

Undocumented Immigrants in the U.S. Health Care System: A Study of Latinos in Oregon

By

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Health care and immigration in the United States are complex and controversial topics. Undocumented immigrants have to overcome numerous barriers in order to gain access to health care services. This study examines the personal experiences of undocumented immigrants in Oregon and how they sought out care and overcame these barriers. Seven in-depth interviews were conducted and then analyzed for thematic content. Results supported previous research that identified five types of barriers undocumented immigrants commonly face; structural, nonstructural, systemic, cultural and linguistic. Over time improvements have been made to help make care more accessible. For example, there are an increasing number of interpreters and/or bilingual and bicultural staff and state programs have been designed to help decrease the number of uninsured. However, systemic changes, along with increased health education and more culturally competent care, will be critical components to address, in order to improve health care for undocumented immigrants in the United States.

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BACKGROUND

Health care in the United States is a very controversial topic. There are many opinions as to how the health care system can better provide coverage to the largest number of people, but the reality is that approximately 43 million Americans are currently uninsured, and millions more are underinsured (Riedel 2009). The World Health Organization has ranked the health care system in the United States 37th in the world because of a variety of factors including disparities in accessibility and health outcomes (Riedel 2009). There are many consequences for those who find themselves living without health insurance. These range from poor quality of care and less access to needed care (McWilliams 2009), to serious financial instability and even bankruptcy because of high medical bills (Riedel 2009).

In Oregon specifically, the Oregon Health Plan was developed to help create a system of universal health care. In The New York Times, William Yardley reported,

It has been more than a decade since the innovative Oregon Health Plan became a forerunner of state health care reform as it pursued universal health coverage. Conceived on a restaurant napkin in the late 1980s, the program had by 1996 reduced the number of the uninsured to about 11 percent of all residents, down from more than 18 percent in 1992. But then, early in this decade, the state endured a wrenching recession. (Yardley 2008)

The lasting effects of the devastating recession can still be seen today with the rate of uninsured Oregonians having returned to 17%. However, within the state, Latinos face an even higher rate of 34% (State of Oregon 2004). Nationwide, Latinos, because of their minority status, are faced with additional health care

disparities. In her article, “Latinos’ Health Care Access: Financial and Cultural Barriers” Patricia Documét et al (2004) states, “Latinos [are] the fastest growing minority group in the U.S. and the ethnic group with the worst access to health care” (p. 1). Like other ethnic minorities, Latinos face a number of systemic and financial barriers, including lower socioeconomic status and less extensive coverage (McWilliams 2009).

As conversations emerge with solutions like expanded coverage or the Affordable Care Act passed in 2010 (Fiscella 2011), one group that is often left out of the conversation is that of the more than 10 million undocumented immigrants living in the United States. With no legal status, how do these individuals handle health problems when they arise? Undocumented immigrants in the United States are already a marginalized group living in the shadows.

[Migrant and seasonal farm workers] are known to be a marginalized population who live in poverty. Three out of five farm worker families have annual incomes that fall below federal poverty levels, and 75% earn less than \$10,000 per year. (Anthony, Williams and Avery 2008)

Leaving their homes or communities for whatever reason, even seeking medical attention, could put them at risk. Furthermore, there are countless barriers, structural, systemic, and linguistic, that they have to overcome before being able to receive the necessary care (Garcés, Scarinci and Harrison 2006).

First, it is necessary to identify the main reasons undocumented immigrants are seeking medical attention. It is important to recognize that immigrants, no matter their home country, after coming to the United States, experience many cultural adaptations while they learn to live within a new

culture. For Latino immigrants there are certain changes that the majority experience related to diet and physical activity.

One study revealed that acculturation, also defined by how many years one has lived in this country, is associated with a rise in fried and high-fat foods consumed (Kaiser 2006). At the same time, it can also lead to a decrease in physical activity. Both are related to incidences of obesity (Kaiser 2006). The Latino population is learning first hand that obesity opens the door for many other chronic diseases. Even though it is true that the diseases mentioned are found in higher rates among the poor in general, it is important to realize that having a lower socioeconomic status is not the only reason why undocumented immigrants are being diagnosed more often.

In the Latino population, high rates of poverty have not always translated into poorer dietary intakes and health status, which are often found in other low-income groups. This paradox may possibly be due to strong family support and other protective cultural factors found in many less acculturated, recent immigrants from Latin America. (Kaiser 2006)

We need to recognize that something distinct is happening when immigrants come and adapt to the culture of the United States. Diabetes and heart disease are two of the main health problems that Latinos are currently facing.

Nevertheless, lifestyle diseases are not the only reason why undocumented immigrants seek medical attention. Work-related injuries can also be serious, even life-threatening, because the work they do is often exhausting and dangerous. Some work in large meat-packing factories, others in fields picking and harvesting a variety of produce and still more work in construction and domestic house work. Each job presents its own set of risks, anything from

loosing a limb to injuring your back doing physically demanding tasks day in and day out year after year.

