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Undocumented Mexican Immigrant Health Care Access in the Southeastern United States: A Quantitative Study of Service Use, Experience, and Affordability

By

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An Abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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ABSTRACT

Undocumented Mexican Immigrant Health Care Access in the Southeastern United States:
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By Cynthia Campos

Currently, there is limited literature available delineating the scope of health care access of undocumented Mexican immigrants in the Southeastern United States. Undocumented immigrant populations are challenging to study because they often are hesitant to share their legal status for fear of stigma, discrimination, or being exposed to immigration authorities, a legitimate concern for those living in states with anti-immigrant legislation. This study aims to look at the health access of undocumented Mexican immigrants who sought consular services at the Consulate General of Mexico in Atlanta from June-July 2018. Surveys were conducted via opportunity sampling in the Consulate General waiting area as participants were waiting to receive consular paperwork, 149 self-reported undocumented immigrants and 54 documented immigrants were surveyed. Over 90 percent of undocumented immigrants reported not having health insurance coverage, nearly double that of immigrants with legal authorization. Undocumented immigrants also reported going longer periods of time without seeing a medical or health professional and nearly half reported that the cost of medical services had a “high” or “very high” impact on their financial situation.

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Introduction

Racial and ethnic disparities play an important role in health care access for minority communities in the United States, in particular amongst Latino undocumented immigrants in the United States. Undocumented immigrants have been reported to use health services less frequently and experience poorer quality of care than US born Latinos (Ortega et al., 2007). Anti-illegal immigration policies targeting immigrants have been found to adversely affect health care access of immigrant parents and their children. After Alabama's 2011 HB56 was passed, pregnant Latina immigrant mothers saw a decrease in health care access due to a change in eligibility for public benefits and employment citizenship verification which made care increasingly unaffordable (White et al., 2014). Similarly, Emory researchers found that Georgia's 2011 HB87 anti-illegal immigration bill resulted in a decrease in Hispanic pediatric emergency room visits while also seeing an increase in visit severity (Beniflah et al., 2013). In families with mixed immigration status (non-citizen parents and citizen children), fewer noncitizen immigrants (documented and undocumented) have Medicaid or employer provided health insurance as compared to native born citizens and their citizen children (Ku & Matani, 2001). Increasing health care access by identifying barriers that directly and indirectly affect the manner in which undocumented immigrants are able to seek and obtain care can have significant implications for improving health outcomes in an often forgotten community.

Undocumented Immigrants in the United States

In 2016, an estimated 5.4 million undocumented immigrants from Mexico lived in the United States, accounting for 51 percent of total undocumented immigrants (Gonzalez-Barrera and Krogstad, 2016). Undocumented Mexican immigrant adults are also more likely to be long-term residents of the United States, in 2016 it was estimated that 80 percent of undocumented

Mexican immigrants had lived in the United States for more than 10 years. Recent undocumented Mexican immigrant arrivals who have lived less than 5 years in the United States accounted for just 8 percent of all undocumented immigrants in 2016 (Gonzalez-Barrera and Krogstad, 2016). The undocumented Mexican immigrant population in the United States reached a peak at 6.9 million in 2007, since then the number of undocumented Mexican immigrants has continued to slowly decline every year and in 2016 was at 5.9 million (Passel and Cohn, 2016). Despite an increase in the undocumented immigrant population during the early 2000s in the Southeast (Passel and Cohn, 2009), a decade later, from 2009 to 2014 three Southeastern states, Alabama, Georgia, and South Carolina, saw a decrease in undocumented immigrant populations that has been tied to the declining numbers of undocumented immigrants from Mexico (Passel and Cohn, 2016).

Undocumented immigrant family units are often multi-generational and family members may be of mixed legal status, undocumented and U.S. born members. Although no figures were found for the number of undocumented Mexican immigrant children living in the U.S., in 2016 there were 5 million U.S.-born children and 675,000 undocumented immigrant children under the age of 18 living with undocumented immigrant parents (Passel and Cohn, 2018). Additionally, 975,000 adult U.S.-born children lived with their undocumented immigrant parents (Passel and Cohn, 2018). Approximately 47 percent of undocumented immigrant couples have children that are living with them in the U.S., a higher percentage than their U.S.-born (21 percent) and authorized immigrant counterparts (35 percent), in part due to undocumented immigrants being younger (Passel and Cohn, 2009).

Undocumented Immigrants and Health Access

Access to health services amongst undocumented immigrant populations has been found to be poorer than their authorized immigrant counterparts. The U.S. health system is multilayered, expensive, and complex, built on a system of public and private health insurance pipelines. Health affordability is a problem for most U.S. residents and can be even more difficult to navigate for the undocumented immigrant population which faces financial, legal, language, and cultural barriers when seeking to obtain care. The largest health insurance program that is available for low-income populations is Medicaid, which "provides health coverage to low-income people and is one of the largest payers for health care in the United States" (Medicaid, 2019), however it only provides coverage for documented US residents. Low-income undocumented adults would similarly be excluded from qualifying for Georgia's state Medicaid program which offers health insurance coverage for pregnant women, legally disabled persons, and adults over 65 years of age (Georgia Medicaid, 2019). Georgia's PeachCare for Kids, Georgia's State Children's Health Insurance Program (SCHIP) offering low-cost health insurance for uninsured low-income children, excludes Georgia's undocumented children (PeachCare for Kids-Eligibility Criteria, 2018). In mixed-status families, U.S. born children of low-income undocumented parents would be covered under the program.

Currently, there is limited literature available delineating the scope of health care access and affordability for this hidden Southeastern population. The little information available on health care access and health services is reported on either undocumented immigrants nationally or focuses on Hispanic and Latino populations more generally without looking at the undocumented immigrant population subset. Undocumented immigrant populations are challenging to study because they often do not wish to share their legal status for fear of stigma,

discrimination, or being exposed to immigration authorities (Shedlin et al., 2011), a legitimate concern for those living in states with anti-immigrant legislation. This study aims to look at the health access of undocumented Mexican immigrants seeking consular services at the Consulate General of Mexico in Atlanta from June-July 2018, a unique opportunity to learn more about a population that has been notoriously difficult to reach. By observing the current health and socio-demographic characteristics of undocumented immigrants visiting the Consulate, it may be possible to inform how future public health efforts are designed to reach this hidden Southeastern population.

Chapter 2: Literature Review

Introduction

Immigration to the United States, and more specifically the Southeastern U.S., grew from 1980 to 2000s, but growth has slowly declined in the last decade. This population influx consists of a mixture of both documented and undocumented immigrants who upon arrival may not be well connected with support systems to help their transition to a new country. In particular, undocumented immigrants in the Southeastern U.S. lack access to affordable healthcare services due to cultural, political, and socioeconomic reasons that may have implications for the overall health of this population. In order for public health professionals to best support and mitigate undocumented immigrants lack of healthcare services, it is important to first be able to understand the challenges and barriers that keep the undocumented Mexican immigrant community in the Southeastern United States from being able to access reliable, adequate, and consistent health services. Due to high rates of diabetes, cholesterol, and heart disease, among other health conditions in the Latino community more broadly, it is of utmost importance that public health professionals learn more about the barriers to health access amongst undocumented Mexican immigrants in the Southeastern U.S. in order to create effective and efficient health programs to reach this hidden population.

Undocumented Immigrant Demographics

There is variation in the data and information that may be found on both the Latino and Hispanic communities as well as undocumented communities in the United States. It is first important to understand that several different terms are used to describe similar populations in academic literature, making it difficult to come to consensus on the correct descriptors for both Latino or Hispanic populations and the undocumented immigrant population. The terms Hispanic

and Latino are often used interchangeably and although there are slight differences in the definitions of these two terms, they are frequently used to describe large portions of the same population. The term *Hispanic* is derived from the word España (Spain in Spanish) and is used to refer to countries where the Spanish language is predominantly spoken whereas the term *Latino* is used more broadly to encompass peoples from all Latin American countries (Granados, 2000). The United States government has historically chosen the term *Hispanic,* the word used on the US Census to refer to peoples of Latin American and Caribbean origin and descent, though more colloquially the terms *Hispanic* and *Latino* are used to refer to similar populations (Alcoff, 2005), (Ennis, 2011). When conducting research on undocumented Mexican immigrants in the United States and Georgia, it is common to find literature referring to Hispanic undocumented immigrants or Latino undocumented immigrants. Both terms seemed to be used interchangeably in academic health journals, rarely was literature found specifically referencing the health of undocumented Mexican immigrants specifically.

