Barriers, challenges and fears from immigrants in access to healthcare: A proposal for undocumented immigrants to being insured

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Abstract

Access to healthcare is a global issue that needs to be addressed. Worldwide organizations have put efforts in place to overcome this problem and offer solutions and recommendations to various countries. However, these efforts have not been entirely successful. Receiving the highest attainable standard of health or only receiving care is extremely difficult or impossible for individuals who are considered vulnerable such as immigrants, especially those who are undocumented immigrants. Through the recognition of barriers, challenges and fears from immigrants accessing healthcare and a shape of social determinants of health, institutions of government, nonprofit sector and community members organized could grant an opportunity to undocumented immigrants to become a healthier population.

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Introduction

The Problem

The lack of access to healthcare for undocumented immigrants is an issue that needs to be addressed. An example on how it can be addressed is creating an opportunity for undocumented immigrants to get an insurance, especially those with low-income status. A suggestion could be giving to low-income undocumented immigrants access to Medicaid with a basic plan to those who pay taxes for five years with an Individual Taxpayer Identification Number (ITIN). An ITIN is a tax-processing number only available for certain nonresident and resident aliens, their spouses, and dependents who cannot get a Social Security Number (SSN). It is a nine-digit number, beginning with the number "9," formatted like an SSN (NNN-NN-NNNN). Another suggestion, after analyzing the problem, could be to grant access to undocumented immigrants to the Health Insurance Marketplace, giving them the access to fill out an application and see for which program they could qualify. Finally, but not least, it is needed to create educational workshops where people would learn how the healthcare system works to have a better understanding and give the tools to undocumented immigrants to seek medical attention. To implement these changes, it is necessary to involve policymakers (state representatives and senators) in the topic to create a change in healthcare, giving opportunities to the vulnerable population. Also, it is important to recruit more physicians who understand the environment where the patient lives, and who represents their patients culturally and linguistically. Healthcare workers who know about the foods their patients eat, their lifestyle, their religion, and the family dynamics. The communities where most of the immigrants need bilingual staff that can eliminate the barriers I mentioned. Leaders and people with the knowledge necessary should collaborate with municipal, state and federal governments and engage in health promotions, research and policy-making.

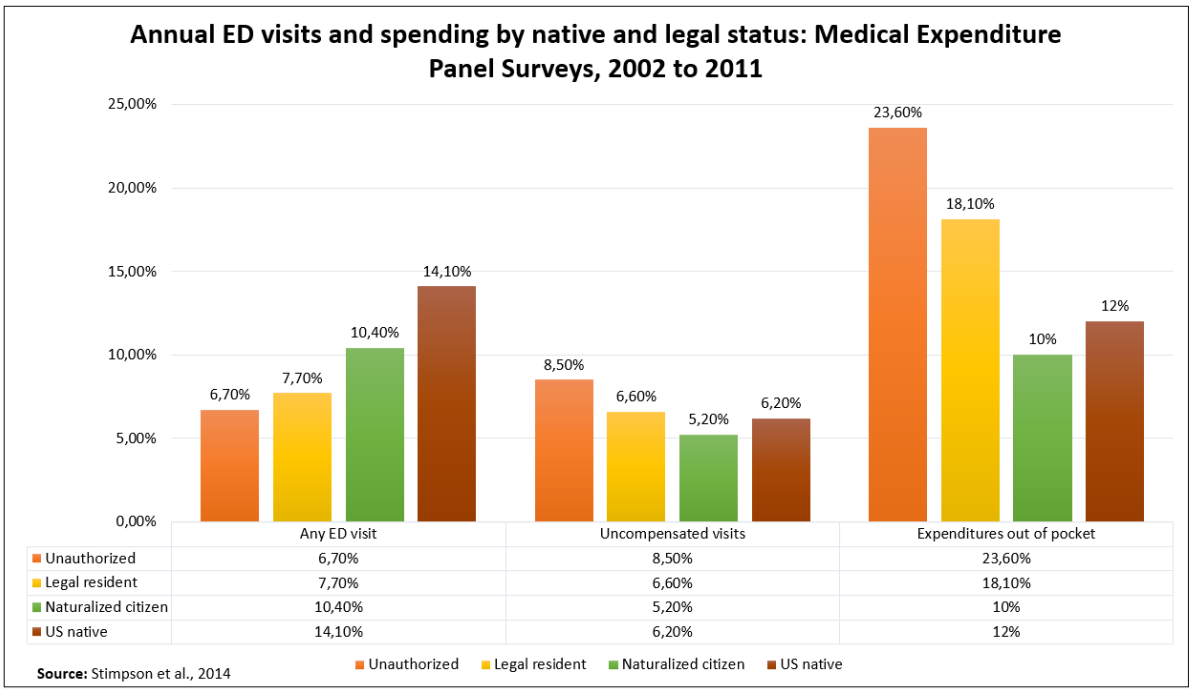
Defining Access

Access to promotive, preventive, curative and rehabilitative care are the most important topics in health policies. Shi and Singh (as cited in Jenson & Fraser, 2011, p. 167) define access as “The ability to obtain needed care, and lack of access is an indication of unmet healthcare needs." Similarly, the Institute of Medicine (1993) defines access as “The timely use of personal health services to achieve the best possible health outcomes." (p. 4) With the information given, access to healthcare can be defined as the ability to obtain needed care at the right moment in the right place to achieve positive health outcomes. Access to healthcare includes different dimensions such as availability, accessibility, accommodation, and affordability (Jenson & Fraser, 2011).

Often times, people do not have access to healthcare because they have obstacles to get it. These obstacles are related to the dimensions of access to healthcare. People are not able to pay for the charges, insurance or copayments (Affordability problem). Another example is when people need the healthcare service in the place where they live, but it does not exist in that place (Availability problem). It can get worse when clients cannot travel to another location because of the transportation and lack of services in their communities (Accessibility problem). Finally, the problem can get worse when patients do not speak English, the provider does not understand his/her culture, or the services are in certain hours (Accommodation problem). The four dimensions are important in having access to healthcare, but the big problem is when people lack insurance (Center for Immigration Studies, 2000; McLaughlin & Wyszewianski, 2002).