Many immigrants fear being injured because injuries like these have many negative affects on their livelihood. Fearing more than just losing the ability to walk, they fear losing work time, or worse, being fired. For that reason alone, many try to work through the pain, putting their life at risk just to avoid seeking medical attention.

Isabel C. Garcés et al (2006) introduces five types of barriers that exist for immigrants in her research of the health care seeking practices of Latina immigrants. The barriers are identified as structural, non-structural, systemic, cultural and linguistic; each one having distinct effects on the quality of medical care one receives.

The first type are structural barriers. This means that society has constructed a specific way to receive appropriate medical care that impedes or makes it difficult for undocumented immigrants to access. One example of a structural barrier is the lack of money. Being undocumented puts these individuals in a socioeconomic position where the jobs they hold are some of the worst paid in the country. Even if they are lucky enough to have medical insurance, there are still additional costs associated with medical care, like co-pays and prescriptions.

Having good transportation is another good example. If an individual does not have a driver's license they cannot drive legally which leaves them totally

dependent on public transportation, when available, or on their social network. Their social network could be made up of family members, friends, or even co-workers. They also lack the ability to take time off of work because they are truly living from paycheck to paycheck (Garcés et al. 2006). Each of the three examples of structural barriers are intertwined and directly related to income and socioeconomic status.

The next type of barrier is known as non-structural. These come from habits and the cultural composition of the Latino culture. It is important to remember that they can vary from person to person and are not exclusively experienced by Latino immigrants, however, they are still relevant. Immigrants who face non-structural barriers may be too afraid or embarrassed by their situation to seek medical care (Hearst, Ramirez and Gany 2009). Culturally, it is inappropriate to talk with, or consult, anyone about certain medical problems. But additionally, it may be due to the fact that they tend to leave things for later, not being accustomed to the “American practice” of seeking medical attention immediately when symptoms present themselves (Garcés et al. 2006).

The third barrier is systemic, meaning that it is based on how the health care system of today is configured. The experiences of undocumented immigrants, in large part, are affected by their migratory status in this country and by their inability to access medical insurance (Garcés et al. 2006). For many immigrants, especially those in the agricultural industry, the type of migratory work that causes them to move with the seasons also has an effect on the

treatment they receive (Anthony et al. 2008). It is possible that doctors do not feel that they really have any control over the patient's care if they are only able to treat them for a brief period of time. That is why they may not treat them as carefully as they would patients seen on a more regular and long term basis.

Their ability to access information about health care is also a contributing factor. Many immigrants are not familiar with the resources available to them in the community. Often they learn from word-of-mouth the services for which they might qualify. Without this social network they would have no way of knowing.

The fourth barrier, cultural, is very complex because there are not only differences between the culture of the United States and that which immigrants bring, but there are also significant differences between the various Latino cultures. Typically, immigrants have grown up in their home cultures' putting a lot of emphasis on the use of home remedies.

Culturally related health practices seen in Latin America continue when immigrants arrive to the United States, particularly with regard to the use of home remedies and self-medication. (Garcés et al. 2006)

In contrast, people from the United States put a lot of trust in doctors and medical professionals, respecting their opinions, instead of trying to find a cure on their own. In addition, Latinos may have a different understanding of injuries and diseases that may make it difficult for them to understand the treatment or medicine prescribed by the doctor.

The final barrier is linguistic. Although the concept is the simplest of the five, it still causes many serious problems. The lack of communication means that neither the doctor nor the patient has a good understanding of the other and

consequently this can lead to mistrust and even a mistaken diagnosis. Even when there is an interpreter present, this does not always guarantee the ideas and feelings are being transmitted with complete accuracy. If an interpreter is not available, many times family members take on the responsibility, but do not have the education or formal training necessary; for them accuracy also becomes a major obstacle. These cases of “informal” interpretation can create very uncomfortable situations for everyone involved, especially when children are interpreting very personal information for their parents.

Having access to health care is not a right for everyone living in the United States. Undocumented immigrants are perhaps the most affected and have to worry about their health constantly, hoping to stay healthy enough to avoid facing the reality of needing medical care without insurance. When health problems arise, there are various barriers that prevent them from receiving the care they need. Each barrier presents distinct consequences that make it difficult to regain their health. Through the process of acculturation, each undocumented immigrant has to figure out and overcome the different barriers on their own when attempting to gain access to the health care system in the United States.

METHODS

The general health outcomes for undocumented individuals in U.S. health care can be found statistically through disease rates and success rates of advanced treatments, but what does this say about how patients actually

experience and perceive the interactions they have and the care they receive?

By looking at these personal experiences we can better comprehend how individuals understand their own health conditions as well as how they seek out and use Western medicine.