Hispanic/Latino Population in Georgia

The Hispanic population in the United States has grown substantially in the last few decades, in particular the U.S. South saw a 57 percent increase in the Hispanic population from 2000 to 2010, four times the growth of the South's total population (Ennis, 2011). In 2010, more than three quarters of the Hispanic population in the United States lived in either the US West, 41 percent, or in the US South, 36 percent (Ennis, 2011). Hispanics account for 16 percent of the South's total population, of all Hispanics living in the South 60 percent of them were of Mexican origin in 2010 (Ennis, 2011). Of the 3,143 counties in the United States, two Georgia counties were in the top 5 counties with highest Hispanic population growth from 2000 to 2010: Henry County with 339 percent and Douglas County with 332 percent (Ennis, 2011). Out of all counties

in Georgia, 129 counties saw a higher Hispanic population growth than the national average of 43 percent (Ennis, 2011).

Undocumented immigrants of any origin accounted for 36 percent of Georgia's immigrant population and 3.6 percent of the state's total population in 2014, and more than 200,000 U.S. citizens in Georgia lived with at least one undocumented family member (Immigrants in Georgia, 2017). In total, there were more than 351,000 undocumented immigrants living in Georgia in 2016, of these, an estimated 60 percent were born in Mexico, calculated by the Migration Policy Institute based on estimates from the 2016 American Community Survey (Migration Policy Institute, 2016). The most common length of U.S. residence for Georgia's undocumented immigrants was from 10 to 14 years (Migration Policy Institute, 2016).

Socioeconomic Status, Education, and Health

Undocumented immigrants represented 5.2 percent of Georgia's total labor force; of all undocumented immigrants over 16 years of age in Georgia in 2016, 68 percent were employed and 28 percent were not in the labor force (Migration Policy Institute, 2016). Although figures for undocumented Mexican immigrants were not available, as a whole 35 percent of undocumented immigrants were at or above 200 percent of the federal poverty level, followed by 19 percent at 100-149 percent of the federal poverty level and 18 percent at 50-99 percent federal poverty level (Migration Policy Institute, 2016). No figures were found on the educational attainment of undocumented Mexican immigrants, however, in 2010 an estimated 44 percent of Georgia Latinos over 25 years of age had attained less than a high school degree with an additional 27 percent completing high school (Andes et al., 2012). Nearly half of all undocumented immigrants in Georgia over the age of 5 years, 45 percent, did not speak English

well or not at all, followed by 26 percent who could speak English well (Migration Policy Institute, 2016).

Nearly three-quarters of all undocumented immigrants in Georgia did not have access to health insurance; 70 percent were uninsured (Migration Policy Institute, 2016). In a 2012 report by Andes et al., looking at U.S. Census data from 2010, only about one-third of working-age Hispanic adults in Georgia between the ages of 18 and 44 had health insurance coverage, for foreign-born Hispanic adults in Georgia, 72 percent of did not have health insurance (Andes et al., 2012)

Economy

In Georgia over half of the Hispanic workforce, regardless of legal status, worked in either the service industry or in the natural resources, construction, and maintenance sector (Andes et al., 2012). The median 2010 annual income for Hispanic Georgians was $34,873, with 28 percent of the state's Hispanic population living below the poverty line (Andes et al., 2012). Although no figures were found on undocumented Mexican immigrants, undocumented immigrants as a whole paid an estimated 351.7 million dollars in state and local taxes, their contribution to state and local taxes would be expected to rise to 455.6 million if they were to be given legal status (Immigrants in Georgia, 2017).

Age, Gender, and Marital Status

Though there were no figures on the undocumented Mexican immigrants in Georgia, data was found separately on Georgia Latinos and undocumented immigrants in Georgia. In 2010, males accounted for 54 percent of Georgia's Latino population, a 5 percent decrease from a decade earlier as the population of Latina women increased in the state (Andes et al., 2012). The Latino population in Georgia is overwhelmingly young; 32 percent of the Latino population was

under the age of 15, with another 66 percent between the ages of 15-65 years old (Andes et al., 2012). In 2010, an estimated 60 percent of Georgia Latinos lived in married-couple families (Andes et al., 2012).

In 2016, 55 percent of undocumented immigrants in Georgia were male (Migration Policy Institute, 2016). The two largest age groups for Georgia undocumented immigrants in 2016 were 25-34 year olds and 35-44 year olds, each comprising 28 percent (Migration Policy Institute, 2016). Approximately 60 percent of Georgia's undocumented immigrants over the age of 15 do not live with children in their home and another 35 percent live with a child who is a U.S. citizen and under the age of 18 (Migration Policy Institute, 2016). According to data from 2016, an estimated 40 percent of undocumented immigrants over 15 years of age in Georgia were married (Migration Policy Institute, 2016).

Barriers to Health Care Access and Services

Threats and Fear of Seeking Health Services

Cultural, political, and physical barriers to accessing health services have a direct impact on the ability of undocumented immigrants to be able to seek and obtain medical attention and health services. Despite the enactment of the Patient Protection and Affordable Care Act in 2010, little has changed for undocumented immigrants because they are neither eligible to purchase health insurance through the health insurance exchanges nor can they receive insurance subsidies (Bustamante et al., 2010), (KFF, 2017). Due to their legal status in the United States, undocumented immigrants are particularly vulnerable to health disparities (Heyman et al., 2009). They are unable to qualify and access public health insurance programs such as Medicaid or other similar healthcare programs with the exceptions of emergency Medicaid and limited public health care services (Heyman et al., 2009).

Although medical facilities and healthcare institutions are not required to contact immigration authorities and report an undocumented patient, the fear of potentially coming into contact with any sort of formal or authoritative entity is great enough to deter undocumented immigrants from seeking medical attention altogether (Heyman et al., 2009). In a review of the literature by Heyman et al. of the late 1990s and early 2000s, it was estimated that the undocumented immigrant population in the U.S. had low rates of health insurance coverage, about 10-40 percent depending on the sub-population and date of study (Heyman et al., 2009). In addition to low health insurance coverage, lack of access to health insurance is compounded by the fact that many undocumented immigrants are unable to afford private health insurance and work in low-wage and low-benefit labor markets that do not commonly offer health insurance benefits (Heyman et al., 2009). Undocumented children of low-income undocumented immigrant families are excluded from public health insurance programs, such as SCHIP, that they would otherwise qualify for (Heyman et al., 2009).

Barriers to health care access are not singular factors, but rather an intricate interplay between several socio-environmental and political factors that together make finding appropriate and effective solutions challenging. In order to study how a "patchworking" system (relying on their social networks to obtain information about formal care providers and medications) is used to overcome barriers to health access and health seeking behaviors, Heyman et al. conducted a survey of 83 undocumented immigrants in El Paso County, 41 in the rural community of Mesquital with few healthcare services and 43 in the more urban El Paso City with greater geographical access to community clinics and hospitals. In order to reach their target population of undocumented immigrants who are often reluctant to share information, snowball sampling

was chosen in order to collect the best possible data since it was more likely to recruit participants if someone they knew and trusted had already participated in the study.

Major findings of the study were that unauthorized immigrants experienced poorer health outcomes both as a result of direct and indirect effects of their legal status. Demands for identification documents were a major factor in participants not attempting to seek medical attention or health services because they knew they would be denied. Participants stated they resorted to using community clinics for out-of-pocket services as necessary, but it was difficult to maintain a steady continuum of care and maintain follow-up appointments. In one family with mixed-status children, legal status led to drastically different health outcomes between siblings. A U.S. citizen child with asthma qualified for SCHIP and received timely check-ups and used emergency services as necessary, whereas their sibling whom had broken their leg resorted to home remedies and over the counter medication due to an inability to pay for the emergency room bill, let alone additional appointments (Heyman et al., 2009).

Additionally, indirect effects of their undocumented status lead to health seeking barriers including: constant fear of law enforcement presence in the region were barriers to free movement to and from healthcare facilities, awareness of deportability, cautiousness around formal institutions, and a perceived position in the U.S. social hierarchy. What Heyman et al. describe as a "web of effects" in health access barriers leads to detrimental health effects. Due to their legal status, undocumented immigrants had limited checkups and diagnostic work for preventable chronic illnesses, only receiving medical care once acute symptoms are present. Furthermore, once care had been received, there was a lack of medical follow-up and poor care chronic disease monitoring (Heyman et al., 2009).

A more recent qualitative study conducted amongst undocumented Mexican immigrant women in Houston found that living with the constant fear of potential deportation manifested into negative mental health effects (García, 2018). Researchers used purposive and snowball sampling to conducted 30 semi-formal in-depth interviews with women in Houston, Texas, in order to investigate how living in a constant threat of deportation affects the stressors faced by undocumented immigrants as well as how a deportation threat affects the ability to access community resources (García, 2018). Data revealed that living with an anticipatory stressor, a stressor that has not yet occurred but has a realistic potential of occurring, such as contact with a police officer or deportation, led to chronic mental health stressors. Women reported that a fear of deportation or detention led them to avoid potentially risky locations and thus prevented them from accessing important medical or social services both for themselves and for their children (García, 2018). Living as an undocumented Mexican immigrant in Houston has directly impacted the overall mental health of immigrant women and has led to their avoiding authoritative figures, including those that provide health services.

