Health Systems of Mexico and the U.S.: A Comparison of National Health Systems and an Analysis of Mexican Immigrants in the U.S. Health System

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Abstract

This thesis examines the aspects of the health systems of both Mexico and the United States, including insurance types offered, average costs for users, and the availability of and access to healthcare services in each respective nation. In Mexico, public healthcare is the most popular option, with the majority of people using insurance provided by the nation's social security system or the universal healthcare program. Private healthcare is mostly used to supplement what public services cannot provide. In the U.S., private healthcare is more popular, with most people using health insurance provided by their employers. Public healthcare is reserved for the nation's more vulnerable groups, such as the poor, disabled, and elderly. This analysis is followed by a brief comparison of the aspects of the two systems, and their effects on their respective users. This thesis furthermore analyzes the overall experience of Mexican immigrants in the U.S. health system. Access to healthcare for Mexican immigrants (as well as immigrants of all nationalities) can be affected by factors such as citizenship status, migration status, and the characteristics of an immigrant's surrounding community. Potential barriers to receiving care include differences between immigrants and healthcare providers in language, cultural values, and expectations of care, as well as legal barriers imposed by U.S. legislation. Finally, this thesis makes several suggestions as to how the experience of Mexican immigrants in the U.S. health system may be improved, including ideas for social and legislative reformation in the U.S.

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I. Introduction

Public health is an important aspect of every society around the world. Members of a society that have good health are more able to perform their activities of daily life, allowing them to meaningfully contribute to the society as a whole. The type of health system that a society has can affect the wellbeing of both its individual members, as well as its overall functioning. Healthcare is important for individuals in the treatment of illnesses and injuries, as well as in matters of birth, death, and living (Childs 10). Outside of providing medical care services, health systems can also help to ensure the functioning of other societal features, such as education, law enforcement, and court systems (Childs 10).

Governing bodies of different societies around the world employ different methods of providing healthcare to the people living in them. Some governments consider good health to be a human right, and therefore their health systems are structured with the intent to provide equal care to all members. Others do not recognize this right, and as such their health systems are more catered to members that can afford services and treatments. Furthermore, in every society, some members face more challenges in obtaining proper healthcare than others. One of the most common demographics that encounters this issue is immigrants. Immigration can affect many social factors that determine one's health, such as economic stability, education, and living conditions (Olson and Anderson 1). Immigrants can also be subjected to further health disparities due to the marginalization and discrimination that they may face in a new society (Olson and Anderson 1). In the U.S., immigrants of many different ethnicities and backgrounds may face challenges with the U.S. health system, such as lack of access to health care and insurance (Olson and Anderson 13).

In this thesis, the first two sections will be devoted to understanding the national health systems of Mexico and the United States—two distinct societies with notable differences in their methods of providing healthcare to their members. These sections will provide an analysis that will compile information from government entities, reputable organizations, and previously-conducted research studies to describe the most prominent aspects of each health system, including the different types of health insurance offered and the average costs for their users, the number of medical facilities and health services provided, and any relevant legislation that has affected healthcare in each nation. This will be followed by a third section, which will contain a comparison of the two systems that centers on differences how healthcare is provided, average costs, availability of services and resources, and the possible overarching effects of each health system on the health of their populations and on other features of their societies.

The fourth section of this thesis will center on this overall experience of immigrants in the U.S. health system, and, as the focus of this thesis is on Mexico and the U.S., this analysis will focus specifically on the experience of Mexican immigrants. This section will provide an examination of data from the U.S. Census and various research studies to assess the access to healthcare among Mexican immigrants, how they utilize healthcare services, and how this access may be restricted by various social and legislative barriers. This section will conclude with a brief proposal that includes ideas of how the health system in the U.S. might be improved to better the experience of immigrants from both Mexico and from many other nations.

1. Terminology

It is important to note that many of the sources referenced in this thesis contain the terms “Hispanic” and/or “Latino/a” to describe the ethnic background of the people observed in their

investigations. These terms are sometimes used interchangeably, but the two are not the same, nor are they mutually exclusive. Because of this, it is important to clarify the difference between them.