In my research I specifically chose to examine how undocumented Latino immigrants navigate the health care system in order to receive the care they need, despite living in the shadows of mainstream society because of their immigration status. Through in-depth, personal interviews, much can be revealed about the challenges and barriers that these individuals face at the very basic, interpersonal level of the system.

Student Qualifications

I have grown up conscious of the presence of the Latino culture in my home, the Pacific Northwest. After getting an academic taste of the Spanish language and Latino culture in Spanish classes in high school, I quickly saw the benefits of continuing to study the language in hopes of some day working with and advocating for this minority population. While majoring in Liberal Studies at Oregon State University, I have chosen to focus on *Bilingual and Multicultural Health Care*. I also actively volunteer with the Latino community teaching ESL classes, interpreting at free medical clinics, and assisting in bilingual elementary classrooms. My sophomore year, I spent three and a half months living and studying in Argentina. This helped improve my understanding of, and fluency in,

Spanish significantly. These volunteer experiences as well as my academic experiences at Oregon State have helped me gain a level of proficiency that enabled me to carry out the consent process and comfortably conduct the interviews in Spanish.

Study Population and Characteristics of Participants

It is estimated that more than 40 million Latinos are living in the United States today, more than 10 million of whom are undocumented. Of that, the majority are coming for the economic opportunities not available in their home countries. They bring with them a rich and varied culture, but also beliefs about health and healing, in many instances, very different than the Western medical practices to which most Americans are accustomed.

Latinos have been in Oregon for centuries. Throughout history there have been waves of Latino immigrants into the United States, some of those ending up in Oregon (Xing et al. 2007). Most came, and continue to come, mainly for the agricultural work available (Xing et al. 2007), however today other industries, such as service and manufacturing, see high numbers of Latino workers (Mendoza 2009).

Summary of Participants: The sample of participants for this study reflected that of the historical patterns of migrants; coming primarily for the economic opportunities available. A total of seven individuals were interviewed; six women and one man (*See Appendix A*). They had all emigrated from Mexico,

had been living in the United States anywhere from four to fifteen years and ranged in age from 22 to 39. The interviews were conducted in Spanish because that was the language of preference for all participants. All but one of the women identified themselves as homemakers and all participants were married with children. The male participant and the spouses of the female participants were all currently employed in industries ranging from agriculture to foodservice.

Having such a disproportionate number of females compared to males may be problematic for some studies, however, research shows that Hispanic women are more likely than men to seek health care (Akresh 2009), therefore women may actually have greater insight into the health care system, especially related to the health care needs of children.

Ariana (all names used have been changed to protect the identities of participants) is a 29 year old female who was born in Mexico. She came to the United States when she was 19 and has been in Oregon for the past three years. Married with two children who were both born in the United States, she stays home while her husband is currently working at a dairy. She and her husband have never had employer-sponsored health care coverage, however her two children are currently covered by the Oregon Health Plan.

Carla is a 32 year old female who immigrated to Oregon from Mexico six years ago to join her husband who has been in the United States for 20 years. She is a stay at home mom with four children and all except for the oldest were born in the United States. Her husband makes his living in agriculture. Her

children have health insurance from the Oregon Health Plan, but she and her husband, currently, do not.

Evelina was the youngest of the participants, 22 years old, who had come directly to Oregon four years ago to join her husband who had come before her to find work. She has one young child and stays at home while her husband works as a cook and dishwasher. They do not currently have health care coverage.

Helena, 32 years old, came to Oregon eleven years ago, when she was 21, because of the employment opportunities for her husband. She stays at home with three children while her husband is currently working in landscaping. She and her husband do not have health insurance however their three children are all enrolled in the Oregon Health Plan.

Juana, 38 years old, and her husband Luis, 39 years old, came to Oregon seeking care for their son, who was not receiving the treatment he needed in Mexico. They have a total of four children; two who were born in Mexico and two who were born in the United States. Luis came a year before Juana to find work as a mechanic. They have been fortunate enough to have had health care coverage throughout the entire time they have lived in the United States which has been essential in helping their son get the care he needs.

Nora is a 35 year old woman who had spent most of her adolescence and all of her adult life in the Pacific Northwest, moving from Washington to Oregon 11 years ago to attend college. She has two children who were both born in the

United States. She is continuing to study Early Childhood Education and her husband had studied Criminal Justice, but recently found work with a fiber glass company. They have had health care coverage on and off, between working and the coverage the university provides.

Recruitment

The recruitment of project participants began by making presentations at local community organizations who work with the Latino community. At these presentations I outlined the study, its purpose, participant eligibility, benefits and possible risks. I then handed out flyers with a summary of this information and my contact information and asked anyone interested in participating in the study to contact me for further information or with any questions they might have (See *Appendix B*). During the initial contact potential participants made with me, I verified that they met the two study criteria: 1) Must be 18 or older and 2) Self-identify as being undocumented at some point in their life.

