not be decoupled from issues of rural health-care provision and delivery. Providers, administrators, and local experts emphasized that increased immigration to the area seemed to intensify issues related to health-care precarity, while immigrant interlocutors noted that working and living in an isolated rural region made it difficult to obtain care and access public resources. People often described these existing care systems for immigrants on the Eastern Shore as "band-aid" solutions or forms of "bastardized care." As I became more involved in the social life of providers and immigrant communities, I began to notice that band-aid care was enacted through informal transactions of medical and nonmedical forms of care, such as bartering, rationing, hoarding, willful noncompliance, and goodwill. These transactions were everyday instances in which immigrants and providers negotiated health and other kinds of supportive care within an economically constrained and politically conservative environment.

Although rural health systems were not a central part of my research interests, what particularly struck me were interlocutors' interpretations of these informal transactions as vital to the understanding of rural health provision and delivery. Anthropologists have made apparent the inherent linkages between immigration and health care, documenting how the embodiment of the complex dynamics of exclusion—economic exploitation, political marginalization, social discrimination—leads to physical and emotional suffering, including the internalization of individual and collective unworthiness experienced by many immigrant communities (Carney 2015; Castañeda et al. 2015; Holmes 2013; Quesada, Hart, and Bourgois 2011; Sangaramoorthy 2014; Willen 2012). They have also argued that constructions of immigrants as an "illegitimate" social group, especially those who are undocumented or have temporary status, propels the notion that immigrants are "undeserving," which further restricts their access to and use of health-care services and exacerbates stress and poor health. Similarly, anthropological scholarship has illustrated that the

enactment of the right to health for immigrants occurs more through claims articulated around the moral economy of health care—that is, the sphere of deservingness, shaped by political, economic, social, and cultural forces as well as personal values and commitments—rather than through formal legal interpretations rooted in notions of universality and equality (Castañeda 2011; Fassin 2011; Ticktin 2011; Willen 2011). Yet I was interested in why issues of immigration, although important, did not necessarily foreground the conceptualization and experiences of band-aid care in my fieldsite. I wanted to understand how band-aid care had come to be seen as a temporary state of permanence in rural health and why informal transactions between immigrants and providers came to signify such care landscapes.

THERAPEUTIC LANDSCAPES: BAND-AIDS, SAFETY NETS, AND IMPROVISATION

The band-aid, as used by my interlocutors, describes care that is seen as a quick fix or temporary remedy and underscores the temporal logic of crisis itself. Inherent in this description is that band-aid care fails to address broader longer-term needs of those deemed most vulnerable (Redfield 2017). David and others, however, engaged in various types of health- and social-care practices that were not limited to addressing immediate health needs of immigrants. In fact, band-aid care maintained and made life possible on the Eastern Shore. "I think anybody who's been a provider knows that when somebody comes in, you can see their leg is practically ready to explode, and they're busy telling you their car broke down and that's the most important thing they need," Christine, a social services provider and nurse, told me. "So long ago we learned to say 'What's the most important thing that's happening at this minute, let's deal with that.' We honor what they think is a priority to stabilize their situation. We do what we call 'stabilize the family,' interacting with landlords, utility companies, car mechanics, automobile insurance dealers, courts, and public defenders." Care, in this way, is both a response to immediate individual affliction and a means to act on the possibility of everyday living.

Although the precise use of band-aid care in anthropological literature is hard to come by, the notion of such care has been documented in various resource-poor settings or whenever people have had to navigate difficult and tenuous circumstances related to providing and receiving care. Recent work on therapeutic itineraries, for instance, has illustrated how care seekers navigate dizzying circuits of ill-coordinated state and nonstate institutions, care providers, and treatment options in places struggling with shifting political, economic, and health structures (Leach et al. 2008; Nguyen 2005). Hampshire and colleagues (2011), Kangas (2010), and Samuelsen (2004), for instance, have richly documented how such therapeutic itineraries have increasingly become the norm in the Middle East and Africa, even as they pose considerable challenges for those who seek care.

In a similar way, scholarship on US health-care safety nets has also documented the experiences of the poor and uninsured within a loosely organized collection of publicly subsidized hospitals, local health departments, clinics, and individual providers who offer free or low-cost care, illustrating how this care is continually at risk of disappearing due to market pressure, reductions in public spending, and increases in demand (Altman and Lewin 2000; Becker 2004). This literature has focused on health-care safety nets as outgrowths of various neoliberal policies and programs and the multiple roles undertaken by providers in the process of helping clients navigate complex public welfare systems (Boehm 2005; Horton et al. 2001; Horton 2006; Lamphere 2005; Morgen and Maskovsky 2003). In many ways, this scholarship on US safety nets brings into focus noncitizens and others who lack mobility and entitlements to health care, such as immigrants and the working poor—those who are often overlooked in the literature on therapeutic itineraries.