In the United States, when people talk about access to healthcare it means they are insured or not (Goddard & Smith, 2001). This affirmation is also true in other countries according to the World Health Statics (2019) because at least half of the world’s 7.3 billion people are not receiving the essential health services they need. They also reveal that around

800 million people spend at least 10 percent of their household budgets on health expenses for themselves, a sick child or other family member, and almost 100 million people were pushed into extreme poverty because they had to pay for health services out of their own pockets. There is a challenge for people who do not have insurance because they cannot receive medical attention. Estimates of the proportion of Americans avoiding healthcare due to cost vary by income and health insurance coverage. Uninsured adults are generally the most likely to experience each of the problems described. Many uninsured people (25%) reported that they put off, postponed, or did not seek medical care in the United States because of the cost because they are unable to pay for it (Weinick et al., 2005). Additionally, some of them may end up in an emergency room when it is urgent, which creates a whole new set of challenges, i.e., social, economic, physical and mental. Undocumented immigrants had a slightly higher likelihood to have had at least one uncompensated visit compared with naturalized citizens or natives, and undocumented are more likely to have uncompensated visits than legal residents. Annual per capita payments for emergency department (ED) services were $1179 for unauthorized immigrants, which was not significantly different than other groups, but undocumented immigrants needed to pay out of the pocket, as shown in the graphic below (Stimpson et al, 2014).



As a vulnerable group, undocumented immigrants face many challenges when trying to receive healthcare. They are considered "vulnerable group" because they are a group of people at large risk for poor physical, psychological and social health outcomes and inadequate healthcare (Derose et al, 2007). This vulnerability is provoked by multiple factors, including political marginalization, social marginalization, lack of socioeconomic resources and societal resources. Studies that are described later have shown that, compared to the U.S.-born population, immigrants and their children (including U.S.-born) typically have lower rates of health insurance, use less healthcare, and receive lower quality care.

There are diverse aspects that create differences even in immigrants' subgroups. These differences are in the socioeconomic background, immigration status, limited English proficiency, residential location, traumas, stigma and marginalization (Derose et al, 2007). Many immigrants face a language barrier and therefore do not feel comfortable voicing an opinion or asking for assistance with an issue that affects them. They fear obtaining healthcare services due to this language barrier, their immigration status, lack of knowledge

about how the healthcare system works, fear of deportation, not being culturally comprehended, ignorance about the existence of community clinics, and the costs not affordable with their economic situation (Heyman et al., 2009).

Migration to the United States is associated with changes in many of the determinants of health status, including access to healthcare, exposure to stressful experiences, health risks, and changes in lifestyle (Goldman et al., 2014). These factors often mean health conditions deteriorate when people arrive in the United States. Not all residents are offered equal healthcare in the United States. Barriers like insurance, access to care and discrimination keep a large part of the country's population from receiving much-needed medicine and procedures. For example, African-American individuals and those in other minority groups receive fewer procedures and poorer-quality medical care than white individuals (Powell, 2016). There are disparities among the different conditions, such as race, immigration status, gender, class and age. Access to adequate healthcare is often only attainable for specific groups, where most immigrants have no part in it. It is necessary to fight for equity and affordable access to healthcare for all people. Policymakers should take care of this issue because healthcare is a human right that needs to be addressed no matter the political affiliation of the people in power because the government has the moral obligation of taking care of healthcare. There are other countries that disagree with the United States because public health and medical care services are embedded in a centralized health system and social and healthcare policies are more integrated than they are in the United States (Philips, 2012).

Undocumented immigrants should have access to healthcare in the United States because it is a human right. The Universal Declaration of Human Rights proclaimed by the United Nations General Assembly in Paris on December 10, 1948 states in the article 25 part 1 that:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (p.7).

Furthermore, the World Health Organization (2006) states in its Constitution that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (p. 1). It is important for society to dismantle the stigmas and promote treating all people as a human being, without any distinction, with the same rights and the same opportunity to access health. As Saurman (2015) states that access to healthcare is "about enabling a patient in need to receive the right care, from the right provider, at the right time, in the right place, dependent on context" (p. 1). Everyone must have access to health facilities, at the time they need it, and in the place where they need it, no matter his/her economic condition. Undocumented immigrants should not be the exception.

It is true that undocumented immigrants are not denied emergency care; but what happens when they have to use it? They do not have the money to afford an emergency room visit, and the high cost of an emergency room visit can be less if people are treated before. An example is given by Kelly and Tipirneni (2018), their study shows that standard dialysis could reduce costs by nearly three quarters as compared with emergency-only dialysis. Also, sometimes they prefer to wait until they have a serious condition that could be prevented if they could have access to health insurance. They could be treated at the right moment, preventing serious conditions (Kelly & Tipirneni, 2018).

This paper will cover the disparities and barriers that undocumented and documented immigrants face accessing to healthcare and how they can affect the social determinant of health from some studies and through some first-hand accounts, readers will hear stories from a medical professional and two undocumented immigrants about their experiences with healthcare, the cost of a visit to a hospital in an emergency room versus investing in prevention, policies that has been implemented for healthcare and how this problem can be observed by some Community Engagement theories.

Disparities and Barriers to accessing Healthcare

There are multiple barriers that immigrants face in receiving high quality healthcare in the United States. The language barrier is an example of one. The lack of knowledge of English is a barrier for the immigrants in not receiving the right information on health from their doctor. Also, because of the culture, or not being insured, people often do not have regular checkups. According to Rodriguez et al. (2009), it is demonstrated that Latinos immigrants have lower access to healthcare than US-born Latinos. It shows that perceived quality of care is different by nativity/immigrants' status. Also, it showed that more undocumented Latinos received no information on health/healthcare from their physicians versus US-born Latinos. This issue needs to be addressed by creating new policies to help people to get insured and find ways to access healthcare.