FINDINGS

Careful analysis of the interviews helped to identify several recurring themes among participant answers. They are divided by theme and discussed below.

Perceptions of Healthiness

As discussed in the background section earlier, many participants in my research stressed that maintaining their own health and their family's health were extremely important in order to maintain their livelihood in the United States. Nora, who has lived in the United States for almost half her life had seen the concern of others around her in relation to this:

“Especially if they have children and are planning to stay here longer, they know that if they get sick they can't work and here, many of them depend on [not getting sick].”

The ability, or lack there of, to take time off work to seek medical care is one of the most common structural barriers according to Garcés et al (2006). The fear and mistrust that medical institutions may turn them in and that they may be subsequently deported, can also deter them (Berk and Schur 2001). For these individuals they must carefully navigate the situation when it arises; not waiting too long and having a condition worsen, but not seeking care too quickly and having to pay large medical bills out-of-pocket.

Perceptions of the U.S. Health Care System

The participants had varied responses when asked about their impressions of, and experiences within, the U.S. health care system. Although they had all faced challenges, there was still an underlying appreciation for, and satisfaction with, the care they had received. This is common for immigrants, especially when they are comparing their experiences in the United States to that of their home countries (Ortega et al. 2007), even more so when they come from a developing country. Juana, the mother of four, had come to the U.S. with her

husband after becoming frustrated with the lack of care and the poor quality of care for their son in Mexico. After coming to the United States, they discovered he had a serious brain condition. When asked about her experiences and how they had been treated within the system she said:

“Good. In all the places we’ve gone with my son it’s been good. We’ve had good doctors that have helped a lot with him. I always thank God that we came and found this help for my son because he was really sick but is better now.”

Juana, like most of the other participants felt lucky to have been able to receive the care they needed and were generally happy with their experiences.

When arriving in a new culture, anyone would be worried about what was in store for them and how their life would be changing. Latino immigrants in the United States face additional stigma, upon arrival, that has arisen out of highly emotionalized debates surrounding modern day immigration. Carla, who has lived in Oregon for six years, reflected on her first thoughts when arriving:

“When I arrived here I had the impression that maybe they weren’t going to accept me because I’m an immigrant or at times there would be people who wouldn’t like someone because they’re Hispanic.”

Over time, and with more and more experiences within the health care system, many immigrants find that their original fears are not always reality. Participants expressed that their trust in, and comfort with the system had increased over time. Ariana, who came to the United States to join her husband who had found a job explained:

“I feel good, it keeps getting better. At first I was shy and more scared of things, more embarrassed, but you keep going along talking with more people and you start understanding. You feel less scared and you know how to go to the doctor. Little by little for ten years but I still don’t feel completely comfortable here.”

However, after a while, as they continued to have positive experiences within the health care system, they became more and more comfortable as their original concerns were dispelled. Most participants felt they had been able to adapt fairly quickly to the medical practices in Oregon and did not feel as though there were any major cultural differences between them and their provider that might affect the care they received.

Unfortunately, even though many had been satisfied with the majority of their experiences, specific situations did come up that created disappointment and frustration with the system. The participants talked about times of discrimination and racism, specific providers' lack of interest in them as individuals, and long wait times for short, incomplete visits as reasons they might not have been happy with their experiences. This is consistent with research that predicts that foreign-born individuals are more likely to report discrimination and that Latinos perceive differential treatment by providers as one reason for unequal health care (Ortega et al. 2007). Nora felt that she had experienced discrimination firsthand, she noted:

“My doctor sent me to the clinic on 27th. I had insurance so I went there and was waiting and waiting. Another woman came in after me and the [front desk person] helped her first and I had insurance! Finally, another worker came and helped me.... I've heard about women who have gone with their sick kids but [the clinic] doesn't want to treat them because they don't have insurance. In the places that have helped, sometimes the doctors aren't so good, or they discriminate a little.”

Another study found that, “A significantly higher proportion of foreign-born permanent and undocumented residents believed that they received poor care due to their ethnic background” (Rodríguez, Bastamante and Ang 2009). Evelina,

one of the younger participants who had been in the U.S. for four years shared her feelings of having providers rush through appointments:

“Sometimes we have to battle with the character of the other people and their attitude. Sometimes they’re annoyed and they want to see you quickly. At times you want to ask more questions but if you feel like you’re bothering them, then you feel it’s better to stay quiet... It’s a 15 or 20 minute appointment and sometimes its bad having to wait so long just to see the doctor have them tell you you’re fine or you have this or that and that’s it. I’ve talked to a lot of people who have felt the same.”

This feeling of being rushed or that the doctor sees you as a disease more than as a person is not unique to undocumented immigrants or immigrants in general. This has been one of the criticisms of the for-profit system of the United States, because doctors are under such tremendous pressure to see a large number of patients that they cannot give a lot of individualized attention. Reversing these negative perceptions can go a long way to improving care. Rodríguez et al (2009) observes:

Positive perceptions of interpersonal processes of care may influence patient outcomes through better adherence to treatment regimens and greater motivation to manage their health problems. (p. 1).