The notion of the band-aid also builds on the growing ethnographic accounts detailing mutuality and cooperation in uncertain and improvised care settings, often in postsocialist environments (Andaya 2009; Brotherton 2012; Ledeneva 1998; Rivkin-Fish 2005) or across the African continent (Benton 2015; Benton, Sangaramoorthy, and Kalofonos 2017; Prince and Marsland 2013; Wendland 2010; Whyte et al. 2013). Praspaliauskiene's (2016) concept of "enveloped care"—informal monetary and nonmonetary exchanges between patients, families, and providers—encapsulates how mutuality is performed through ambiguous forms of exchange as a routine practice of health and care. Likewise, Livingston's (2012) work on the only cancer ward in Botswana identifies adaptive or informal strategies that providers, patients, and families use in difficult circumstances, illustrating how improvisation is a fundamental aspect of health-care provision and delivery in highly underresourced and unpredictable contexts.

The dynamics of improvisation were a central feature of providers' work and lives on the Eastern Shore. Providers often used the concept of "creativity" to signal these types of informal and unofficial engagements. Laura, a nurse practitioner, for instance, recounted, "A lady I met last week was diagnosed in Texas with having a mass in her breast, and she migrated without ever getting follow-up. She comes with this paper that said that she had a mass in her breast and needed to have an ultrasound. I don't have the original mammogram. I don't have anything to follow up with, and I've got to figure out how to get her over to the hospital, which has very limited hours for mammography without impacting her work environment, and she has no insurance, and so you get very creative."

Health workers were not alone in this type of improvisation. Immigrants also improvised. Isabelle told me that when she first came to the country, she was undocumented and cleaned houses to make ends meet, "I worked for very

good women who let me clean for them. The people who I assisted were doctors' wives, lawyers' wives. It was not like, 'Come here, work for me like a housemaid.' That's how I would get care, they would not charge me either, just say 'Isabelle come and bring the bill.' One family paid for my insulin at Walmart for eight months. Another paid my schooling fees for two years. So this is how I would get by."

Although Isabelle's case is somewhat uncommon, it is illustrative of the ways that many immigrants actively navigated complex systems of care in unintended and informal ways. Improvisation, for both providers and immigrants, highlighted the particular and ongoing decisions and practices involved in the provision of "good enough" care beyond therapeutic interventions and sites (Mol, Moser, and Pols 2015).

INFORMAL CARE TRANSACTIONS

Informal transactions constitute the everyday work through which band-aid care is enacted on the Eastern Shore. Providers and immigrants engaged in informal transactions as a means to negotiate care within a landscape constituted by issues related to rural precarity and against the backdrop of growing political uncertainties related to immigration and health-care reform. Such transactions worked to produce new alignments of social relations and new values of place and personhood. They also engendered a particular kind of relationship between informal and moral economies.

Bartering

I heard of numerous accounts of bartering practices from those seeking care. Diego, for instance, told me that his provider often offered to "write off" the cost of his care because he was undocumented and uninsured. But Diego was explicit about paying whatever amount of cash he had on him, "Hispanics have a lot of pride. I don't want to do it for free, so we have a system already set up where my doctor will charge me like $20 or whatever I have that day." Others were also able to negotiate down certain costs of care with various providers, sometimes on their own or with the help of another provider.

Some providers were also open about engaging in bartering practices. Mary, a nurse practitioner who worked in a small, impoverished community, constantly worried about the affordability of basic medical care for her patients and found herself bartering care for goods and services with new immigrants and longtime residents alike. "They finally have understood that I actually mean when I say that they can pay me with whatever their product is," she once told me. When I asked for specific examples, she explained, "Ana is the best tamale maker in the world, and she would come with her kids. My rule has always been if I take care of your children who are insured, I take care of the family for free whether they are insured or not. It's about family medicine. I need them to buy their medicine, and so I'll say to them, 'Please don't pay me, please buy your medicine.'" She showed me some of the tamales that Ana had given her that were still in the refrigerator. She described how she handled the seasonal shifts that threatened to disrupt the exchange, "I do this with my watermen. They pay me with crabs. At this time I get crabs, and in the winter I get oysters. From January through April, they don't have crops so I don't accept anything. They then say they have me on crab consignment." She pointed to some boxes next to the tamales, "Actually, I have three pounds of crab in my refrigerator right now from payment today."