The disparities and barriers have been analyzed by multiple institutions, especially the World Health Organization (2010) that created a workgroup who is in charge to analyze the Social Determinants of Health. The Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The World Health Organization (WHO) created the SDOH Framework to explain the structural mechanisms that generate stratification and social class division in the society and that define

individual socioeconomic position within hierarchies of power, prestige and access to resources. The term “social determinants” relates factors such as health-related features of communities (e.g., walkability, recreational areas, and accessibility of healthful foods), which can influence health-related behaviors. Evidence has accumulated, however, pointing to socioeconomic factors such as income, wealth, and education as the fundamental causes of a wide range of health outcomes.

It is important to understand how the social factors have influence over the health of the individuals. There exist some studies that have shown that social factors, education, employment status, income level, gender and ethnic have a direct influence on the health of individuals. Examples of this studies are from Paradies (2006) and Williams and Mohammed (2009) that explain how racial discrimination could harm the health of individuals of all socioeconomic levels by acting as a pervasive stressor in social interactions, even in the absence of anyone's conscious intent to discriminate. There are some disparities among these groups that have been called Health Inequities. According to the WHO (2018), health inequalities and their causes are:

> Differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age… Health inequities are unfair and could be reduced by the right mix of government policies (para. 4).

There is denial of access to health insurance for undocumented immigrants. It is an unfortunate and highly problematic issue for this vulnerable group of people. For example, in some states, undocumented kids don not have access to Medicaid or SCHIP, because of the immigration status. Programs ask for a proof of documentation -being citizens or residents- (Heyman et al., 2009). It makes immigrant individuals to face problems accessing to

healthcare, taking a decision of putting off or delay visit a doctor for their health needs because of the cost, immigration status, discrimination or fear of deportation. It can provoke immigrants to suffer from more serious conditions, complicated conditions that can put their life in risk, or the function of one part of the body. It is not fear that people die just because they do not have the economic conditions to face the disease, they fear of being discriminated against at the hospital, the migratory status or the knowledge to receive medical attention in the right moment, at the right place with the ideal equipment. It is necessary to address the problem and help undocumented immigrants access to healthcare, promote and share the information with the people about how the healthcare system works, where are the places where they can access healthcare with a low cost, and how to be benefited by the institutional programs.

Racial discrimination affects the mental health of the immigrants, and it is a stigma that contributes to deteriorate the social determinants of health. According with data collected from Gee et al. (2006), their article examined whether self-reported racial discrimination was associated with mental health status and whether this association varied with race/ethnicity or immigration status. Data were from the New Hampshire Racial and Ethnic Approaches to the Community Health 2010 Initiative (designed to implement culturally effective programs for addressing health disparities in diabetes and hypertension within the Black and Latino population). Reports of healthcare discrimination were similar between African descendants and Mexican Americans, but lower among other Latinos. Reports of goals discrimination were highest among Mexican Americans, then other Latinos. Reports of discomfort/anger discrimination were highest for African descendants, followed by Mexican Americans. Discrimination may be an important predictor of poor mental health status among Black and Latino immigrants (Gee et al., 2006). The information given helps to demonstrate that discrimination play an important role in health.

Hacker et al. (2011) conducted a research to investigate the impact of enhanced immigration enforcement on immigrant health in Everett, Massachusetts. Community partners and researches conducted six focus groups with fifty-two immigrants (documented and undocumented) in five languages in May 2009. The themes that were treated: (1) Fear of deportation; (2) fear of collaboration between local law enforcement and The U.S. Immigration and Customs Enforcement (ICE) and perception of arbitrariness on the part of the former; (3) concerns about documentation required for insurance and healthcare; (4) fear of deportation and its relationship to emotional well-being and healthcare compliance. The results showed that undocumented fear that anytime, they might be arbitrarily deported. Documented participants were concerned for the welfare of family and friends. Participants believed that local police were an arm of federal authority and were working with ICE. Also, they believe that local and state police have the authority to deport immigrants. They fear that giving out personal information to acquire health insurance or healthcare would be reported to ICE. Because of the fear of being deported, and feeling of anxiety, in some cases immigrants missed doctor appointments, refusal to complete state documents to obtain health coverage and subsequent lack of insurance. The results gave important data to identify why immigrants avoid healthcare; they feel observed. They think that every police officer can deport them. This approach impacts their physical condition and their emotional health that will be explained later in this work, especially in the immigrant's stories section.

Use of health services

Ortega et al. (2007) as seen in the chart below offer an analysis about the use of health services among the population living in the United States by race, ethnic, and citizen/immigration status. The results demonstrated that undocumented immigrants constitute the lowest proportions with health insurance (47.2% versus 85.2% of the U.S.-born)

and are the youngest (most of them, 66.1%, are from 18 to 34 years old). Mexicans and other Latinos had a high rate of poverty.