System Comparisons to Home Country

In the past Mexico has seen large disparities in its health care coverage. High numbers of uninsured, almost half of Mexico’s population, meant that most health care spending was out of pocket (Ruelas 2002). This created huge financial difficulties for citizens when in 2000, “An estimated 3 to 4 million Mexican families incurred catastrophic or impoverishing health expenditures” (Frenk, Gomez-Dantes and Knaul 2009). The Ministry of Health then developed

the *System of Social Protection in Health* in 2003 that increased funding for health with the outlook of eventually providing universal health care (Frenk et al. 2009). Disparities still remain though, with problems of limited access in rural areas, high costs in urban settings and overall issues of quality (Ruelas 2002).

Each participant in this study had a different level of familiarity, understanding and memory of the health care system in Mexico. This is because they had all left Mexico at different ages, and many had not returned since. This means that it could have been a decade or more since they had used the system and may not have been familiar with the changes and how they may or may not have affected them. Helena expressed this in her interview:

“No, I don’t think [there’s anything too different from Mexico]. I’d say that the care is a little better here. I almost never went to the hospital but one time when my cousin got sick it was different, but now I don’t know. It’s been awhile since I’ve gone to Mexico.”

A few participants discussed the differences in expectations when seeking care. They said that, in Mexico, there is an expectation that if you are not feeling good, for whatever reason, the doctor will give you some sort of medication or pill that will help. In Oregon, their experiences were that doctors will only give you medicine in certain situations and, when they do not think it is necessary, they will send you home without anything. Evelina explained:

“With medication it’s really different. Here you can’t get it like in Mexico. In Mexico they’ll prescribe medication, like penicillin, for anything. Here they don’t always give you medicine, they just tell you to take something like ibuprofen that doesn’t really help a lot. So that’s something different.”

Finally, most did have a strong feeling that the system overall in Oregon was better. With or without insurance they appreciated that care would be

available if they really needed it, unlike in Mexico where care may not be as accessible. Luis shared his observations with me:

“[A lot is different here]: the health insurance, payment plans, there’s emergency care all the time, it’s close, accessible, the doctors explain everything. In Mexico it’s a little bit harder; if you go to the doctor you have to have the money in your hand. If you don’t pay, you don’t leave... There are good doctors in Mexico that do everything well, like here, but in a lot of places the doctors aren’t as professional as a doctor should be.”

The participants also noted that the accessibility of health care for children in Oregon was a lot better. In their experiences, most children can get some type of health care coverage. Ariana, the mother of two children, both born in the United States, explained:

“It is better here, that’s why we are here. In Mexico there’s also help for children that is similar but here kids born here always have insurance, and if they aren’t it isn’t really a problem... In Mexico you have to pay for everything for the kids and your entire family. It’s different and harder.”

Similarly, Helena who has three children, all of whom were born in the United States, said:

“It is better here because in Mexico not every child gets health care. If you have the money and go to the doctor, they’ll help you. There are also smaller places and free clinics but if you live in the cities there’s not a lot of help. You have to have money. If your child has to go to the hospital you have to pay or he won’t get released from the hospital. Here it’s different; almost all kids have insurance.”

Resources Available

Since all participants had been living in Oregon for three years or more, all of their most recent experiences had been very specific to the way health care is set up in this state. The Oregon Health Plan (OHP), Women Infants and Children (WIC), and county and community clinics were the primary resources used.

Participants had learned about the resources available to them in a variety of ways. Some had learned by referrals from other state or county programs. The most common ways they were learning about resources were through community groups and their social networks. Nora explained this to me saying:

“Before I didn’t know a lot of people but my husband is one of those who gets out and finds a way... with other people I know they look for help from friends to see if they know where to get help; it’s within the community.”

Large amounts of information and support coming from these types of informal social networks are consistent with the findings of other studies and lead to an overall increase in visits to the doctor (Documét and Sharma 2004).

After actually finding and receiving care, all participants said that having translators and interpreters was the most helpful resource. Some had close family members who could speak English, but translators and interpreters were helpful when family could not be with them at their appointments. This is encouraging because in the past the dominance of English in health care settings has negatively impacted its utilization by undocumented immigrants (Rodríguez et al. 2009). Ariana explained to me her frustrations when going to appointments with her daughter:

“[I wish] that a translator would always be there or someone to help make the appointments because I don’t speak a lot of English and if I make them sometimes they don’t really understand me. When I take my daughter for her eye appointments to know how she’s doing, she herself doesn’t understand that much English even though she’s in school and a lot of words she doesn’t know so I try to get her to tell me [what they’re saying] and she says, mom I don’t understand what they told me.”