Rationing

In contrast to the emerging literature that has documented the negative impacts of policing on immigrants' care-seeking strategies (Hacker et al. 2011; Kline 2017; Rhodes et al. 2015), many on the Eastern Shore avoided care until they were faced with medical emergencies because of the high cost of care, not policing. "If I get sick, I hold out as long as I can until I absolutely have to go to the doctor," Alba told me firmly. When I asked her to explain, she continued, "I do like the doctor, but sometimes you just spend so much money. I don't go because I save the money for other things."

Others turned to alternative forms of care. Monica and Juan Carlos, both undocumented, received regular care from their respective providers for free. However, upon finding out treatment options cost far more than they could afford, both sought therapeutic options obtained from Mexico, such as *gorgojos chinos* (Chinese weevils) to "control" diabetes and "Oaxacan tea" (herbs) to treat kidney stones.

Likewise, a key tactic used by Rhonda and other providers I encountered was to modify normative modes of caregiving when working in nonclinical spaces such as migrant camps or housing. "A lot has to do with their mobile lifestyle. They don't get continuity of care. They don't get follow-up on what's been started," said Rhonda, a nurse, detailing how temporal and spatial disruptions to care and treatment are the norm within this landscape. "High blood pressure is outrageous. They can stroke out at any time. I can't treat as aggressively as I would with high blood pressure and diabetes because if they stop some of these meds, they'll stroke out. So I have to say, 'Ok, we'll start this, did you need more? When you get back home, follow up with your doctor because this isn't going to be enough, and I focus on the $4 medicine. Or $10 for three months.'" She paused to gather her words. "Because if we put them on some fancy medication that I got as a sample, they couldn't afford it. You've got to be realistic."

Hoarding

Due to her caseload, which included hundreds of migrant men and women working throughout the Eastern Shore, Sara, a physician, told me that she often was forced to perform a system of "triage" to focus on those who were in extreme medical distress during her visits to remote areas in her mobile unit, a simple car or van that carried medical supplies, two or three staff members, and exceptional amounts of paperwork (Figure 2). The topic of treatment,

FIGURE 2. *Provider using a nebulizer during a mobile health clinic visit. (Photograph by Emilia Guevara) [This figure appears in color in the online issue]*

especially the scarcity of prescription medications, was a key component of conversations between Sara and the rest of the team. The migrant workers who lined up for hours to see Sara often requested medications—ranging from ointments for rashes to high-blood-pressure treatments—despite the fact that many would and could not be examined by the staff during their visit.

Sara had devised a way to get around this constant source of tension. She stockpiled extra medication as a way of providing care to those she couldn't see directly. She ordered medications in bulk given her caseload and, often, local pharmacies provided duplicate prescriptions by mistake. Because she was working with severe shortages of staff and resources, instead of reporting these mistakes, she would save these prescriptions for use by other clients in the future, what she called "a rainy day." Hoarding these medications and then dispensing them to clients who were not triaged, couldn't come into the clinic to be seen, or didn't have money to get prescriptions were ways Sara circumvented the precariousness of health-care provision and delivery, especially for immigrants.

Much in the same way, many of the (documented and undocumented) Latino and Haitian farmworkers that I met on the Eastern Shore, most of whom migrated north from Florida during the summer months, explained that they often waited to receive care in Maryland through the subsidized migrant program. At the local federally qualified health clinic, they found ways to amass enough medication until their return the following season. William, for instance, suffers from asthma. Since he began to work for a local contractor three years ago, he has spent the summers in Maryland. He told me that he refuses to seek care in Florida, "It's better. It's cheaper to go right here. I'll be honest with you. I live in Immokalee. That's my town. But, I'd rather go to the clinic right here every day than I go once in a year in Immokalee. I like the way they treat people over here." When I asked him how he manages to go so long without getting a prescription for asthma, he explained, "When I am about to go back to Florida, I tell them I'm leaving and need a refill. They give me medication that lasts me for six months, maybe a year, and so I have enough until I come back."

Willful Noncompliance

Both providers and immigrants demonstrated various modes of willful noncompliance with bureaucratic mandates. Such practices ranged from looking the other way to deliberately refusing to comply with rules and regulations related to health-care provision. Cassie, a nurse, told me that she often kept immigrant clients on a low-cost migrant health plan even though they no longer qualified. She mentioned that recently, two of her clients, both Haitian, were recruited to work at local poultry plants with annual sales in excess of six billion dollars. Although they were full-time employees, the plants did not offer insurance for the first three months of employment, a practice that contradicts continuity of care, a key component promoted by the ACA (Department of Health and Human Services 2016). "They were diabetics," she said, articulating the immediacy of her clients' suffering. "They couldn't afford their insulin. There was a couple that I knew who were so desperate for their insulin. They came back and I ordered their insulin and their diabetic meds because they couldn't make it without their diabetic meds, and they were trying to get through their ninety days at their poultry plant. That was their only chance at any kind of life."