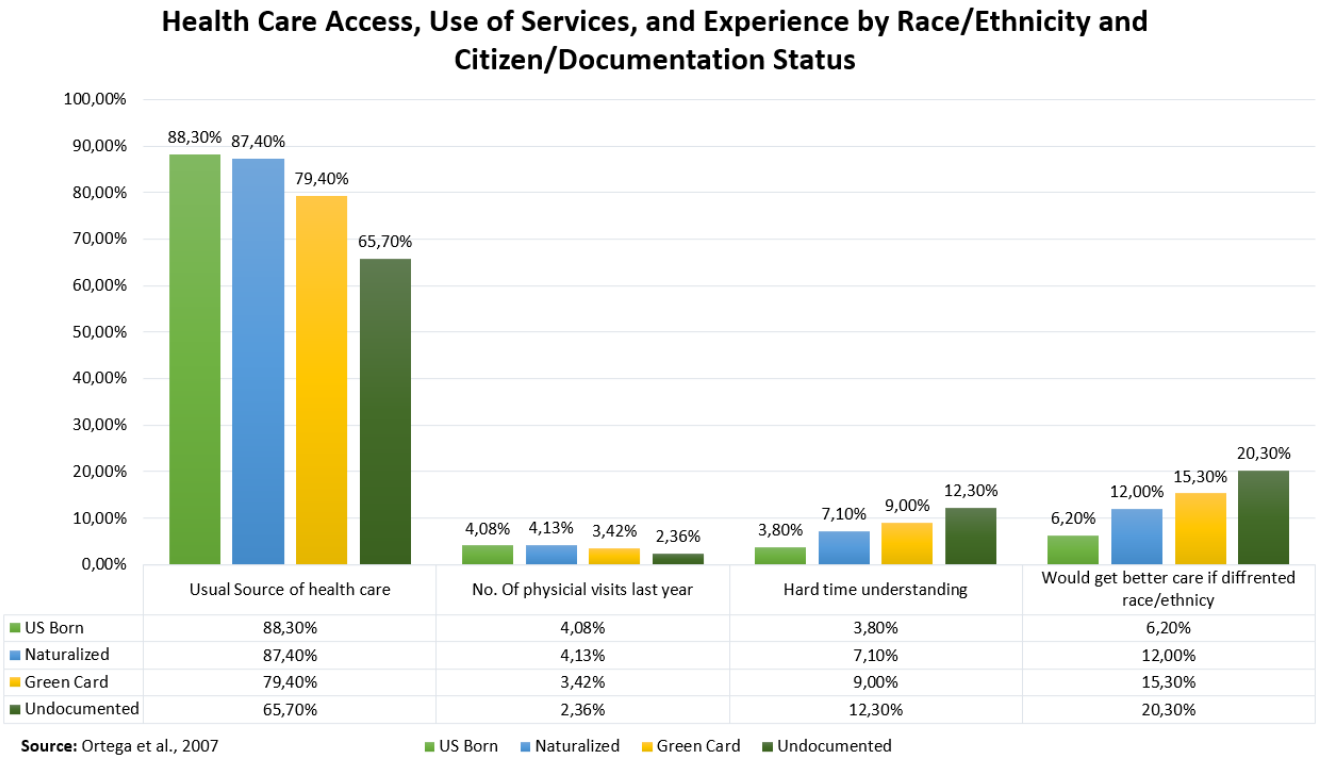
Table 1. Descriptive Statistics by Race, Ethnicity, and Citizen/Documentation Status: CHIS 2003[a]

	Mexican					Other Latino					
Variable	US Born	Naturalized	Green Card	Undocumented	*P* Value[b]	US Born	Naturalized	Green Card	Undocumented	*P* Value[c]	US-Born White
No. of respondents	2851	1218	1352	1317		852	546	327	271		23 178
Female	59.7	55.8	54.8	54.8	<.01	56.1	61.4	54.4	56.5	.13	58.8
Married	44.9	66.1	64.4	49.0	<.01	39.0	56.8	48.9	37.3	<.01	51.4
Health insurance	85.2	79.5	67.5	47.2	<.01	84.4	84.4	69.1	43.2	<.01	92.8
Age, y											
18-34	43.4	20.4	36.2	66.1		33.1	18.7	29.7	52.0		16.1
35-49	29.2	42.6	45.9	29.3		33.2	37.2	46.2	40.6		28.6
50-64	17.2	24.4	13.0	4.0	<.01	20.3	26.7	15.9	5.9	<.01	29.4
65-74	6.1	8.7	3.9	0.5		7.8	10.8	5.8	1.1		13.2
≥75	4.1	3.9	1.0	0.2		5.6	6.6	2.4	0.4		12.7
Educational achievement											
<High school	15.2	46.2	63.8	69.6		12.5	21.6	37.6	54.2		4.7
High school graduate	37.0	24.6	20.0	20.4	<.01	28.2	21.6	22.0	19.6	<.01	23.6
>High school	47.8	29.2	16.2	10.0		59.3	56.8	40.4	26.2		71.7
Employment											
Not in labor force	27.1	34.0	30.2	30.1		29.4	28.4	26.6	23.2		37.9
Unemployed	7.2	4.3	9.5	8.9	<.01	7.6	5.1	9.8	12.2	.01	3.0
Employed	65.7	61.7	60.4	61.0		63.0	66.5	63.6	64.6		59.1
Federal poverty level, %											
0-99	14.0	21.0	35.9	55.1		11.3	15.9	31.2	46.9		5.3
100-199	23.6	34.2	41.2	34.4	<.01	17.5	24.4	31.8	36.9	<.01	12.4
≥200	62.4	44.8	22.9	10.5		71.2	59.7	37.0	16.2		82.3
Location of residence											
Urban	74.6	78.7	73.1	81.6		72.7	82.4	86.9	92.6		59.4
Suburban	13.5	9.0	8.0	6.9	<.01	15.5	12.1	10.4	5.2	<.01	18.5
Rural	11.9	12.3	18.9	11.5		11.8	5.5	2.7	2.2		22.1
Health status											
Poor	5.0	8.0	6.7	3.0		5.5	5.9	5.5	3.3		4.5
Fair	14.1	27.3	31.0	36.9		14.6	20.0	28.8	32.5		10.4
Good	29.2	32.5	37.2	42.1	<.01	26.6	29.3	31.2	36.5	<.01	25.0
Very good	31.9	17.1	13.3	9.1		31.1	26.7	18.4	14.4		35.4
Excellent	19.8	15.1	11.8	8.9		22.2	18.1	16.2	13.3		24.7

Abbreviation: CHIS, California Health Interview Survey.
[a]Unless otherwise indicated, data are expressed as percentage of respondents.
[b]Calculated by means of χ^2 tests within Mexican and US-born white samples.
[c]Calculated by means of χ^2 tests within other Latino and US-born white samples.