As stated by Heyman, one of the major drawbacks of the research on undocumented immigrant populations in the United States is that the research that has been done on undocumented immigrants is limited to qualitative and quantitative studies in small pockets of the population. What makes El Paso County unique in this scenario, and differs from Georgia, is that El Paso is a border-town located near the U.S.-Mexico border and Texas is one of the most populous states for undocumented immigrants to settle in (Passel and Cohn, 2009). Although Georgia does not border Mexico and has a smaller undocumented immigrant population, there are similarities in that both states are historically conservative with a contentious undocumented immigrant atmosphere. Similarly, since the Affordable Care Act was enacted in 2010, both

Texas and Georgia have not expanded Medicaid, both of their low-income undocumented adults are unable to qualify for Medicaid, and undocumented children are unable to qualify for their state's SCHIP programs. Heyman posits that building off of the El Paso study, further research would be necessary to further understand where along the path to seeking health services undocumented immigrants encountered both "facilitating and obstructive factors" in order to find possible routes for intervention.

Anti-immigrant Policies and Detrimental Health Effects

Undocumented immigrant health has also been found to be affected by anti-immigrant sentiments in their states of residence, which have direct effects on public health outcomes and trust between public health professionals and undocumented communities. Although health care facilities are considered to be "sensitive places" where immigration officials and legal authorities are to avoid detainments, there have been reports of Customs and Border Patrol (CBP) officers following undocumented immigrants to hospitals and detaining them as they leave (Kerani and Kwakwa, 2018). Stories of undocumented immigrants being detained by CBP after visiting a health facility or having their personal information shared with government agencies have been widely circulated in the media, increasing anxiety and fear of being arrested when seeking health services. In mixed-status families, despite the fact that some members may be eligible for health insurance programs, a fear of bringing attention to their undocumented family members or communities has led to a reluctance to seek care and consequently has led to poorer health outcomes in these communities (Kerani and Kwakwa, 2018).

Changes in health policy that exclude undocumented immigrants from being able to receive care have immediate effects on health seeking behavior and a subsequent decline in use of health services. In California, the passage of Proposition 187 in 1994 prohibited

undocumented immigrants from using state-funded nonemergency services and required health care providers to report undocumented patients to the now defunct Immigration and Naturalization Services (Berk, 2001). After Prop. 187 was passed, a health access survey among 973 undocumented immigrants in four major cities, Fresno and Los Angeles in California and Houston and El Paso in Texas, found that across all four sites, 39 percent of respondents reported being afraid they could not receive medical services due to their legal status. Respondents who expressed fear of not being able to receive medical services were more likely than respondents who did not express fear to have their medical service needs go unmet. Fear of being detained accounted for more than a fourfold increase in the probability of respondents having their prescription drug needs go unmet (Berk, 2001). Although Prop 187 only applied to California, researchers believed that the discourse and publicity surrounding Prop 187 spread beyond California and had an effect on the fear expressed by undocumented immigrants in Texas.

It is important to note that Prop 187 alone was not the driving force behind increased restrictions on undocumented immigrants' access to publicly funded health services. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which imposed health care access restrictions for authorized immigrants, may have also affected public discourse in deterring immigrants altogether from being able to seek medical care. Perhaps most importantly, Berk et al. concluded that regardless of whether or not initiatives limiting undocumented immigrants from accessing medical care are passed, public discourse and debate alone about the rights of immigrants to use publicly funded health care may be a strong enough deterrent to keep immigrants, undocumented and authorized, from seeking needed health services.

Similar anti-immigrant legislations have been passed in Georgia that may have detrimental impacts on the state's public health. In 2011, Georgia passed the Illegal Immigration

Reform and Enforcement Act of 2011, more commonly known as HB87. The bill stipulated that anyone may be charged with transporting an "illegal alien" if they "while committing another criminal offense, knowingly and intentionally transports and moves an illegal alien in a motor vehicle for the purpose of furthering the illegal presence of the alien in the U.S." (Aponte-Rivera and Dunlop, 2011). Physicians have also shown concern that HB87 will increase the number of undocumented immigrants that seek medical care in illegal healthcare settings staffed by medical professionals trained outside the United States (Aponte-Rivera and Dunlop, 2011).

The effects of HB87 have already led to a decrease in parents of undocumented children seeking medical attention for their children. In a 2013 study by Beniflah et al., a retrospective chart review of all Hispanic patients who presented to the pediatric emergency department in the four-month period after HB87's implementation was compared to the same time period in the two years prior, 2009 and 2010. Researchers compared patients' acuity score, dispositions, demographics, and payment type. After HB87's implementation, fewer Hispanic patients visited the emergency department and had higher acuity. Additionally, more patients were also admitted to the hospital that in years prior.

Health Access

Health Insurance

Cultural, socio-economic, and political barriers to accessing health are not the only factors that contribute to undocumented Mexican immigrants' not accessing quality and reliable health services; the sheer cost of paying for health services out of pocket can be insurmountable for many. In the United States, low-income U.S. citizens in states with expanded Medicaid who make below 135 percent of the federal poverty level are eligible for low-cost public health insurance programs. On the whole, undocumented immigrants are low-income households with a

median annual household income of $36,000 in 2007, which would place them squarely within the qualifications for Medicaid (Passel and Cohn, 2009). However, accessing affordable health insurance or being able to pay for health services on their own is a major barrier to undocumented immigrants being able to receive reliable and quality health care.

Medical expenditures and the ability to pay for health services can hinder undocumented immigrants from being able to receive health services. A systematic review by Flavin et al. of 188 peer-reviewed studies related to immigrant health compared immigrant medical expenditures in the United States to the medical expenditures of U.S. born persons (Flavin et al, 2018). It was found that undocumented immigrants comprise the majority of Emergency Medicaid users although emergency Medicaid accounts for less than 1 percent of Medicaid's total budget annually. When looking at health care expenditures of both undocumented and authorized immigrants, undocumented immigrants represented the largest population share with out-of-pocket healthcare expenditures, in part due to the low rates of public health insurance funds and private insurance coverage (Flavin et al., 2018). Despite the fact that undocumented immigrants do not receive a large portion of publicly funded health services, the undocumented immigrant community makes high financial contributions to public health trust funds, including the Medicare Health Insurance Trust Fund (Flavin et al., 2018).

In a study by Stimpson et al. looking at healthcare spending from 2000 to 2006 of both U.S. citizens and noncitizens, including undocumented immigrants, researchers found that noncitizens had median public-sector per capita health expenditures of less than $200 annually compared to $1,100 for U.S. citizens. One reason for this is that only certain subsets of the undocumented immigrant community -- pregnant mother, dependent children, elderly or disabled

persons -- may access publicly funded healthcare programs via emergency Medicaid services once they meet certain income and residency requirements (Stimpson et al., 2010).

Furthermore, a second study by Stimpson et al. analyzing data from the 2000-2009 Medical Expenditure Panel Survey (MEPS) illustrated that only 7.9 percent of undocumented immigrants benefitted from public sector health care spending in comparison to 30.1 percent of U.S. born citizens. Additionally, undocumented immigrants comprise the smallest share of annual U.S. healthcare spending at 15.4 billion dollars compared to the slightly more than 1 trillion dollars spent on U.S. citizens (Stimpson et al., 2013). Stimpson et al. also analyzed the percentage of undocumented immigrants who receive uncompensated care, any form of health service for which a healthcare provider does not receive monetary compensation. Data showed that from 2000 to 2009, undocumented immigrants were more than twice as likely as U.S.-born citizens to use uncompensated health services.

Although information could not be found on undocumented Mexican immigrants in Georgia and their use of Emergency Medicaid services, a second Southeastern state that has not expanded Medicaid, North Carolina, showed that childbirth and pregnancy complications accounted for the majority of Emergency Medicaid spending for undocumented immigrants in North Carolina. In a study by DuBard and Massing, descriptive analysis of North Carolina's Emergency Medicaid reimbursement claims from 2001-2004 found that 99 percent of the 48,391 individuals who received services reimbursed through Emergency Medicaid were undocumented immigrants. Undocumented patients were 93 percent Hispanic and 95 percent female, correlating with the fact that childbirth and pregnancy complications accounted for 82 percent of Emergency Medicaid spending and 91 percent of hospitalizations in 2004. Aside from pregnant women and

mothers, the elderly and disabled saw a rapid increase in spending from 2001 to 2004, 98 percent and 82 percent respectively (Dubard and Massing, 2007).

Conclusion

The complex and politically sensitive of nature of undocumented immigrants living in the United States often makes it difficult for people to seek medical attention. Most of the available literature on undocumented Mexican immigrants is limited in scope and scale. Current literature focuses on either undocumented immigrants or Hispanic/Latino populations at a national level and does not explicitly look at Mexican immigrants, with even less information available on undocumented Mexican immigrants in the Southeast or by state strata. Looking at the health access barriers and health seeking patterns of Mexican undocumented immigrants on a smaller scale at the state level, when taking into account a state's social and political environment, can help inform public health authorities on population-specific barriers to obtaining care.