Anne, a local clinic director, also reluctantly revealed that she often ends up giving "free" care to those without the ability to pay by not reporting the interaction, disrupting a critical step in the order of formal health-care delivery. "So, I often eat the cost myself and don't even charge the patients. It's just easier for me to document nothing big," she explained. "And sometimes this population comes to me at the end of the day, once they're done in the fields. So it's five o'clock at night, and they walk in the door and say, 'I have a bladder infection or vaginal discharge,' and it will be an undocumented female and I just say, 'Come on back, let's get it over with and just do it.' It's so much easier."

Rovert and Esther, a Haitian couple, even after obtaining provisional legal status through the Temporary Protected Status program, explained that they have continued to ignore the new insurance requirements under the ACA because of its unaffordability. In fact, Pear (2016) has found that many like Rovert and Esther are electing to pay a financial penalty for remaining uninsured instead of purchasing health insurance. When I asked if they tried to enroll in the ACA and whether they qualify for free care, they insisted that it's too expensive, "I don't have the money for insurance. I just can't afford it," Rovert explained. "Now they're charging me and taking money from my IRS money because I don't have insurance. It's Obama's law . . . . If you don't have insurance, they take that money from you." When we clarified that this is the individual mandate penalty—ACA's requirement for taxpayers to have full insurance coverage or otherwise claim exemption or pay a penalty tax—I asked them what

they will do. Esther pronounced that she would continue to overlook the legal mandate, "I'll wait for another government. They've got to change that."

Goodwill

Providers also used the goodwill of personal networks and contacts to support immigrants, while others worked with immigrants outside the scope of their formal work duties and hours. "I have taken people to the post office during my lunch time to get passport pictures or fill out the forms," explained Rosa, a social services provider who herself was an immigrant and had lived on the Eastern Shore for decades. She continued, "When my friends give me clothing, I distribute it among them. For Christmas, local agencies give out presents for poor children, and I call anonymously and tell [clients] to put their children's names on the list so they can get backpacks for school or presents."

Others, like Dana, a social service provider at a small community center, helped operate an emergency food pantry and a thrift center, conducted health screenings and counseling, and provided immigration and housing assistance. When Maryland began issuing "second-tier" driver's licenses that allowed undocumented immigrants to drive, register cars, and obtain insurance, many pro-immigration advocates heralded the move as highly progressive. Dana, however, worried about her undocumented clients because individuals needed to show proof of residency in the form of a lease or utility bill in order to obtain these licenses. "It's a problem because they have so many people sharing housing; then if the lease is in one person's name, it eliminates everyone else," she explained. In order to circumvent unexpected barriers that would prevent clients from obtaining this valuable resource—identification—Dana worked outside the spatial confines of her professional networks to engage closely with a trusted group of personal contacts who were landlords willing to continuously amend leases to reflect new tenants for the sole purpose of allowing individuals to obtain licenses.

Goodwill was also reciprocal. Carmen and her husband, Gabriel, were naturalized citizens. They had known Mariana, an immigration advocate who helped them become naturalized citizens, for over two decades and had developed a deep friendship. Carmen and Gabriel lived in the Eastern Shore from April to October, working as temporary farm laborers, and then returned to Zacatecas, Mexico, for the remaining months. Mariana visited them frequently in Mexico. When Mariana's husband died a decade earlier, Carmen was one of the first people to get in touch with her to provide emotional support to her and her son during a difficult time. Carmen and Gabriel also helped Mariana care for her son regularly while on the Eastern Shore.