Among Mexicans, the undocumented immigrants reported the lowest proportion of having a usual source of care, followed by green card holders, naturalized citizens, and U.S.-born citizens. Naturalized citizens and undocumented immigrants reported the highest proportion of problems in obtaining necessary healthcare in the past 12 months. The undocumented immigrants and green card holders had the lowest mean number of physician visits in the last year. The undocumented immigrants in both groups constituted the highest proportions of those having difficulty understanding their physicians during their last visit and thinking that they would get better care if they were of a different race or ethnicity. undocumented only the 65.7% have a usual source of healthcare compared with the U.S.-born

that have it in 88.3%. The 12.3% undocumented immigrants have hard time understanding physician's vs the 3.8% of US natives. Also, 20.3% of the undocumented reported that they would get better care if different race/ethnicity versus the 6.2% of the U.S.-born that can be visualized in the graphic below.

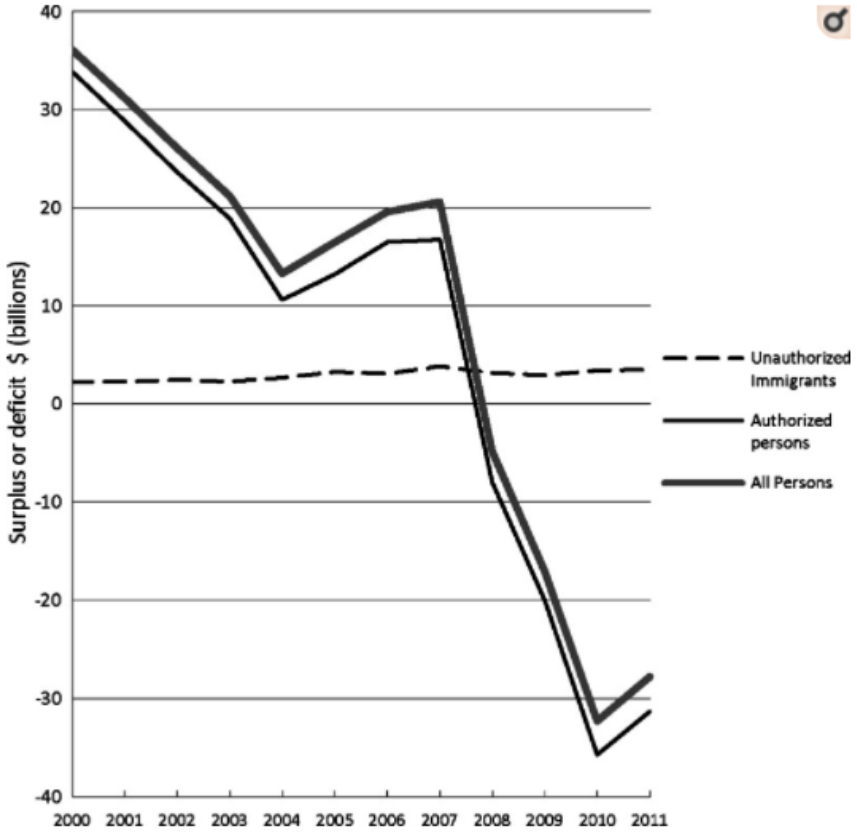


Universal Healthcare & Cost of the services

Most of U.S. citizens, U.S. nationals and lawfully present immigrants are eligible for coverage though the Health Insurance Marketplace, but undocumented immigrants are not eligible to buy an insurance. Under Medicaid and Children's Health Insurance Program (CHIP), no federal funding may be used to cover unauthorized immigrants, except for payment for limited emergency services. It leaves them just one option: to pay the medical attention out of their pocket at a high price. Fortunately, some states have implemented programs to cover undocumented immigrants, particularly children and/or pregnant women,

that are some vulnerable populations in the country, for example, pregnant women and infants are eligible for MassHealth Standard regardless of status in Massachusetts (Mass Legal Services, 2007). But what happened with the rest of the population? Why discriminate undocumented people when most of them are taxpayers? As the information given said, undocumented immigrants are not eligible to get any insurance from the Marketplace, just vulnerable people (such as child and pregnant woman), but immigrants do contribute to the government and federal fund by paying taxes. It means that the undocumented immigrants are subsidizing the healthcare of other United States residents. For this reason, it is necessary to recognize and appreciate the contributions that undocumented immigrants give to the healthcare system.

Actually, undocumented immigrants are contributing more money to the healthcare for other people than they take out for their healthcare. Undocumented people from 2000 to 2011 contributed $2.2 to $3.8 billion more than they take out a year, a total of 35.1 billion in the period mentioned (Zallman et al., 2016). Also, it is estimated that the money is undercounting their payroll tax contribution because not all the unauthorized immigrants report their employment out (Zallman et al. 2006).



Net hospital insurance trust fund surplus or deficit attributable to unauthorized immigrants and authorized persons. Source: Author's analysis of data from the 2001–2012 Current Population Surveys (CPS) and 2000–2011 Medical Expenditure Panel Surveys (MEPS). Adapted from Zallman et al. [13], Exhibit 4

If undocumented immigrants had not contributed to the federal fund for healthcare in the period and also not drawn, the Hospital Insurance Trust Fund (HITF) would have become insolvent one year before that was estimated. It means the taxes from undocumented people have support Medicare for one year, and they cannot access to any benefit from Medicare. It is somewhat contradictory that undocumented people contribute for the healthcare system, but the healthcare system makes them unable to receive any benefit. Also, when people become legal in the United States, they cannot get any benefit because they come back to their home country. It has been shown that most of the immigrants come back home after 15 years working in the United States.

While public debate and policy are driven by these concerns, data suggest that unauthorized immigrants utilize less healthcare than U.S. natives, even those enrolled in some public programs. Only 7.9 % of unauthorized immigrants incur publicly financed health

expenditures (averaging $140 per person annually), compared to 30.1 % of U.S. natives (who received $1,385 per person annually). While we previously assessed Medicare contributions of foreign-born persons, no previous studies have specifically assessed contributions of unauthorized foreign-born persons.