This study aims to help delineate and characterize health accessibility, health costs, and health seeking behaviors of undocumented Mexican immigrants living in the Southeastern state of Georgia. Given the recent uptick in anti-immigrant legislation in Southeastern states, it may affect the ways in which Mexican undocumented immigrants seek care when they need it. Mexican undocumented immigrants compose a significant portion of the population in Georgia and being able to characterize an often hidden population to understand how this population actively seek medical care will be important in being able to create informed policies and programs within the state to help address their health needs. Characterizing the health behaviors of undocumented Mexican immigrants will be important for researchers, medical and health practitioners, and policymakers to find new ways of reaching out to this community to inform and offer health services. This study will also help to bring light to a community that is often

forgotten and difficult to obtain health information from due to their understandable risk of sharing personal information on themselves or their communities for fear of placing their families at risk of coming into contact with immigration officials.

Chapter 3: Methodology

Study Design

The research design of this survey was non-experimental and aimed to learn more about health access and experiences of Mexican nationals living in the Southeastern United States and sought consular services at the Consulate General of México in Atlanta between May 2018 and July 2018. Survey questions were created in order to help characterize the Mexican immigrant population that seeks consular services, and particularly those who are undocumented and are difficult to research.

The Consulate General of Mexico in Atlanta is one of 50 Mexican consulates in the United States and the only consulate in Georgia. Its jurisdiction includes Georgia, Alabama, and most of Tennessee. The Consulate General assists Mexican nationals with issuing passports, visas, birth registrations, and identification cards amongst other services. Additionally, the Consulate General of Mexico has departments and programs dedicated to serving the Mexican national population living in the United States. Developed by Mexico's Department of Health and Ministry of Foreign Affairs, the *Ventanilla de Salud* is a program run out of Mexican Consulates in the United States providing free information on health topics and referrals to counseling and health services available to Mexican immigrants in their local communities. The *Ventanilla de Salud* was an ideal location to conduct a health survey because of its central access to Mexican nationals, most of whom who living in the United States as undocumented immigrants and would have otherwise been difficult to reach.

Survey Instrument

The survey instrument was developed using questions from a previously designed *Ventanilla de Salud* health survey and the U.S. Census Bureau's Current Population Survey and

American Community Survey. Respondents were asked to share information on household characteristics, languages spoken, educational background, health insurance coverage, health costs, and health service seeking behavior over the last 12 months. Additionally, participants were asked about their opinions on medical costs over the last 2 years and medical care quality over the last 5 years. The survey instrument consisted of 44 questions in seven sections, the sections were as follows: Demographics, Languages, Education, Family Dynamics, Medical Health Insurance Coverage, Medical Services and Costs, and Opinions on Medical Services and Expenses.

Study Population and Sample Size

The study population consisted of documented and undocumented Mexican immigrants living in the Southeast who sought consular services at the General Consulate of México in Atlanta. There were a total of 206 respondents, 107 females and 99 males. Respondents self-reported their legal status in the United States; three respondents declined to report their legal status and were subsequently removed from data analyses involving legal status.

Data Collection

The survey was implemented through the *Ventanilla de Salud* at the Consulate General of Mexico in Atlanta, located in the main consulate waiting area. Data collection took place in June and July 2018, on weekdays from 8:00am to 1:30pm. Surveys were conducted via opportunity sampling in the waiting area; persons were individually approached by the principal investigator and received verbal explanation of the purpose of the survey and informed consent. Persons who volunteered to take the survey were then taken to a small office for privacy where they were read survey instructions. Before beginning the survey interview, the principal investigatory asked

participants to consent to the survey by checking “yes” on the survey collection instrument, a laptop computer. All persons who agreed to take the survey were accepted, only adults over the age of 18 could participate. Survey interviews were conducted in Spanish by the principal investigator.

Data Entry and Cleaning

Survey instrument was created using the 2018 Survey Gizmo survey form building software in Spanish, the language that survey interviews were conducted. Survey data was collected using the Survey Gizmo survey link on a MacBook Air. Upon completion of survey interviews, data was exported as a Microsoft Excel CSV data file where data was cleaned, translated back into English. Inconsistent export response discrepancies and formatting were compared against the original survey instrument and corrected. The Microsoft Excel CSV file was then imported into SAS 9.4.

Statistical Analysis

All statistical analyses were conducted using SAS version 9.4. Descriptive analyses of each survey question were first conducted in order to obtain a distribution of responses for each individual question. 2x2 and 2x3 frequency tables were conducted to compare legal status (undocumented immigrants vs persons with legal authorization), sex (males vs females), and all their responses to respective survey questions.

IRB Consideration

No identifying information was collected from respondents. Survey instrument was submitted to the Emory Institutional Review Board (IRB) which determined that no IRB review was required and provided a letter of non-research determination.

Chapter 4: Results

Sex, Age, State Residence, and Legal Status

The first section of the survey sought to learn more about the demographics of the undocumented immigrant community that visits the Consulate General. There were a total of n=206 survey respondents (Table 1), 52 percent of respondents identified as female(n=107) and 48 percent identified as male (n=99). Only 3 respondents declined to report their legal status (Table 2), these respondents have subsequently been removed from tabulations involving legal status. A respondent was defined as being undocumented if they resided in the United States without legal authorization or had DACA (Deferred Action for Childhood Arrivals) status. A respondent was defined as being documented if they resided in the United States with legal authorization, including: U.S. citizen, permanent resident, a valid visa, work permit. Undocumented immigrants composed 72.3 percent of total respondents, 3 times the number of documented respondents. Of the 149 undocumented immigrants, 6.7 percent (n=10) had DACA.

Table 1

Age of All Respondents (years)					
	N	Mean	Std. Dev.	Min	Max
Females	107	40.2	9.9	18	67
Males	99	37.3	9.9	18	68
Total	206	-	-	-	-

Table 2

Participants by legal status				
	Undocumented	Documented	No Response	N
Females	74	31	2	107
Males	75	23	1	99
Total	149	54	3	206

Undocumented females and males were younger than their documented counterparts (Table 3). Respondents were broken down into 3 age groups: 18-34 year olds, 35-50 year olds, and 51+ year olds. The age groups were chosen to allow for generational divides between participants and to ensure that DACA respondents, all under the ages of 34, would remain in the same age group.

Participants with legal authorization were slightly older. The largest age group was 35-50 year olds (n=106), with the smallest group being 50 years of age (n=25). There were similar numbers of undocumented and documented men in the 18-34 and 35-50 year groups.

Table 3

Participants by Legal Status and Average Ages						
		N	Mean	Std. Dev	Min. age	Max age.
Females	Undocumented	74	38.7	8.4	18	59
	Documented	31	43.9	12.3	18	67
Males	Undocumented	75	36.2	9.7	18	68
	Documented	23	40.7	10.3	21	55
	Total	203				

Table 4

Participants by Legal Status and Age Group					
		18-34 yrs	35-50 yrs	50+ yrs	Total
Females	Undocumented	23	47	4	74
	Documented	5	16	10	31
Males	Undocumented	38	31	6	75
	Documented	6	12	5	23
Total		72	106	25	203

Respondents who shared their legal status resided primarily within the Consulate's jurisdiction: 81.5 percent of respondents were from Georgia (n=160), 10.5 percent from Tennessee (n=21), and 8 percent from Alabama (n=16). An additional 0.5 percent of respondents were from neighboring Southeastern states, South Carolina (n=3), Texas (n=1), Florida (n=1), and Kentucky (n=1).

Table 5

Participants by Legal Status and State of Residence									
		GA	AL	TN	SC	TX	FL	KY	Total
Females	Undocumented	58	6	10	0	0	0	0	74
	Documented	26	2	3	0	0	0	0	31
Males	Undocumented	59	6	6	2	0	1	1	75
	Documented	17	2	2	1	1	0	0	23
Total		160	16	21	3	1	1	1	203

US Arrival and Immigration Status

Nearly all respondents who shared their legal status were born in Mexico (98 percent, n=199), with only 2 percent born in the United States (n=4) (Table 6). The vast majority of

respondents, 79.3 percent, arrived during the two decades between 1990 and 2009 (Table 7). Relatively few arrived more recently than 2009, less than 9 percent of respondents. The sample had fewer than 3 percent of participants who arrived prior to 1950. The majority of undocumented immigrants arrived in the 1990s (26.2 percent, n=39) and the first decade of the 2000s (42.9 percent, n=87). In comparison, documented immigrants reported arriving to the United States in earlier decades, with 26 arriving in the 1990s and 11 in the 1980s.