EXCHANGES AND ECONOMIES

Pluralistic forms of exchange, both material (e.g., monetary) and moral (e.g., obligation, reciprocity), ground these informal negotiations around band-aid care, signaling intimate connections between care seeking and provision and broader transformations in governance and social and economic relations. In his work tracing the effects of the introduction of antiretroviral treatments on the HIV/AIDS epidemic in Francophone West Africa, Vinh-Kim Nguyen (2005, 126) states, "Therapy always involves a form of exchange and is embedded in 'regimes of value.' Exchange may be monetary, as in the purchase of medicines, or it may constitute 'moral economies' as individuals call on networks of obligation and reciprocity to negotiate access to therapeutic resources, thus drawing attention to the constraints that shape therapeutic itineraries." Informal transactions on the Eastern Shore likewise highlight multiple forms of exchange, value, and social relations. However, these transactions were often considered illicit, even illegitimate, and ultimately forbidden in the landscape of formalized health-care delivery in the United States, which is marked by health consumerism, the primacy of the private health insurance industry, and exclusionary provisions related to poverty and citizenship.[4]

Providers and immigrants who engaged in these dynamic and fluid transactions of caregiving and care seeking were surveilled, criticized, and marginalized for their participation. In addition to David, in the prologue, others like Jennifer were often warned or punished by their supervisors and others. Jennifer stated, "There was an undocumented man, and I would talk to him in Spanish because you never know. I was able to get his paperwork worked out. I wasn't supposed to do that but I wasn't giving him legal advice or anything. He just needed help." She continued with another example, "There was another client who had a case with us related to work, and he needed to return to Florida. He had no money. I bought him a ticket, and I put it on a credit card. They admonished me because I shouldn't have done that. That it wasn't my job. But, what to do?" When asked if she would continue to do this despite the possibility of negative consequences, she replied, "I would do it again, but I wouldn't tell anyone. How could you leave someone in the street like that? If someone needed help, I'm supposed to say no? I can't."

Others have written about ethical dilemmas faced by providers involved in the rationing of care in this therapeutic economy, particularly on whether their participation implicitly continues to maintain support for existing politics of exclusion (Castañeda 2011; Gottlieb, Filc, and Davidovitch 2012; Rosenthal 2007; Willen 2011, 2012). In her work with German nongovernmental health facilities that provide the bulk of care for the uninsured and undocumented, for instance, Castañeda (2011) contends that providers working in these clinics struggle with the realization that their temporary measures to ensure health services have become the norm, permitting what should be offered by the state to be left to the realm of humanitarian aid.

The permanency of band-aid care, in many ways, illustrates the synchronization of the work of the humanitarian sector to the rationale of state-sponsored health care. The resulting ongoing and coextensive relationship between the

two expands neoliberal practices of governance, reaffirming humanitarian values of the state while avoiding obligations to ensure entitlements. "The biggest hurdle I deal with, whether it be migrant or the settled population, is that many don't have insurance," Anne explained, alluding to the economic scarcity and geographic isolation that hampers the provision of care in this landscape. "I can do what I can to provide, to help them out and provide free care, but when they need specialty services there's *nothing*. Then when you add in [undocumented status] and you just start stacking all these issues, the hurdles become higher than the average person."

Many interlocutors were convinced that the ACA would continue to uphold existing uneven geographies of access to health care. Only thirty-two states have opted to expand Medicaid, including Maryland, leaving a "coverage gap" of more than 2.5 million people—those already with incomes too low to qualify for federal subsidies—after the 2012 federal ruling that allowed states to choose whether or not to expand Medicaid under the ACA. Other effects of the ACA include inadequate coverage under both private and public plans, higher cost-sharing requirements, privatization of Medicaid programs by some states, and accelerated consolidation of hospital systems and decreased funding for safety-net hospitals (Mulligan and Castañeda 2017; Rao and Hellander 2014).

Furthermore, although the ACA substantially increases the number of individuals who have health insurance, thirteen million recent legal immigrants and eleven million undocumented immigrants are not covered because the ACA left intact previous restrictions for immigrants (e.g., the Personal Responsibility and Work Opportunity Reconciliation Act and the Illegal Immigration Reform and Immigrant Responsibility Act). The exclusionary aspects of the ACA are purposeful and are designed to prevent disproportionate access to public benefits by immigrants. For instance, several additional restrictions for immigrants exist. For legal immigrants in Maryland, there is a time restriction; those who have been in the country for less than five years have access to health insurance coverage through exchanges and to premium and cost-sharing subsidies but are otherwise ineligible for Medicaid. Those who are undocumented, roughly 17 percent of Maryland's uninsured population, are not eligible for any coverage under the ACA.

Therefore, such enactments to provide care in the absence of a rights-based notion of health and health-care access on the Eastern Shore increasingly occur through claims articulated around the moral economy of health care—shaped by social and cultural forces and personal values and commitments (Bornstein and Redfield 2011; Fassin 2011; Ticktin 2011; Willen 2012). Anne and other providers often spoke about a moral responsibility to serve and to provide, especially for those with very little means. "You don't ever do this because you want to make money," Anne reflected. "You do it because you have a passion for it. I often go months without a paycheck. I'm okay. I live a decent life. It's perspective. I've got nothing to complain about."