This type of situation is all too common for immigrant families. Medical terms can be hard even for a native English speaker to understand, so putting the pressure

on children to be accurate translators can lead to much frustration by everyone involved.

Over the years participants have seen an increase in the number of interpreters available, as well as bilingual medical staff which is really the ideal way to handle the situation. Additionally, some participants mentioned having resources, like information in Spanish, available to them. In the case of Luis and Juana's son, they told me that they had had a Spanish-speaking medical social worker to help them get through the process, figure out how to pay for the treatments, and answer any questions they had.

Barriers and Challenges

There were three main challenges that seemed to be common in all interviews. The first was the cost of treatment and the inability to pay for it. Especially for the families that did not have any sort of health insurance, not seeking care, paying everything out of pocket, or finding out what resources were available in the community became their only three options. Strategies such as saving for health emergencies, asking family members for help, or returning to Mexico for cheaper care were the few solutions participants had. Nora had seen this happen with people she knew:

"In other people I've seen that when they [get sick or injured] and they don't go to the doctor. They stay like that, or sometimes they look for help but may choose to go to Mexico to get cured and then come back. For example, with dentists it is really hard sometimes to get help so what many do is they save money, go to Mexico, look for help, find treatment and then return. I have various friends who work, then go to Mexico for treatment and to get better, even though they have papers. I know one girl who was born here but didn't have insurance so she goes

to Mexico and then comes back. It's cheaper there too.”

Carla also had experience with this saying:

“The costs are really high. Here my husband doesn't do anything when he gets sick. If he does he goes to Mexico... I think that if there were the possibility of getting treated here and if the payments in the hospitals were more reasonable and accessible to pay then you wouldn't have to travel to Mexico.”

I also found that very few had a “Plan B” or alternative plan if they were not able to get the care they needed in Oregon. Some said that even returning to Mexico was not really an option for them because their lives had become so fixed in the United States. Nora, after living in Oregon for eleven years and having two children said:

“[If I couldn't receive the care I needed] I would save money. I think it is like when you buy a house you have to save money for so much time because if there isn't work then you can't make the payments. For me, our life is already made here so we wouldn't go to Mexico.”

Desired Changes and Suggestions from Participants

When asked about what changes they would make to the health care system in the United States, participants had different responses. Some felt that making insurance more affordable and accessible was important, as Ariana said:

“I would make insurance plans where it didn't matter if you were born here or not, you would pay a certain amount but not too much because sometimes we don't have money to pay a lot. Sometimes you need an operation or something like that and you have no way of paying and that is a big frustration... That's how I would change it so that there would be help for everyone, not completely free but some sort of help so there wasn't such a big difference between having papers and not having papers.”

Other participants had changes more focused on the availability of treatment, the specific care provided by medical professionals and the way they treat patients.

In their research, Ortega et al (2007) seem to agree:

Worse health care experiences for undocumented Mexicans imply that efforts to improve processes of care need to address this specific vulnerable group. Strategies to improve the delivery of health care services to legally authorized immigrants and US citizens, to the exclusion of undocumented individuals, will likely miss an opportunity to influence health care for the individuals most affected by inequities in health care access. (p. 5)

Evelina said that having more clinics was necessary so that the current ones would not be so full and waiting times for appointments would not be so long.

Nora suggested having more education, not only for undocumented immigrants about the resources available, but also to change the mentality of care providers.

“Educating [immigrants] in what to do when they have problems and where to go because many don’t know... And also maybe educate the doctors a little more because they are trained in their profession, how to cure people, but not compassionately. I think politics has a lot of influence too... because if a law says they have to do this then they are limited in what they can do. So changing the laws would help.”

This is important because the lack of knowledge of available resources has been found to be a factor in individuals waiting longer to receive care, either until they could get health insurance, or until their condition had drastically declined requiring immediate care (Documét and Sharma 2004).

CONCLUSIONS AND RECOMMENDATIONS

As shown above in the information gathered in the interviews, the five types of barriers discussed by Garcés et al (2006) can be seen in the everyday experiences of undocumented immigrants. Interviewees seemed to spend the largest amount of time discussing the structural barriers they faced. The cost of care and lack of financial resources put these individuals in a precarious situation

when health care is needed either for them or for their children.

Because the research was conducted in Oregon, the majority of the findings can only be examined within this context since we are unaware of how experiences may compare for undocumented immigrants in other states. In Oregon, systemically, undocumented immigrants find themselves in a place where a variety of resources do exist, from free community and county clinics, to state-run programs such as the Oregon Health Plan. However, gaining access to the knowledge about these resources is another question because of the complexity of the system and the lack of easy-to-understand information available to them in Spanish.