It is a common misconception that undocumented workers do not contribute to the tax base, however Zallman et al. (2016) has shown that immigrants pay payroll taxes using an Individual Tax identification Number or an unauthorized Social Security number (invented names or from another person). The payroll taxes are the most important revenue source for Medicare funding that is used to pay hospital bills. Medicare is paid for through two trust fund accounts held by the U.S. Treasury. These funds can only be used for Medicare. Hospital Insurance (HI) Trust Fund that pays Medicare part A (Health Insurance) and Medicare Program administration. It is funded by payroll taxes paid by most employees, employers, and people who are self-employed, and other sources, like income taxes paid on Social Security benefits, interest earned on the trust fund investments, and Medicare Part A premiums from people who are not eligible for premium-free Part A (Centers for Medicare and Medicaid Services, n.d.). An important part of the funds from Medicare are supported by tax contributions from undocumented immigrants.

Stories of barriers, challenges and fears from immigrants to accessing healthcare

This section will cover the stories of some undocumented and documented immigrants on how they experience a disease in the United States, the barriers and fears that they experience and the delay in seeking for medical attention. The stories will be shared as a narrative and the names of the participants will be hidden. The names that appear in this paper are fake and do not have any relationship with the patient that shared the experience.

Macy V came to the United States in 2010 looking for new opportunities in this country. She felt alone because she has no family members in the United States. She is a 34-years-old server woman. She has been a waitress in a restaurant since she came to this country. She earned a considerable amount of money that allowed her to live in good conditions, but she had a lot of stress because of the clients at the restaurant and the pressure of the owner that delegated a lot of administrative tasks that were not in her role.

She started with some symptoms of anxiety such as fatigue and difficulty sleeping. She thought that it was normal because of the adaptation to the new environment and the place where she worked. Macy experienced those symptoms for almost five years, but she thought it was not important until she learned that a family member died because of the COVID-19 pandemic. She has never seen her family again since she is in the United States. This event causes her a lot of emotional instability, because she started to think that she will never see her family again. The stages of the grief were painful because of this thinking, and also, she felt guilty because she could not do anything to help her loved one and see her before her death.

Some of her friends encouraged her to see a psychologist, but she was scared because she was illegally residing in this country. She was afraid of being judged for having a mental condition, she thought that seeing a psychologist was for “crazy people” and she was not one. Macy continues to develop more anxiety symptoms. She contacted some psychologists by phone to receive therapy, but it was not successful. Her symptoms continued to get worse. The last psychologist that helped her, explained the situation that she looked for help too late, because her symptoms could not be treated just with therapy, she needed medication. She did not follow the advice of her therapist.

She continued with her symptoms. One day, she started to feel more symptoms such as chest pain, shortness of breath, pain in her arm, shoulder and neck, dizziness and palpitations. She was scared because she thought that maybe she was experiencing a heart attack. She decided to go to the emergency room, the doctors attended urgently because she had the heart attack symptoms. They tested her, they ordered some blood tests, electrocardiograms, computed tomography scans, urine tests, and maintained her under observation. They did not find anything that could confirm the heart attack diagnosis. The only thing they found was an arrythmia (not severe). Macy was not insured, and she did not qualify for any insurance from the healthcare connector because of her illegal status; nor did she qualify for the Uncompensated Care Pool (Free Care) is for people with low incomes because she earned more money than required.

She was billed by the hospital for a total of $1,400. She was relieved because she did not have a heart attack, but she was not able to pay which made her more anxious. They recommended her to find any other options to obtain health insurance, but she was scared to ask for more information. She tried to contact some clinics in order to get medical attention from a psychiatrist, but the clinics where she called said that they could not attend to her because she has no insurance and the bill would be so expensive. They denied medical service to her. Two weeks later, Macy experienced the same symptoms like a heart attack, she went to the emergency room, and it was the same result, she had nothing but anxiety. Once again, she got a similar bill. She was tired of experiencing her symptoms. She decided to contact one doctor in her home country, and he offered to deliver some medication from her home country with a prescription to the United States. She is under treatment with some anxiolytics and she is feeling better. She is still worried if she experiences any other anxiety attack and not having any doctor to see.

As it was described, Macy faced the barriers and challenges that most immigrants do, such as the socioeconomic condition, immigration status, fear of deportation and marginalization.

Marcos is another example of the immigrants that face barriers in the United States. He was born in Mexico. He came to the United States because he had some problems in the town where we used to live. He came to the United States as a visitor. He lost his status because he decided to stay longer than permitted to avoid the problems in Mexico. He is scared because he does not have an immigration status in the United States. He is working under a fake name; he does not want the government to know that he is in the United States. He has not bought anything under his name. He has not visited any doctor in the last fifteen years. He does not know anything about his health; he has obesity apparently but he is scared about going to the doctor because he is thinking that the hospitals or community clinics will share the information with the government such as ICE and he will be deported. He says that sometimes he feels very tired, palpitations, dry skin, but he prefers to stay at home and think that everything will be better in some time. This story is an example and proof that undocumented immigrants are not always a burden to the system as some people would believe. He knows that he needs to go to the doctor for at least a check-up, but his fear of deportation is bigger. He shared his story only because the interviewer knows him and he is sure that he will not share any information with any government agency.

Fernando is an immigrant from Mexico. He used to work in the United States for more than 20 years. He is now in Mexico because of his health condition. When he came to the United States, he lived in Essex County. He was able to get free insurance for some period of time, but when he changed his job and income, he lost the benefit. He got his insurance because a doctor used to go to the place where he worked, explain how to get the insurance and apply for it. He has diabetes type 2; he was under control with anti-diabetic medication.

He did not follow any diet and was under a lot of stress in his job, making that his medication needed to be adjusted so often increasing the medication. One day, they needed to change the oral medication to insulin. He was scared and tried to eat better, and he could be controlled until he lost the insurance benefit. Because he was not able to buy insurance and he could not attend his regular visits to the doctor and get the insulin, it made him lose control of his disease. He went to the Emergency room because got an altered level of consciousness and was dehydrated. He was diagnosed with an infection that provoked a hyperosmolar nonketotic coma. He got medical attention and was recovered but he got an expensive bill (he does not remember the amount). He could not pay at all. Then, he needed to restart his treatment, he was uninsured. He talked to the doctor that he met at his job. He was able to send the prescription and he did not charge for the consultation. He started his treatment again, but he did not feel comfortable when he needed to get some blood tests because he does not have insurance. He tried to get insurance with some benefits, he needed to pay some copayments, and he started his diabetes control again. After time he was not able to pay for all the copayments, and he decided to come back to his home country.