However, providers' engagement in band-aid care was also a way to act on their commitment to formal legal interpretations rooted in notions of universality and equality. As I have documented elsewhere (Sangaramoorthy and Guevara 2017), providers were steadfast in their belief that immigrants should have legal entitlements, including those related to seeking and obtaining care without restrictions, stating that they were "pro-immigration" or "wished that immigrants could become legal." ''I think that our patients would do better all the way around if they could become legal," Sara, for instance, said reflexively. "I think that's a huge barrier. It's a huge fear." For providers working in this landscape among immigrants, there is a moral recognition of the immediacy of suffering and the precariousness of care. But this moral recognition is constitutive of and mediated by understandings of a right to health as a political right, only made possible through the realm of legalized citizenship.

PLACE, PERSONHOOD, AND PRECARITY

Randall, a physician who traveled to remote and sparsely populated areas of the Eastern Shore to provide care to migrant workers, was down to seeing only a handful of individuals every few weeks. According to Randall, increasing budget cuts, the elimination of provider positions, and a heavy caseload for remaining staff had become the reality for many working in rural health. He explained that when he started working with immigrants on the Eastern Shore, there were three to four providers working full-time in addition to a mobile clinic. Then the positions and the mobile clinic were suddenly cut. "It became cost prohibitive. At least that's what I was told," Randall told me. "And then another person just left. And then another person left, and they didn't replace her. And for three years it was just me." He recounted working sixty to seventy hours per week without being paid overtime and having his hours routinely cut. Over the years, his work conditions deteriorated, and as a result, the number of patients he is able to see has drastically dwindled: "I've had to focus on a few camps to give them decent care and hopefully the rest can get into clinics."

Randall's experience underscores how rural health-care systems, in particular, faced difficult challenges in implementing cost-saving and profit-motivated measures beginning in the 1990s, and continuing today (Ricketts 2000). Operating with already limited resources while serving populations with high levels of mortality and morbidity, rural health systems experienced drastic reductions in hospitals, lower Medicare reimbursement payments for rural providers, and a rise in consolidation of health-care delivery through the formation of care alliances and networks (Ricketts 2000). Community health centers, like the one that Randall worked for, are the main source of comprehensive primary care for those considered medically underserved in the United States. Under the ACA, there has been noted growth both in the number and capacity of health

centers due to increased patient revenue from Medicaid expansion and private health insurance as well as federal investment (Rosenbaum et al. 2017). However, even with such progress in coverage, many of those who utilize health centers remain uninsured or underinsured because of increased cost sharing associated with insurance plans. Furthermore, insufficient funding and insurance reimbursement and workforce recruitment and retention remain critical challenges for rural health centers (Horton et al. 2014; Joseph and Marrow 2017; Rosenbaum et al. 2017).

Maryland ranks as one of the wealthiest states in the country, yet the rural counties of the Eastern Shore have some of the highest poverty rates, the poorest health status, and the greatest need for health-care access in the state (Maryland Department of Health and Mental Hygiene 2011). Many of these counties, located within a short drive from Washington, DC, where the ACA was passed into legislation, are federally designated health-professional shortage areas or medically underserved areas, with only two federally qualified health centers—organizations that receive Medicare and Medicaid reimbursements to assist underserved populations—serving those living in the nine counties.

When asked about the continued needs of rural communities, such as those on the Eastern Shore, one key interlocutor explained the dire situation of rural health delivery in the wake of health-care reform, "A dentist? What's that? We don't have an eye doctor in this entire county, and we have one pediatrician. We have *nothing*." These spatial depictions signifying precarity, deficiency, and scarcity were common among both providers and immigrants. Immigrants described the Eastern Shore as "the land that time forgot," alluding to the temporal and spatial distinctness of the place as isolated, primitive, and undeveloped. Daily living in this context assumes distinctive temporal and spatial attributes, characterized by seasonality in relation to the availability of work and food, uncertainty of political attention and engagement in relation to economic development and aid, insecurity brought about by acute poverty, and the invisibility of rural economic and social life (Figure 3).