Linguistically, the field of health care in Oregon has come a long way in the past fifteen to twenty years. More and more hospitals provide interpreters on a regular basis, either in person or with over-the-phone systems, and community clinics are also making interpreters more available. The number of bilingual and bicultural staff also continues to grow, leading not only to more accurate and effective care, but also more culturally sensitive care. Culturally sensitive care plays an important role because it can help create equality as well as facilitate the process of understanding the specific needs of Latinos for policy makers and health care providers (Documét and Sharma 2004).

Undocumented immigrants make up a large portion of the manual labor workforce in the United States, especially in Oregon where agriculture is one of the main economy-sustaining industries. Without major immigration policy

changes that could have a devastating impact on the economy, this will continue to be true for decades to come. Changes to the health care system will not only lead to better care for undocumented immigrants, but would also boost the economy by allowing our state's hardest workers to maintain their health and well-being and therefore positively affect productivity. One argument against this is that immigrants are already "overusing" the system. However, research reveals the opposite; that in fact undocumented immigrants have much lower rates of health care usage compared to citizens while also reporting poorer experiences within the system (Ortega et al. 2007).

Changes would need to allow undocumented individuals to enroll in insurance plans, not necessarily free ones, but plans they could pay into in order to have coverage when faced with health problems. Immigrants, when they enter the country, tend to be some of the healthiest individuals in society because very few people with poor health can survive the immigration process. This means that the key is helping immigrants maintain their health through early and preventative treatment.

Education is also key in allowing them to better care for their own health. As undocumented immigrants acculturate, many of them are unaware of the negative consequences lifestyle and dietary changes can have on their health. Several programs are in place, like WIC and Comienzos Saludables (*Healthy Beginnings*), an educational program designed for first time mothers and parents, which help to disseminate some of this information, but more programs with a

wider reach, need to be in place to spread the information on a large scale.

It is important to continue to observe the current experiences of undocumented immigrants within the health care system of the United States. Further research needs to be done on a larger scale, including interviews with immigrants from many more states, in order to adequately and most accurately tell the story of undocumented immigrants in the health care system of the entire United States.

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APPENDICES

Appendix A: Table 1. Characteristics of Participants

<i>Pseudonym</i>	<i>Age</i>	<i>Sex</i>	<i>Country of Birth</i>	<i>Length of time in USA</i>	<i>Length of time in Oregon</i>	<i>Reason for moving to OR</i>	<i>Marital Status</i>	<i>Number of Children</i>	<i>Employment</i>	<i>Spouse Employment</i>	<i>Current Medical Coverage</i>
Ariana	29	Female	Mexico	10 years	3 years	Spouse's job	Married	2	Housewife	Works at Dairy	No
Carla	32	Female	Mexico	6 years	6 years	Spouse's job	Married	4	Housewife	Agriculture (Christmas Trees)	No
Evelina	22	Female	Mexico	4 years	4 years	Spouse's job	Married	1	Housewife	Cook/Dishwasher	No
Helena	32	Female	Mexico	11 years	11 years	Spouse's job	Married	3	Housewife	Landscaping	No
Juana	38	Female	Mexico	10 years	10 years	Get care for sick child	Married	4	Housewife	Mechanic	Yes
Luis	39	Male	Mexico	10 years	11 years	Get care for sick child	Married	4	Mecanico	Housewife	Yes
Nora	35	Female	Mexico	15 years	11 years	To study	Married	2	Student	Criminal Justice	Yes

A Study of Latino Immigrants in US Health Care

- Are you 18 years or older?
- Are you a Latino/a who has been undocumented at some point in your life?



If you answered yes to the above questions you are invited to become a part of a study that will collect the stories and experiences that undocumented immigrants have had with US Health Care. This will help researchers to better understand the challenges undocumented immigrants face in the United States when they try to access health care.

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Undocumented Immigrants in US Health Care
IRB Application Number: 4818

Un Estudio de Inmigrantes Latinos en el Sistema de Salud en los Estados Unidos

- ¿Tiene 18 años o más?
- ¿Es usted un latino/a que en algún momento en su vida no tenía papeles?



Si contestó sí a estas preguntas está invitado/a a participar en un estudio que va a coleccionar las historias y experiencias que inmigrantes indocumentados han tenido con el sistema de salud en los Estados Unidos. Esto nos ayudará entender mejor las dificultades inmigrantes enfrentan aquí cuando tratan de acceder asistencia médica.