Table 6

Participants by Legal Status and Birthplace				
		Mexico	U.S.	Total
Females	Undocumented	74	0	74
	Documented	28	3	31
Males	Undocumented	75	0	75
	Documented	22	1	23
Total		199	4	203

Table 7

Participants by Legal Status and Decade of Arrival in U.S.											
		Before 1950	1950-1959	1960-1969	1970-1979	1980-1989	1990-1999	2000-2009	2010-2018	DNK	Total
Females	Undocumented	0	0	0	0	2	21	47	3	1	74
	Documented	3	0	1	0	4	19	3	1	0	31
Males	Undocumented	0	0	1	0	2	18	40	14	0	75
	Documented	2	0	0	1	7	7	6	0	0	23
Total		5	0	2	1	15	65	96	18	1	203

Household Demographics

The majority of undocumented respondents reported either being married or in a consensual union, a pattern that was also seen across documented respondents (Table 8). The majority of undocumented and documented respondents currently live with their spouse or partner (Table 9).

Table 8

Participants by Legal Status and Marital Status							
		Single	Married	Consensual Union	Divorced	Separated	Total
Females	Undocumented	17	36	18	2	1	74
	Documented	5	22	0	3	1	31
Males	Undocumented	21	35	15	0	4	75
	Documented	4	16	1	2	0	23
Total		47	109	34	7	6	203

Table 9

Participants by Legal Status and Residing With Partner if Married or in Consensual Union				
		Live Together	Live Apart	Total
Females	Undocumented	54	0	54
	Documented	21	1	22
Males	Undocumented	39	11	50
	Documented	17	0	17
Total		131	12	143

The mean household sizes for undocumented respondents was larger than for their documented counterparts; undocumented household ranges were also wider (Table 10). There were also differences in the types of residences. For the purposes of this analysis, the options of living in a personally owned home and living in a home owned by a relative were placed together because when asked about the type of home lived in, respondents would clarify that a home was not in their name but they were “homeowners”. The majority of undocumented immigrants reported either living in a rented home or apartment (62.4 percent, n=93) (Table 11), while 64.8 percent (n=35) of documented respondents reported living in a home that they or a relative owned.

Table 10

Household Size (Persons)						
		N	Mean	Std Dev	Min.	Max.
Females	Undocumented	74	4.5	1.5	2	9
	Documented	31	3.8	1.4	1	7
Males	Undocumented	75	4.4	1.6	1	7
	Documented	23	4	1.3	2	10
Total		203	-	-	-	-

Table 11

Participants by Legal Status and Type of Home/Residence					
		Personal or Relative Owned House	Rented House	Rent Apartment	Total
Females	Undocumented	24	33	17	74
	Documented	20	8	3	31
Males	Undocumented	32	24	19	75
	Documented	15	5	3	23
Total		91	70	42	203

There were also differences in the frequencies of undocumented females and males living with children under 18 in their home. Undocumented females and males reported living with children under 18 in their home more frequently than did their documented counterparts, which may be correlated to undocumented respondents being younger than documented respondents (Table 12).

Table 12

Presence of children under 18 years of age in home				
		Yes	No	No
Females	Undocumented	63	11	74
	Documented	20	11	31
Males	Undocumented	48	27	75
	Documented	15	8	23
		146	57	203

Nearly half of undocumented immigrants, 49.7 percent (n=74) reported only speaking Spanish at home, while another 49 percent (n=73) reported speaking both English and Spanish at home. All 10 of the DACA recipients spoke both English and Spanish at home (Table 13). Only

28.8 percent of undocumented respondents reported speaking English "well" or "very well", lower than their documented counterparts, of whom more than half could speak English "well" or "very well", (61.1 percent, n=33) (Table 14).

Table 13

Participants by Legal Status and Languages Spoken at Home

		Only English	Only Spanish	Both	Total
Females	Undocumented	0	31	43	74
	Documented	0	11	20	31
Males	Undocumented	2	43	30	75
	Documented	2	9	12	23
Total		4	94		203

Table 14

Participants by Legal Status and English Language Fluency

		Don't Speak English	Not Very Well	Well	Very Well	Total
Females	Undocumented	9	42	16	7	74
	Documented	0	16	9	6	31
Males	Undocumented	9	46	14	6	75
	Documented	1	4	9	9	23
Total		19	108	48	28	203

Education Level and Household Income

The majority of both documented and undocumented immigrants received formal education in Mexico only (Table 15). Of the respondents that received formal education in the United States only or in both Mexico and the U.S. over half were undocumented. Nearly half of these respondents were DACA recipients who were brought to the U.S. as young children.

The mode for the highest education level attained by undocumented immigrants who studied in Mexico was the 3rd year of *secundaria* (equivalent of 9th grade in the United States) with 32.2 percent (n=46), followed by 23.1 percent (n=33) who completed the 2nd year of *secundaria* (equivalent of 8th grade in the United States) (Table 16). The most reported highest education level achieved in Mexico by documented immigrants was the 3rd year of *secundaria*, followed by a smaller group that only completed primary school. When looking at the number of

respondents who studied in the U.S., nearly all have completed a high-school level education, with a small group of them having completed a university-level degree.

Table 15

Participants by Legal Status and Location of Formal Education						
		Only Mexico	Only U.S.	Both	Other	Total
Females	Undocumented	63	3	7	1	74
	Documented	21	5	5	0	31
Males	Undocumented	65	3	7	0	75
	Documented	19	0	4	0	23
Total		168	11	23	1	203

Table 16

Participants by Legal Status and Highest Eduaction Level Completed in Mexico												
		Did Not Complete Primary School	Comleted Primary School	1st year of Secondary School	2nd year of Secondary School	3rd year of Secondary School	1st year of preparatory school	2nd year of preparatory school	3rd year of preparatory school	University-level studies	No Response	Total
Females	Undocumented	9	12	1	3	17	2	1	18	7	0	70
	Documented	3	5	0	1	6	0	0	7	4	1	27
Males	Undocumented	4	7	2	3	29	4	5	15	3	0	72
	Documented	4	5	1	1	8	0	0	2	2	0	23
Total		20	29	4	8	60	6	6	42	16	1	192

Participants by Legal Status and Highest Eduaction Level Completed in the U.S.												
		Did Not Complete Elementary School	6th grade	7th grade	8th grade	9th grade	10th grade	11th grade	12th grade	GED	University-level studies	Total
Females	Undocumented	0	0	0	0	1	0	1	5	1	2	10
	Documented	0	0	0	0	0	0	0	5	3	2	10
Males	Undocumented	0	0	0	1	1	0	2	4	1	1	10
	Documented	0	0	0	0	1	0	0	1	0	2	4
Total		0	0	0	1	3	0	3	15	5	7	34

The household income ranges between the two legal status groups were different, with undocumented immigrants reporting lower income ranges than their documented counterparts. Male respondents also skewed towards slightly higher incomes than females, regardless of legal status (Table 17). Over two-thirds of undocumented immigrants reported incomes in the range of $501 to $3,500 a month, with a modal income of $1,501-2,000/month. Documented immigrants on the other hand, reported income ranges that were higher, with a mode of $2,501-3,500. A higher frequency of undocumented immigrant females reported making under $1,500/month (n=21), less than their documented counterparts. A similar pattern was seen with

undocumented immigrant men with n=13 of them reporting making less than $1,500/month, while only one documented male reported making under $1,500/month. It is important to note that the survey population was not a random sample and that the 3:1 proportion of undocumented to documented survey respondents may have contributed to the income distributions.

Table 17

Participants by Legal Status and Monthly Household Income ($)

		<500	501-1,500	1,501-2,500	2,501-3,500	3,501-4,500	4,501-5,500	>5,501	DNK	No Response	Total
Females	Undocumented	4	17	19	20	7	3	1	3	0	74
	Documented	2	5	5	8	4	5	0	1	1	31
Males	Undocumented	1	12	25	19	4	11	2	0	1	75
	Documented	1	0	3	6	7	4	2	0	0	23
Total		8	34	52	53	22	23	5	4	2	203

Health Insurance and Medical Expenditures

Undocumented immigrants rarely reported having health insurance coverage, while just over half of documented immigrants reported having health insurance (Table 18). A mere 6.8 percent (n=5) of undocumented immigrant females and 12.0 percent (n=9) of undocumented males reported having some type of health insurance, much lower than documented females (51.6 percent; n=16) and males (56.5 percent; n=13). Of the 43 respondents with health insurance, there does not seem to be much of a difference in health insurance satisfaction between legal status groups; though a higher frequency of documented immigrants reported having health coverage that "Always" met their medical and health needs (Table 19). The most common types of health insurances reported in households were Medicaid, Private Insurance, and Peachcare (Table 20). Table 20 clearly suggests that Medicaid is an important resource for undocumented respondents; 87.5 percent of those who have someone in their home with Medicaid were undocumented respondents.