Depictions of both place and people as *nothing*—including David's comment about undocumented immigrants being equated to nothing in the opening vignette—signal precarity as a shared condition in which many contend with social, economic, and health insecurities. Although precarity implicates some identities more than others through an unjust distribution of vulnerability to harm, violence, and death, it is also relational, generating circuits of social connections and belonging through the care of others (Butler 2006; Lorey 2015). Diverging from neoliberal notions of an individualized self, precarity suggests a profound dependence on others and a responsibility to each other in consideration of that precarity. Describing precarity as "that politically induced condition in which certain populations suffer from failing social and economic networks of support more than others"—the condition that makes some lives more vulnerable, exploitable, and disposable than others—Judith Butler (2015, 33) argues for a coalition politics that mitigates against such conditions of vulnerability. I argue that the care provided by both providers and immigrants for each other, and the recognition of this interdependence as opening up possibilities for a livable life, is a political act in itself.

FIGURE 3. *Farmworker housing on the Eastern Shore. (Photograph by Emilia Guevara) [This figure appears in color in the online issue]*

Although American health care is often linked with a neoliberal logic that engenders precarity, it is also a generative force for conditions of sociality and interdependence. Band-aid care and the informal transactions that characterize it both signify and underscore that precarious working and living conditions are no longer perceived as exceptional but are instead recognized as ordinary facets of life. Band-aid care also reconsiders American health care as a set of assertions related to our interconnectedness. Immigrants and providers simultaneously forego and take up particular kinds of care in ways that reaffirm precarity as a configuration of mutual cooperation and concern.

Although providers and immigrants have very different stakes in the system, care, more broadly, and health care, specifically, shape their common and shared insecurity because the idiom of health on the Eastern Shore signals uncertainty. Health care is a familiar manifestation that is critical to rural and immigrant precarity and the demoralized sense of self that precarity engenders. In the indeterminacy of everyday life on the Eastern Shore—against the backdrop of health-care reform, an ongoing immigration crisis, diminishing welfare safety nets, and deepening infrastructures of social exclusion—precarity entails suffering and anxiety. But it also brings about resourceful ways to react to precarity through the provision and quest for care. Band-aid care, in many ways, serves as a way for providers and immigrants

to enact an *insurgent politics of care* that is suggestive of social relationality and mutual cooperation, and where moral and legal dimensions of health-care access are continually in flux.

Because it is both far reaching and communal, care also conditions identities, especially people's sense of being and belonging. In this landscape of care, interdependence, rather than being experienced as a dilemma or a hindrance, becomes "the principal mechanism for personhood" (Ferguson 2013, 226). Rural providers, themselves experiencing various conditions of precarity, work to provide care through the labor of improvised caregiving—work for which they and others are often denounced, reprimanded, and marginalized. Such work confers a sense of obligation and legitimacy by way of moral positioning as caregivers to the neediest individuals. Immigrants are not simply subjected to obligations to engage in medical care, and their means of navigating these complex landscapes of care are neither passive nor conditional. Most immigrants expressed that they were treated well and were supported by providers, incurring material and moral rewards through informal and formal care transactions. They, like their providers, incorporate themselves into a social and moral system in which they generate both ruptured and fluid life rhythms. Such experiences of sociality and interdependence engender opportunities (however fraught) for living—to be something, rather than *nothing*—despite their precarious legal and economic status. Such exchange relations between providers and immigrants in this landscape of care, although still enmeshed in social hierarchies and inequality, are experienced and lived as worthwhile, moral, just, and necessary under the neoliberal logics of exclusion and inequality.

CONCLUSION

Informal transactions, specifically, and band-aid care, more broadly, blur the boundaries between formal and informal and between the shadow and the more open free-market health economy (Misztal 2000; Stan 2012). Yet they are reactions to the restrictive federal- and state-level immigration and health-care policies that create uneven geographies of access to public resources for immigrants, including health care, and marginalize frontline providers who work mainly with immigrant populations. Immigrants' ineligibility for various health-care benefits renders them unable to access basic and specialized forms of care, forcing providers who care for them to engage in various modes of improvisation. Band-aid care, however, has an emancipatory effect in that it allows providers and immigrants the potential to refuse capitalist rhythms of American health care by conferring a sense of sociality and interdependence, reinscribing place value to rural spaces and shifting the possibilities of living precarity.