**Para más información por favor póngase en contacto con
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Inmigrantes Indocumentados en el Sistema de Salud en los Estados Unidos
Numero de Aplicación de IRB: 4818

Appendix C: Case Study Questions

Screening questions

1. How old are you?
2. Have you ever been an undocumented person living in the United States?

Study Questions

3. Where were you born?
4. How long have you been living in the United States?
 - a. How long have you been in Oregon?
 - b. What caused you to move to Oregon?
5. What is your marital status?
6. Do you have children?
 - a. If so, how many, and what are their ages?
 - b. Do your children live with you?
7. Are you currently employed?
 - a. What kind of work do you do?
 - b. How many people do you support with your salary?
8. Do you have medical coverage or a health care plan from where you work?
9. While being undocumented, what did you do when you got sick or injured?
 - a. (If married) What did your spouse do?
10. When you were undocumented, if someone in your family became ill and needed to seek medical care, what would you do?
 - a. Did you have a plan B if you couldn't receive the treatment here?
11. Can you please tell me about your experiences with the US health care system? *(It is not necessary to identify where or for what reason you were seeking medical attention.)*
 - a. What were your first impressions? How were you treated by the admissions department? Nurses? Doctors?
 - b. Did you understand all that they were talking about and advising you to do?
 - c. What was the quality of care you received? What could have been done differently?
 - d. Did you feel that anything was unusual, especially in comparison to how things are done in your home country?
 - e. Did you have to fill a prescription? How did you manage this?
12. How did you figure out where to go to get medical care when you or your family member was sick or injured?
13. What were the biggest difficulties you faced when trying to receive care?
14. Considering your first health related emergency and any subsequent emergencies, did your level of comfortableness seeking medical attention change over time? If so, in what

way and how long did it take?

15. Were there any services or resources available to you that helped make dealing with the health emergency easier? (i.e. interpreter, information/pamphlets in your language, medical social worker, patient advocate)
 - a. If so what were they?
 - b. What services or resources do you wish had been available to you?
16. Were there any cultural differences between you and your medical care provider, especially related to diagnoses and/or treatment plans?
17. What differences have you noticed between the health care system in the United States and the one in your home country?
18. If you could make changes to the current U.S. health care delivery model or the health care service providers (hospitals, doctors, nurses) what would you change in order to make care better for undocumented people?

Preguntas de Investigación

Preguntas de Selección

1. ¿Cuántos años tiene?
2. ¿En este momento está indocumentado o ha estado sin papeles en el pasado?

Preguntas de Investigación

3. ¿De donde es?
4. ¿Por cuánto tiempo ha vivido en los Estados Unidos?
 - a. ¿Por cuánto tiempo en Oregon?
 - b. ¿Por qué se mudó a Oregon?
5. ¿Cuál es su estado civil?
6. ¿Tiene hijos?
 - a. Si tiene, ¿Cuántos y cuáles son sus edades?
 - b. ¿Viven con usted sus hijos?
7. En este momento, ¿tiene trabajo?
 - a. ¿A qué se dedica?
 - b. ¿Cuántas personas mantiene con su salario?
8. ¿Tiene seguro médico o un plan de asistencia médica de su empleador?
9. Mientras estar indocumentado, ¿qué hizo cuando se enfermó o se lastimó?
 - a. (Si casada) ¿Qué hizo su esposo?
10. Cuando estaba indocumentado, si alguien en su familia se enfermara y tuviera tener cuidado médico, ¿qué haría?
 - a. Tenía un plan B u otro plan si no pudiera recibir tratamiento aquí?
11. ¿Por favor puede decirme de sus experiencias con el sistema de salud aquí en los Estados Unidos? (No es necesario identificar dónde o por qué razón estaba buscando

atención médica.)

- a. ¿Qué eran sus primeras impresiones? ¿Cómo le trató el departamento de entrada? ¿Los enfermeros? ¿Los médicos?
 - b. ¿Entendió usted todo lo que estaban diciendo y aconsejándole hacer?
 - c. ¿Qué era la calidad del cuidado que recibió? ¿Qué podría haber hecho diferente?
 - d. ¿Se sintió que hubo algo extraño o raro, especialmente en comparación a cómo cosas están hechos en su país de origen?
 - e. ¿Tuvo que llenar una receta? ¿Cómo lo hizo?
12. ¿Cómo sabía dónde pudo ir para recibir atención médica cuando usted o su familiar lo necesitaba?
 13. ¿Qué eran las dificultades más grandes que usted encontró cuando intentó recibir cuidado?
 14. Pensando en su primera emergencia y las que siguieron, ¿cambió, con tiempo, su nivel de comodidad cuando estaba recibiendo atención médica? Si cambió, ¿en qué manera y cuánto tiempo lo tomó?
 15. ¿Había algunos servicios o recursos disponibles que le ayudaron hacer la experiencia más fácil? (interprete, información/folleto en su idioma, trabajador social médico, defensor de pacientes)
 - a. ¿Cuáles eran?
 - b. ¿Cuáles servicios o recursos esperaba que hubieran sido disponibles?
 16. ¿Había algunas diferencias culturales entre usted y su proveedor médico, especialmente relacionado al diagnóstico o plan de tratamiento?
 17. ¿Cuáles diferencias ha notado entre el sistema de salud en los Estados Unidos y el de su país de origen?

Si pudiera hacer cambios al sistema de asistencia médica de hoy o a los proveedores de servicios de salud (hospitales, médicos, enfermeros) ¿qué haría para mejorar el cuidado para personas indocumentadas?