Doctor Sanabria was born in a country in Latin America (he prefers not to share his home country). He is a Latino doctor in Massachusetts that has helped some undocumented people to get a consultation and medication. He came to the United States as an undocumented immigrant. When he came to this country, he did it as a visitor, then he became documented. He had a child and wife who needed to be fed, provided housing and clothing. He got his degree in Medicine in his home country. He wanted more opportunities for him and his family. He was able to start to study English and then to apply for a school to get a migratory status in the United States. He improved his English and got an opportunity to get the license to practice medicine in this country. He always remembers how difficult his situation was before arriving in this country and during his first years. He has a connection

with all immigrants and feels part of the community because he experienced the same problems. Now, he is able to support some people who do not have insurance to give advice on health problems related. Also, he is the person who helped Fernando to get medication. He is willing to help people in these conditions because he says that being healthy is the most important thing.

Theories Community Engagement

Being part of a community is important to build some part of your identity and values, but participating in the community is more important to improve your life and other members. Community is a group of people with a shared space that have some characteristics in common. People tend to create communities and maintain them to improve their quality of life. This section describes the importance of a community, how people are influenced by it and how they can work for a common goal and improve the conditions where people live. Working on improving the community is a way to have a better life and create more opportunities to grow up. We should live in a world where the people have the same opportunities to grow up and have equal access to goods and services. In this section will be described three of the multiple frameworks that can be used in Community Engagement that can help and support this work related to healthcare. The frameworks that are described in this section are Sense of Community, Social Capital and Intersectionality.

Immigrants have many intersections that make their situation awkward. They are oppressed by social condition, race, gender and economic class. These oppressions can be seen in a different way by the lens of the Intersectionality framework. Intersectionality helps us to understand and see how inequalities and/or disadvantages are together. This recognition also helps us to understand the obstacle that the people have to address an issue, in this case accessing healthcare. According to Crenshaw (2006), intersectionality “offers a way of mediating the tension between assertions of multiple identities and the ongoing necessity of

group politics" (p. 16). Intersectionality offers us to see in a deeper way the identities that conform the undocumented immigrants and how those identities are related with each other. For example, race and gender create a barrier. Also, intersectionality offers us a way to observe social inequalities and how they are related and are a sum in inequalities that affect in a worse way the person's life.

The intersectionality framework plays an important role to combat marginalization, as Crenshaw (2016) says "through an awareness of intersectionality, we can better acknowledge and ground the differences among us and negotiate the means by which these differences will find expression in constructing group politics" (p. 18). Putting that framework into practice, people and policy-makers will be able to address the inequalities that exist in accessing healthcare. Access to healthcare is attainable only for specific groups, where most immigrants have no part in it. It is necessary to fight for equity and affordable access to healthcare for all people. Policymakers should take care of this issue because healthcare is a human right that needs to be addressed no matter the political affiliation of the people in power.

Another way in how access to healthcare for undocumented immigrants can be addressed is by taking a look at the Sense of Community lens. Sense of Community is defined by McMillan and Chavis (1986) as "a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to being together" (p. 9). Sense of Community has four components: membership, influence, reinforcement integration of fulfillment needs, and shared emotional connection.

If the immigrants put into practice the Sense of Community and help each other as a community, many of them would not be in a bad condition. It is necessary to fight for the recognition that all lives matter and all human beings need to have access to goods and

services, especially access to healthcare. The feeling of belonging to the immigrant community and working together will allow people to create new policies in favor of immigrant rights. For this reason, the membership talks about what membership should be put in practice by all immigrants, especially those who are in power. How things will be different if an immigrant helps another immigrant. This help is not by giving money, this help could be by helping the other to create a group of immigrants that can be met together to talk about the issues that affect them and how they can congregate and make the voice heard. These meetings and working together will make a personal connection with each other.

Also, influence is important. McMillen and Chavis (1986) described "members are more attracted to a community in which they feel they are influential" the immigrants will be more comfortable voicing an issue or an opinion when they feel that their voice will be heard. That this voice, this opinion or this issue that needs to be addressed is taking into account the development of new activities by people in power, professional immigrants and other people that could help. Once the opinion is heard, it is necessary to create an action plan to address that issue. If the issue is resolved or at least it is heard and people know that the members of the community are working on it, they will have the feeling of being integrated in the group. Integration and fulfillment of need are the result of how "communities organize around needs, and people associate with communities in which their needs can be met" (McMillen & Chavis, 1986). Once their needs are met people will be thankful for it and will have a shared emotional connection that will allow them to really create the Sense of Community in the group of immigrants.

Also, the Social Capital framework could also be put in practice to work in addressing the issue of access to healthcare. If immigrant healthcare workers of the immigrant's communities could be able to help them, it would prevent people from having complications for some diseases. People can get what they need (in this case access to healthcare) by social

influence, social control, and social participation. These dimensions help people to be benefited from different aspects of life. Maybe it could be seen as something that breaks the system, but it could be just a gift for people that have the same culture, language and traditions as they.

This gift is an example of how Social Capital works. Social capital refers to features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit" (Putnam,1995). This means that social capital is the interaction and relationship that human beings can integrate as a group or community to achieve benefits from each other. It would be easy to have access to a medical consultation if you had the connection with a doctor if your own community would help or maybe you can know someone who knows that doctor. In the lecture of Kimmerer's, The Gift of Strawberries says that "gifts from the earth or from each other establish a particular relationship, an obligation of sorts to give, to receive, and to reciprocate" it can be translated not exactly as an obligation, but in accessing to healthcare it could create a snowball that if one doctor starts to do it, maybe it provokes by consequence more people are attracted to give that gift. Also, Social Capital would be put into practice where people know the policy-makers and work with them to obtain some benefit for people who are in need of medical attention.