There is still much uncertainty that surrounds the impact of neoliberal reform on rural health systems and rural populations. Spatially, many rural health systems tend to be composed of loosely integrated and ill-coordinated public hospitals, community health centers, local health departments, and free clinics. In places like the Eastern Shore, individual providers themselves constitute the only semblance of a safety net. It is a logic of safety-net patchworks, band-aid care, and improvisation that has become the default in many rural regions throughout the United States. Add an increasingly tenuous economic and policy environment to this landscape of care and it becomes understandable why many of those living on Maryland's Eastern Shore feel that the ACA does very little to shift the everyday conditions of living.[5]

This precarity that characterizes rural health systems is intensified for growing communities of immigrants, who must constantly contend with the broader logics of exclusion that are at the heart of health-care and immigration reform, while also seeking care. Frontline providers, especially those who provide care to immigrants, are also left to improvise forms of caregiving under heavy surveillance and scrutiny. Providers and immigrants engage in informal transactions, such as rationing, bartering, hoarding, willful noncompliance, and goodwill, as a way to negotiate and navigate this landscape. These moral and material exchanges between providers, immigrants, and others work to strengthen and dynamize social relations and meanings of place that are fashioned and remade in the context of caregiving and care seeking. Providers frame informal transactions as a way to provide band-aid care that is motivated by moral values and commitments around health-care delivery and access as well as assumptions about immigrants' rights to certain kinds of political and social membership.

Although challenges and hurdles by way of social injury exist at every turn for immigrants in such contexts, they are by no means wholly encumbered and left only subjugated by such transactions and the broader landscape of care. They gain entry and access to vital resources through various social entanglements and particular forms of care practices. They also gain recognition as vulnerable others in need of and entitled to basic rights for living, such as to health care. In a landscape defined and shaped by neoliberal logics of exclusion and inequality, band-aid care and informal transactions serve as a way of experiencing precarity, not only in the exchange of vital resources but also as a mechanism for restoring social personhood and place value through relations of interdependence.

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NOTES

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1. Maryland is a new-receiving destination—a convention allotted to places without high concentrations of immigrant communities—for immigrants primarily from Latin America and Asia. Migration to the Eastern Shore, composed of nine counties east of the Chesapeake Bay, has been driven in large part by low-skilled employment opportunities in the seafood, poultry, and agriculture industries. In these nine counties, although the foreign-born population is predicted to be between 3.1 percent and 8.3 percent (US Census Bureau 2014), in the past decade, the population of Latino immigrants on Maryland's Eastern Shore has increased significantly: 165 percent from 2000 to 2010, and in two counties the growth rate has exceeded 200 percent (US Census Bureau 2000, 2011). Many interlocutors have overwhelmingly insisted that census data do not accurately reflect population counts, especially because a vast majority of the immigrant population is undocumented. My own fieldwork substantiates this claim. A handful of studies show that immigrants are increasingly establishing permanent roots rather than staying temporarily as seasonal migrant workers (Dunn and Liebman 2004; Sangaramoorthy and Guevara 2017). Still, there is a dearth of information on the current immigrant populations—including a large number of Haitians, mixed-status families, and temporary migrants who live and work in the Eastern Shore. In my own fieldwork, I have conducted approximately fifty interviews with immigrants who are between the ages of 20 and 70; speak Spanish ($n = 37$) and Haitian Creole/Kreyòl Ayisyen ($n = 13$); and are from Mexico ($n = 31$), Central America ($n = 4$), Haiti ($n = 13$), and the United States ($n = 2$). See Sangaramoorthy and Guevara (2017) for further sociodemographic details of the Eastern Shore.
2. The implementation of the ACA, popularly known as "Obamacare," began in 2010 and represents the most significant change to health-care funding and delivery since the introduction of Medicaid and Medicare in 1965. A primary goal of the ACA was to reduce the number of uninsured Americans, which at the time stood at approximately fifty million, through the expansion of both private insurance and government-funded Medicaid (Horton et al. 2014). Another key element of the ACA was to contain soaring health-care spending and taxpayer costs and increase efficiency in health-care delivery.
3. The ACA has been fully implemented in Maryland. However, it is uncertain whether the provider and institutional capacity in rural Maryland can adequately serve these newly insured individuals. Rural residents continue to face financial and systemic barriers that are spatially configured such as health-provider shortages, continuation of diminishing resources to rural health departments and hospitals, and transportation limitations.
4. Although former President Obama (2016) recently extolled the significant progress made by the ACA, many insist that the ACA falls far short of providing universal coverage and instead operates within a neoliberal logic, framed by less government intervention and increased deregulation and privatization in the market economy, which began to take shape during the postwar years (Gaffney 2015). The so-called neoliberal turn in American health care led to significant transformations including the rise in corporatized managed care, increased cost-sharing among insurance plans, and consumer-driven health care. Health care, under this logic, is commoditized, and its distribution determined by individual "consumers," seen as rational actors exercising their economic and political freedom in electing the quantity and quality of health-care goods that they desire.
5. The growing uncertainties about the future of health care and immigration prompted by the Trump administration will likely intensify band-aid care and informal transactions within rural landscapes.

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