Table 18

Participants by Legal Status and Health Insurance Status				
		Yes	No	Total
Females	Undocumented	5	69	74
	Documented	16	15	31
Males	Undocumented	9	66	75
	Documented	13	10	23
Total		43	160	203

Table 19

Participants by Legal Status with Health Insurance: Does your health insurance meet your medical/health needs?							
		Never	Sometimes	Generally	Always	DNK	Total
Females	Undocumented	0	2	1	2	0	5
	Documented	0	4	3	8	1	16
Males	Undocumented	0	2	4	2	1	9
	Documented	0	4	2	6	1	13
Total		0	12	10	18	3	43

Table 20

Do you or someone in your family have any of the following types of health insurance?									
		Peachcare	Medicaid	Medicare	Other Govt Insurance	Private Insurance	No Insurance	DNK	Total
Females	Undocument	6	39	1	0	8	23	1	78
	Documented	4	8	2	1	12	9	0	36
Males	Undocument	5	24	0	0	11	36	4	80
	Documented	5	1	0	1	14	5	0	26
Total		20	72	3	2	45	73	5	

Undocumented immigrants reported going longer without having visited a medical or health professional than documented respondents (Table 21). The most reported time period without seeing a medical or health professional was more than 1 year (n=88); undocumented immigrants accounted for 86.4 percent of this group and were younger. Additionally, there is a notable difference amongst females 35-50 years of age; there were slightly more than twice as many undocumented females who saw a physician or health professional within the last 6 months.

Table 21

Time Since Last Doctor/Health Professional Visit and Immigration Status														
		Never			< 6 mths			6mths-1yr			> 1yr			Total
		18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	
Females	Undocumented	0	0	0	4	24	3	4	6	1	15	17	0	74
	Documented	0	0	0	2	11	4	3	4	3	0	1	3	31
Males	Undocumented	1	0	0	11	7	2	6	3	1	20	21	3	75
	Documented	1	0	0	3	7	0	1	1	2	1	4	3	23
Total		2	0	0	20	49	9	14	14	7	36	43	9	203

The most reported monthly medical expenditures for both legal status groups was $100/month (Table 22). However, at the higher end of monthly expenditures, 5.4 percent (n=8) of undocumented immigrants stated spending more than $500/month compared to only n=2 documented respondents. Of these 8 undocumented respondents, 7 were females. Though there were more undocumented respondents, when looking at the percentages for each expenditure category there were more undocumented respondents at higher monthly expenditures. Respondent frequencies decrease when looking at population subcategories, leading to stark differences between groups; again, potentially due to the fact that the survey population was not a random sample.

Table 22

Participants by Legal Status and Monthly Medical Expenditures ($)										
		< 100	101-200	201-300	301-400	401-500	501-600	601-700	> 701	DNK	Total
Females	Undocumented	40	11	9	6	1	2	1	4	0	74
	Documented	14	7	5	1	1	2	0	0	1	31
Males	Undocumented	40	16	13	5	0	1	0	0	0	75
	Documented	11	5	5	1	1	0	0	0	0	23
Total		105	39	32	13	3	5	1	4	1	203

Sources of Medical Care

A higher percentage of undocumented respondents, 54.4 percent (n=81), reported not having a primary source of medical and health services as opposed to 27.8 percent (n=15) of documented respondents (Table 23). Higher percentages of documented females had a primary source of medical care, 77.4 percent (n=24), than did undocumented females, 58.1 percent

(n=43). This pattern that can also be seen when comparing males by legal status. In particular, a greater portion of undocumented males between the ages of 18 and 50 reported not having a primary source of health care than did documented males. For participants that reported having a primary source of medical care, the most common sources of medical and health services for both undocumented and documented respondents were community clinics or clinics where respondents paid in cash (n=59), two or fewer persons reported going to an urgent care center and walk-in clinics such as "Minute Clinics".

Table 23

Do you having a primary source of medical/health services?								
		18-34 yrs		35-50 yrs		50+ yrs		Total
		Yes	No	Yes	No	Yes	No	
Females	Undocumented	11	12	29	18	3	1	74
	Documented	3	2	12	4	9	1	31
Males	Undocumented	11	27	10	21	4	2	75
	Documented	4	2	9	3	2	3	23
Total		29	43	60	46	18	7	203

Amongst undocumented respondents who stated that they did not have a primary source of medical services, the most common reason was that the cost was too high (n=44). It is of note that many respondents stated that they also had "other" reasons that were not specified (Table 24).

Table 24

If you don't have a location that you visit regularly, why do you not have a location where you regularly receive medical services?								
		Cost is too high	Don't speak my language	Services are too far	Appts are not convenient	Put it off	Other	DNK	Total
Females	Undocumented	20	0	3	1	2	9	0	35
	Documented	4	1	2	1	1	1	0	10
Males	Undocumented	24	1	8	2	4	16	0	55
	Documented	1	0	0	1	0	5	3	10
Total		49	2	13	5	7	31	3	-

Across all age groups, documented women and men rarely reported that they were unable to seek medical services because they were unable to afford to pay for an appointment in the past

year (5 women, 0 men). In contrast, 34.9 percent of undocumented immigrants (n=52), reported being unable to afford medical services (Table 25).

Table 25

In the last 12 months, have you ever chosen not to seek medical services because you could not afford an appointment?								
		18-34 yrs		35-50 yrs		50+ yrs		Total
		Yes	No	Yes	No	Yes	No	
Females	Undocumented	9	14	18	29	4	0	74
	Documented	0	5	4	12	1	9	31
Males	Undocumented	9	29	10	21	1	5	75
	Documented	0	6	0	12	0	5	23
Total		18	54	32	74	6	19	203

Furthermore, fully one quarter of undocumented respondents reported spending less on essentials in order to pay for medical or health services (females 32.0 percent, n=24; males 21.3 percent, n=16), compared to just 13.0 percent among documented respondents (Table 26). Higher frequencies of younger and undocumented respondents stated having to spend less on essentials than did older respondents.

Table 26

In the last year have you ever had to spend less on essentials (housing, food, personal expenses) in order to afford medical or health services?									
		18-34 yrs		35-50 yrs			50+ yrs		Total
		Yes	No	Yes	No	DNK	Yes	No	
Females	Undocumented	8	15	13	34	0	3	1	74
	Documented	0	5	2	13	1	2	8	31
Males	Undocumented	9	29	6	25	0	1	5	75
	Documented	1	5	2	10	0	0	5	23
Total		18	54	23	82	0	6	19	203

A lower percentage of undocumented immigrants 10.7 percent (n=16), reported visiting the emergency room (ER) than did documented respondents, 20.4 percent (n=11) (Table 27).

Table 27

Participants by Legal Status: In the last year, have you personally visited the emergency room?				
		Yes	No	Total
Females	Undocumented	10	64	74
	Documented	8	23	31
Males	Undocumented	6	69	75
	Documented	3	20	23
Total		27	176	203

Undocumented respondents, overall, had lower frequencies of living with someone that has a chronic illness in their home. The proportion of documented respondents having someone with a chronic illness in their home (42.6 percent; n=23) was nearly double that of undocumented respondents (18.8 percent; n=28) (Table 28). These differences may suggest that lower access to medical and health services may mean that chronic illnesses such as diabetes or cancer have go undiagnosed in undocumented populations.

Table 28

Participants by Legal Status: Is there someone in your home living with a chronic illness?					
		Yes	No	DNK	Total
Females	Undocumented	15	58	1	74
	Documented	14	16	1	31
Males	Undocumented	13	59	3	75
	Documented	9	14	0	23
Total		51	147	5	203

Opinions on Medical and Health Services

The last section of the survey asked participants to share some of their opinions on the state of the medical and health services that they had received and the impact of paying for said services. Participants were asked if they believed the cost of the medical and health services they had received in the last two years had changed, only one person said their healthcare had become less expensive. Over half of undocumented (57.1 percent; n=85) and documented immigrants (63

percent; n=34) reported their healthcare had become more expensive in the last two years (Table 29).

Table 29

How do you think the cost of medical services you've received in the last 2 years has changed?													
		Less Expensive			Stayed the Same			More Expensive			DNK or No Response			
		18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	Total
Females	Undocumented	0	0	0	4	22	2	16	24	2	3	1	0	74
	Documented	0	0	0	2	3	3	1	13	7	2	0	0	31
Males	Undocumented	1	0	0	12	9	3	22	18	3	3	4	0	75
	Documented	0	0	0	4	2	1	2	9	2	0	1	2	23
Total		1	0	0	22	36	9	41	64	14	8	6	2	203

When asked to describe the impact of medical and health services costs on their personal financial situation, a large proportion of both undocumented and documented respondents stated that medical costs had a "high" or "very high" impact (67.1 percent and 57.4 percent, respectively) (Table 30).