Recommendations

There is a need for people to understand why health is important in their life, because health does not only affect the health as it is, it affects the whole dimension as a person, the social, economic, affective part and have a larger implication for the society as a whole. For this reason, education in health is important to give the tool to the patients to recognize when it is needed to see a doctor. As it has been explained, the disparities in health can provoke that individuals do not seek medical attention at the right moment. Eliminating health disparities, achieving health equity and attaining health literacy to improve the health and well-being of

all, it is one of the initiatives that Healthy People 2030 has as a central focus. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030 addresses both personal health literacy and organizational health literacy and provides a definition for each one. First Personal health literacy is defined as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.” Second, organizational health literacy is explained as “the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." It is important to understand and put a highlight in the word use, since it is important to people to use the information and services and not just knowing and understanding what can be done. It is important to encourage people to use the tools that are given to them in order to improve their health conditions. Also, something to remark is the ability to make well-informed decisions, when they have to decide on their health. It is important to know about the disease or the preventive medicine in order to make a good decision. Finally, it is also important to share responsibility with the health organization in order to improve the health of their communities. It is important to involve hospitals, community clinics, government and non-profit organizations in the health disparities and lack of knowledge about health in the community.

As it was explained in the Literature Review section, undocumented immigrants face barriers and fears when they look for medical attention. They fear obtaining healthcare services due to this language barrier, their immigration status, lack of knowledge about how the healthcare system works, fear of deportation, not being culturally comprehended, ignorance about the existence of community clinics, and the costs not affordable with their economic situation. Undocumented immigrants have not had a good health standing.

It is important to establish a goal for the community. Given the analyzed information, the needs in some communities are to educate people on how the health system works, what type of information the agencies can share with the government and getting medical attention from a bicultural and bilingual doctor. There are some cities of immigrants that even when they have more access to healthcare and opportunities to be treated than other states or cities, they are still experiencing some issues, barriers and fears. Migration to the United States is associated with changes in many of the determinants of health status, including access to healthcare, exposure to stressful experiences, health risks, and changes in lifestyle. It means health conditions deteriorate when people arrive in the United States. Not all residents are offered equal healthcare in the United States. Barriers like insurance, access to care and discrimination keep a large part of the country's population from receiving much-needed medicine and procedures.

The first step necessary to address the disparities and reduce the barriers to access to healthcare is making the people comfortable to go to the doctor. Immigrants do not want to go to see the physician for diverse reasons. They fear obtaining healthcare services due to this language barrier, their immigration status, lack of knowledge about how the healthcare system works, fear of deportation, not being culturally comprehended, ignorance about the existence of community clinics, and the costs not affordable with their economic situation. One example in how to reduce this fear is giving the opportunity to them to have medical attention in their first language and with a physician that could understand the life of the patient. It is important to recruit more physicians who understand the environment where the patient lives, and who represents their patients culturally and linguistically. Healthcare workers who know about the food their patients eat, their lifestyle, their religion, and the family dynamics.

Given the reasons explained before, one of the programs/activities that need to be implemented/improved are giving affordable, bilingual and bicultural medical attention to the

population in one community. Those activities will allow people to not be scared because of the high costs when they are not insured and also it will destroy the language barrier and they will feel understood. Also, it will facilitate the engagement with the patient, because is easily to talk to them in the language that they prefer, the healthcare workers will be able to inform about their health status, the medication that they will need, the importance to exercise and eating healthy food, and it will allow the relationship doctor-patient that will make the patient to come back and have regular checkups or follow up if it is needed.

Those activities will facilitate the second part of the goals discovered, that is to achieve that the 75% of the population will be able to have a comfortable visit with their doctors/physicians understanding the problem/illness they have and enable them to follow the instructions/treatment plan. This comfortable environment will allow the patient to trust in the provider, share more information and engage with their doctor that will allow them to look for them again and have a usual source of healthcare. When trust is built, it is easy for people to ask for help to those who they trust in.

It is necessary to increase at least 10% bilingual/multicultural healthcare education programs in X City. Through the time and implementing some workshops/classes as the Health Education and Literacy program (HEAL) people will be aware and confident to have regular visits to the clinics. HEAL is an eight-week health literacy curriculum designed to teach adult basic health education on topics such as nutrition, medication, emergency recognition and healthcare access to English-as-a-Second-Language Learners. This program was delivered in Lawrence, Massachusetts in 2019 and was worthy. This HEAL pilot was delivered out of Lawrence's Notre Dame Education Center (NDEC-L). NDEC-Lawrence is a nonprofit community-based organization with the primary goal of educating low-income, undereducated adults and empowering them to improve their lives and those of their families. Delivering the program in this time of institution allows people to be more willing to attend

the classes because they do not ask for a lot of documentation when people want to register and they feel welcomed. It is necessary to expand this program in other communities to encourage and give the tools to more people to understand the health aspect of their lives. This will allow people to be confident going to the doctor and will allow the population to have a usual source of healthcare, having regular checkups, preventing tests, medical attention in the right moment and trusting that their information will not be shared with government agencies.

Conclusion

Barriers such as socioeconomic status, immigration status, limited English proficiency, residential location, traumas, stigmas and marginalization have left apart undocumented immigrants to access healthcare in the United States. Undocumented immigrants do not have a usual source of health, have lower number of visits to the physician, have hard time understanding a physician and are treated differently than United States citizens because of the barriers described before. Oftentimes, they delay or postpone a visit to the physician because of the cost that is translated in uncompensated emergency room visits, and paying high bills out of their own pocket making them unable to pay for it. Those barriers, challenges and fears can addressed by giving the opportunity to Undocumented immigrants to access to the healthcare, recruiting more bicultural/bilingual healthcare workers, increasing educational programs among the population to make them able to feel comfortable in a doctor visit which can create a big difference in health outcomes and become healthy individuals.

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