Table 30

How would you describe the impact medical costs have had on your financial situation?																			
		No Impact			Very Low Impact			Low Impact			High Impact			Very High Impact			DNK			Tota
		18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	18-34 yrs	35-50 yrs	50+ yrs	
Females	Undocumented	4	10	1	0	0	0	0	4	0	15	20	3	4	13	0	0	0	0	
	Documented	2	2	2	0	0	0	0	1	3	2	9	3	0	4	2	1	0	0	
Males	Undocumented	10	7	2	6	3	1	0	0	0	19	14	3	2	7	0	1	0	0	
	Documented	3	1	3	1	2	0	0	1	0	0	4	2	1	4	0	1	0	0	
Total		19	20	8	7	5	1	0	6	3	36	47	11	7	28	2	3	0	0	2

In order to help offset the impact of medical costs, respondents reported taking several different measures in order to save money. The most common measures reported were putting off purchasing medication and purchasing medication outside the United States (Table 31). Respondents also reported having to establish a payment plan with a provider, being contacted by collection agencies, being unable to pay for necessities, and spending most or all of their savings (Table 32).

Table 31

In the last 12 months, have you done any of the following to save money?							
		Skipped a dose of medication	Took a smaller dose of medicine	Put off purchasing medication	Purchased medication outside the U.S.	None of the above	Total
Females	Undocumented	2	3	10	6	54	75
	Documented	0	0	2	3	26	31
Males	Undocumented	1	3	7	5	59	75
	Documented	0	0	0	0	23	23
Total		3	6	19	14	162	-

Table 32

Has the cost of medical services impacted you in any of the following ways?									
		Established a payment plan	Spent all or majority of savings	Contacted by collection agencies	Unable to pay for necessities	Taken loans that will be difficult to repay	None of the options	DNK	Total
Females	Undocument	26	2	7	9	1	38	0	83
	Documented	8	1	2	2	0	19	1	33
Males	Undocument	12	7	5	6	1	50	0	81
	Documented	7	1	1	0	0	15	0	24
Total		53	11	15	17	2	122	1	

Few respondents reported receiving poor quality health services, 5.4 percent of undocumented (n=8) and 5.6 percent of documented immigrants (n=3) (Table 33).

Table 33

In the last 5 years, have you ever felt that you received low quality medical or health services?										
		18-34 yrs		35-50 yrs			50+ yrs			Total
		Yes	No	Yes	No	DNK	Yes	No	DNK	
Females	Undocumented	3	20	1	46	0	0	3	1	74
	Documented	0	5	0	15	1	1	9	0	31
Males	Undocumented	3	35	1	30	0	0	6	0	75
	Documented	0	6	2	10	0	0	5	0	23
Total		6	66	4	101	1	1	23	0	203

About half of both undocumented and documented respondents stated they receive their health information in both Spanish and English (Table 34). Undocumented women and men were relatively evenly split between receiving information only in Spanish and in both English and

Spanish. The four most popular sources of health information across all groups were: Doctor (43.2 percent, n=89), Family and Friends (34.0 percent, n=70), Television (33.0 percent, n=68), and Internet (33.0 percent, n=68). Undocumented immigrants followed this trend with the addition of learning health information from the television (36.9 percent, n=55) (Table 35).

Table 34

Participants by Legal Status: In what language do you receive your health information?					
		English Only	Spanish Only	Both	Total
Females	Undocument	4	35	35	74
	Documented	8	8	15	31
Males	Undocument	3	34	38	75
	Documented	6	7	10	23
Total		21	84	98	203

Table 35

From which of the following sources do you receive information about health or health services?												
		Doctor	Radio	TV	Internet	Social Media	Family/Friends	Churches	Community Groups	DNK	No Response	Total
Females	Undocumented	36	8	26	27	18	27	11	9	1	1	164
	Documented	15	3	10	14	8	9	4	3	0	0	66
Males	Undocumented	21	17	29	21	8	27	6	4	0	1	134
	Documented	14	2	3	6	0	6	4	2	0	1	38
Total		86	30	68	68	34	69	25	18	1	3	-

Chapter 5: Discussion

The purpose of this research was to develop a greater understanding of demographic and health characteristics of the undocumented Mexican immigrant population in the Southeastern United States in the context of health access, health expenditures, and health seeking behaviors in order to increase characterization of an otherwise hidden community. Survey results suggest that there are differences in how undocumented Mexican immigrants and those with legal authorization feel the burden of medical costs, quality of care, and access to health services. On the whole, undocumented immigrants tend to have lower incomes, go longer without visiting a medical or health professional, and experience medical costs as a heavier financial burden.

Age and Marital Status

The Migration Policy Institute reported that 28 percent of undocumented immigrants in Georgia are between the ages of 28 and 34 with another 28 percent between the ages of 35 and 44, this is in keeping with the distributions in this survey with the largest majority of undocumented immigrants falling into these two age groups (Migration Policy Institute, 2016). This study found a lower percentage of undocumented immigrants being married or in a consensual union (47.7 percent; n=71) than the 60% marriage rate reported by Andes et al. in 2012.

US Arrival and Immigration Status

Among undocumented immigrants, the most commonly reported decade of arrival was between 2000 and 2009, closely followed by the previous decade of 1990-1999. These findings correspond with a 2007 peak in undocumented immigrants in living in the U.S. (Passel and Cohn, 2016). Although it is not known if the 50 documented respondents that were born in

Mexico, first arrived to the United States as undocumented immigrants and were later granted a form of legal authorization, it is of interest that 44 of them who arrived prior to 1999.

Household Demographics

The composition of respondents' family units, paralleled patterns found by Passel and Cohn (2009) in which immigrant families were multi-generational and of mixed legal status. A higher percentage of undocumented immigrants in this survey lived with children in their home than did documented immigrants.

Undocumented immigrants had lower education attainment levels than documented immigrants, with only 38.3 percent (n=57) of undocumented immigrants reporting completing the equivalent of a high school diploma compared to 44.4 percent (n=24) of documented immigrants. These survey findings are in keeping with those found by the Migration Policy Institute which found that only 25 percent of undocumented immigrants over 25 years of age had attained the equivalent of a high school diploma. Another similarity found in this survey to previous studies are the percentages of undocumented immigrants who reported not being fluent in English language. Approximately 71 percent of undocumented immigrants in this study reported speaking English "not very well" or "not at all", percentages that mirror those found by the Migration Policy Institute where 45 percent of undocumented immigrants did not speak English well or not at all (Migration Policy Institute, 2016). However, it is important to note that the Migration Policy Institute figures were looking at all undocumented immigrants, of any country of origin in Georgia.

Lower education levels coupled with limitations on places of employment due to legal status may also influence the lower ranges of monthly incomes for undocumented immigrants as compared to their documented counterparts. This also is in keeping with Andes et al.'s findings

that a greater proportion of Georgia Latinos live at or below the poverty line as compared to the general Georgia population. Survey results show that documented respondents reported a slightly higher range of monthly income, with most reporting incomes being between $2,500 and $3,500 a month, while undocumented immigrants who most commonly stated incomes between $1,501 and $2,000 a month. The average annual household income for Georgia Latinos, regardless of their legal status, was $34,873 annually or about $2,906 a month (Andes et al., 2012). This falls within range of documented respondents but is higher than the monthly income ranges for undocumented immigrants.

Health Insurance Coverage, Health Service Expenditures, and Sources of Care

One of the starkest differences between undocumented and documented respondents was in the groups' differences in health insurance coverage, health access, and health expenditures. The Migration Policy Institute which found that 70 percent of undocumented immigrants in Georgia did not have health insurance. Survey results mirrored these figures, as 90.1 percent (n=135) of undocumented immigrants did not have health insurance coverage, nearly double that of documented respondents.

In their 2013 study, Beniflah et al. found a decrease in pediatric emergency room visits for Hispanic patients but an increase in case severity, although there were no minors surveyed in this study, a lower percentage of undocumented immigrants surveyed reported going to the emergency room than did documented respondents. However, a drawback to this information is that there were no specifics gathered about the reason for emergency room visits nor to the severity of their cases. In mixed status families with undocumented immigrant parents and US-citizen children, Ku and Matani found that fewer immigrants have Medicaid or other employer provided health insurance when compared to U.S.-born citizens with U.S.-born children (Ku and

Matani, 2001). Although this study did not inquire about the citizenship or legal authorization status of the children of undocumented immigrants, a proxy to learning more about the mixed status health care access of their U.S-born children was asking a question about the types of health care and health insurance programs that persons in their household had used in the last year. When asked about having someone in their household who had been enrolled in Medicaid or Peachcare, a higher percentage of undocumented immigrants 46.3 percent (n=69) reported having someone in their household.

A systematic review of the literature by Flavin et al. found that undocumented immigrants were most likely to receive emergency Medicaid and were also the population who was more likely to have greater out of pocket expenditures. Although the survey did not directly ask about receiving or having been eligible for emergency Medicaid in the past, of the respondents who reported having a primary source of medical and health services, both undocumented immigrants and those with legal authorization reported community clinics as the most common location to seek care. Although similar percentages of undocumented and documented immigrants, the largest portion of each group, reported spending less than $100/month on medical and health expenditures, there were deviations between the two at the higher end of monthly expenditures. Despite the small size of this survey, amongst the 10 respondents who reported spending more than $500/month, 8 of them were undocumented. For both legal status groups, a large portion of the respondents stated visiting a medical or health professional within the last 6 months. However undocumented immigrants comprised nearly 85% of respondents that went more than 1 year without a medical or health visit.

Opinions on Medical and Health Services

When designing this portion of the survey, the aim was to learn more about the opinions of undocumented immigrants on the quality, cost, and types of health services used. Although little to no previously reported information was found on the opinions of undocumented immigrants and the type of care that they receive in the Southeastern United States, this section provided new insight into how this often "hidden" population perceives and experiences the care they are receiving. On the whole, undocumented immigrants reported having poorer quality of care and had higher percentages of dissatisfaction with the cost of medical care. This may be due to the fact that undocumented immigrant adults are ineligible for many of the social and public service programs, such as Medicaid, that would help offset medical costs. Were it not for their legal status, a large portion of undocumented immigrants would otherwise be qualified for low-income programs like Medicaid.

Undocumented immigrants reported having poorer quality of care than documented respondents. Of the 11 participants who reported experiencing poor quality of health services, 72.7 percent (n=8) were undocumented; additionally, undocumented women comprised the largest portion (n=4). This finding is in keeping with findings by Ortega et al. who reported that undocumented immigrants use health services less frequently and experience poorer quality of care.

Although both legal status groups have similar sources of health information, a lower percentage of undocumented immigrants receives health information from a doctor, possibly related to the fact that undocumented immigrants reported going longer without seeing a medical professional. Additionally, it is of interest that although 71 percent of undocumented immigrants reported not speaking English well or not at all, only 44 percent of undocumented immigrants

reported receiving health information only in Spanish. This discrepancy between undocumented immigrant's primary language and the language they are receiving vital health information in may mean that information is often lot in translation or undocumented immigrants may face an additional barrier in having to find their way through health information in English.

Strengths, Limitations, and Future Research

One strength of the survey interviews was that they were all conducted in Spanish by a native-Spanish language speaker, allowing little to no language barrier, and for respondents to easily ask clarifying questions to the researcher as need. Survey interviews were also conducted in a small, quiet office where respondents felt comfortable that their responses to questions would not be overheard by others. Additionally, a strength of conducting the survey at the Consulate General of Mexico in Atlanta is that it was a central location for reaching otherwise hidden populations across the Southeast.

One limitation of data collection was the use of opportunity sampling, this meant that persons were self-selecting to participate in the survey, introducing bias between the persons who agreed to participate and those who did not. Participants were approached and asked to participate in the survey as they sat in a Consulate waiting room, thus common responses for not participating in the survey was the fact that they were pressed for time, did not want to leave the waiting room, or were in a hurry to leave after receiving their documents. Records of how many persons declined to participate in the survey were not kept. Although the study aims to draw conclusions about the experiences and opinions of Mexican immigrants living in the Southeast, the sampling was limited to recruiting participants from persons who sought consular services, thus excluding Mexican immigrants who did not seek consular services.

Future studies should aim to gather a more even distribution of undocumented immigrants and those residing in the United States with legal authorization. Due to opportunity sampling used and constraints on the data collection timeframe, it was not possible to gather a more even distribution of participants. Had the survey been conducted with a larger and randomized population at the Consulate, a clearer distinction between the two legal status groups may be stronger. Given that participants were recruited at the Consulate, proximity to the consulate also led to a greater proportion of participants living in Georgia, in the future it would be of interest to also increase the number of participants from neighboring states, Alabama and Tennessee, the second and third most commonly reported states of residence. Additionally, it would be of interest to have a third group of participants who were only U.S.-born Americans and had lived in the United States their entire lives. Adding this group would allow for a greater understanding of not only how undocumented Mexican immigrants differ from their documented Mexican immigrant counterparts, but also how undocumented Mexican immigrants compare to non-immigrants. In future research, it would be beneficial to add a section to the survey asking more specific questions about health insurance coverage and state-sponsored health programs for U.S. born children born to undocumented Mexican immigrant parents. This section would allow researchers to further delve into the preliminary discrepancies in health access patterns between undocumented immigrant parents and their U.S.-born children.

Conclusion

In summary, the goals of this research project were to characterize the undocumented immigrant Mexican community in the Southeastern United States by learning more about their current heath access, expenditures, and opinions on health services received. In conducting the literature review, little was known specifically about the current health characteristics of

undocumented Mexican immigrants in the Southeast. Most of the previous studies done on health access and costs of care for undocumented Mexican immigrants were conducted at a larger macro level, either focusing on undocumented immigrants as a whole, or on small samples of Mexican immigrants in states with larger immigrant populations such as California, Texas, or Florida.

Although there was limited information describing the health access landscape of undocumented Mexican immigrants in the Southeast, information that was available on undocumented immigrants of all backgrounds in Georgia matches some trends within this survey's undocumented immigrant population. Overall, undocumented immigrants surveyed had similar patterns of not having health insurance coverage, receiving poorer quality of health services, going a longer period of time without seeing a medical professional, and paying higher out-of-pocket monthly expenditures than their authorized immigrant counterparts. Undocumented Mexican immigrants also reported having lower education levels, lower monthly household incomes, and were overall younger than their documented immigrant counterparts.

Research specific to undocumented Mexican immigrants in Georgia, Alabama, and Tennessee, or the Southeastern US more broadly is lacking. Given the important role that undocumented immigrants play in the Southeastern U.S. economy, employment, and communities, it is of vital importance to be able to learn more about the health access landscape of an integral part of the Southeast's demographic.

Public Health Implications

Although the current political climate surrounding undocumented immigrants in the United States is tumultuous and highly complex, federal and state policies that may seem highly removed from the health of undocumented immigrants can still directly affect the health of this

hidden population. Survey findings suggest that there is still a major public health void to be filled as there is an unmet need for accessible and affordable high quality health services for undocumented Mexican immigrants in the Southeast. Heyman et al. best described the indirect barriers to obtaining health services due to being an undocumented immigrant as a "web of effects", these were ways in which a person's environment influences where and how they are able to seek health services. Survey results suggest that there is no singular public health solution to increasing access to health services or decreasing costs of medical services for undocumented immigrants. However, data shows that are some simple ways in which public health officials can intervene and work with the socioeconomic landscape at hand that would reach the undocumented Mexican immigrant community. For example, data on the locations of health services and sources of health information most frequented by undocumented Mexican immigrant could be used in designing health information campaigns tailored to maximize exposure in this population.

Perhaps one of the greatest ways in which the Consulate General of Mexico in Atlanta can help increase access to affordable health services for undocumented immigrants is through daily health presentations to Mexican nationals that come through the main Consulate waiting room. Currently, the *Ventanilla de Salud* offers short 5-15 minute presentations by community organizations that have a history of working with Mexican immigrant communities in the Southeast. This could be further expanded by increasing the number of community organization representatives who can provide specific information on free or low cost community health services, offer basic financial literacy lessons, or share physical resources on basic health topics affecting the community. These small approaches can temporarily help address the need for affordable and accessible health services.

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EMORY UNIVERSITY

Institutional Review Board

July 18, 2018

Karen Andes, PhD
SPH: Global Health

RE: Determination: No IRB Review Required
Title: *Health Access Study 2018*
PI: Karen Andes & Cynthia Campos

Dear Dr. Andes and Ms. Campos:

Thank you for requesting a determination from our office about the above-referenced project. Based on our review of the materials you provided, we have determined that it does not require IRB review because it does not meet the definition of "research" with "human subjects" or "clinical investigation" as set forth in Emory policies and procedures and federal rules, if applicable. Specifically, in this project, you will survey Mexican nationals seeking services at the Mexican Consulate in Atlanta, Georgia, to assess access to care. The results of this survey will be used to improve the quality of the local system of care for the Ventanilla de Salud program at the Mexican Consulate in Atlanta, Georgia only.

Please note that this determination does not mean that you cannot publish the results. This determination could be affected by substantive changes in the study design, subject populations, or identifiability of data. If the project changes in any substantive way, please contact our office for clarification.

Thank you for consulting the IRB.

Sincerely,

Carol E. W. Corkran

Digitally signed by Carol E. W. Corkran
DN: cn=Carol E. W. Corkran, o=Emory University, ou=Institutional Review Board, email=ccorkra@emory.edu, c=US
Date: 2018.07.18 09:57:58 -04'00'

Carol E. W. Corkran, MPH, CIP
Team Lead Analyst

CC: Cynthia Campos