The Pew Research Center states that the terms “Hispanic” and “Latino/a” are “meant to describe—and summarize—the population of people living in the U.S. of that ethnic background” (M. H. Lopez et al.). When drawing distinctions between the two terms, generally, “Hispanic” is used to describe a person born in or with ancestors from a country that is primarily Spanish-speaking (including Spain, as well as various countries in North, Central and South America and the Caribbean), while “Latino/a” or “Latin American” describes a person born in or with ancestors from a country that is a part of Latin America (including most nations in Central and South America, along with some nations in the Caribbean) (M. H. Lopez et al.). The majority of nations that comprise Latin America are Spanish-speaking, but can also include non-Spanish-speaking nations, such as Brazil. Therefore, some people in the U.S. can be described as solely Hispanic or Latin American, and some can be described as both. In this thesis, for the purpose of transparency, any data or information concerning Hispanic or Latin American populations will be discussed using whichever term was used in the source from which the data originated.

II. The Health System of Mexico

In Mexico, the federal government has a mandated responsibility to provide healthcare for everyone in the nation. This responsibility is officially written in Article IV of the Federal Constitution of Mexico, which states "toda persona tiene derecho a la protección de salud" (English: "Everyone has the right to health protection"; all translations are mine) (*Constitución política de los Estados Unidos Mexicanos*).

Following that mandate, today, the right to healthcare is provided to people in Mexico through public institutions, private entities, and private physicians. Public health insurance and care is provided to government and private workers by social security system, and a universal healthcare program is provided by the federal government for those who need it. Private insurance and care is paid out-of-pocket by those who can afford it. This section will discuss the features, benefits, and utilization of the various institutions that provide healthcare and insurance to the people of Mexico.

1. Public Healthcare

The 2015 Intercensal Survey conducted by the Instituto Nacional de Estadística y Geografía (INEGI) (National Institute of Statistics, Geography, and Informatics) found that public health insurance is the most popular type in Mexico ("Derechohabiencia"). This type of healthcare is fully or partially funded by the Mexican federal government, depending on one's employment status. According to a 2017 report by the World Health Organization (WHO), the level and type of healthcare available in Mexico varies depending on the system, with each having coverage over different medications and devices, as well as different standards for quality

of service (5). Public healthcare is provided both by various branches of the social security system of Mexico, as well as by the Mexican federal government.

1.1 Insurance Provided by the Social Security System

The Government of Mexico's official website states that idea for social security was introduced in the nation's constitution of 1917, and, in 1943, a social security system was instituted with the creation of the Social Security Act. Article 2 of this act states "La seguridad social tiene por finalidad garantizar el derecho a la salud [y] la asistencia médica" ("Social security is intended to guarantee the right to health [and] medical care") ("IMSS").

The social security system of Mexico offers healthcare services to its employed citizens and their families and/or dependents. Employees in the private sector are covered by the Instituto Mexicano del Seguro Social (Mexican Social Security Institute, IMSS), and those employed by the federal government, as well as the majority of state governments, are covered by the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (Institute for Social Security and Services for State Workers, ISSSTE).

a. Instituto Mexicano del Seguro Social

A 2014 report by Norma Gutiérrez over the availability and cost of healthcare in Mexico touches on the history of the health system of the nation. This report states that the IMSS was originally created under the Social Security Act of 1943 in order to provide social security to formal workers employed in the private sector and their families (Gutiérrez 2). In 2013, the institution underwent a major reform in order to stabilize its finances and to improve the quality of its services. Today, it is one of the largest healthcare providers in Mexico (González Anaya

and García Cuéllar 189). The INEGI 2015 Intercensal Survey found that, after the nation's universal healthcare program, Seguro Popular, the IMSS was the most popular form of insurance used, with 39.2 percent of those surveyed stating that they were affiliated with the social security institution ("Derechohabiencia"). Insurance provided by the IMSS is financed by equal contributions of employees, their employers, and the federal government (Gómez Dantés et al. s225).

A 2015 study by José González Anaya and Regina García Cuéllar observed the transformation of the IMSS that began in the year 2013, as well as the current state of the institution. The researchers reported that medical care made up the main portion of services provided by the IMSS, accounting for 80% of the institution's overall spending (González Anaya and García Cuéllar 190). In 2015, this spending was allocated toward the management of 5,726 medical units (clinics, as well as general and specialty hospitals) and 1,400 pharmacies in both rural and urban areas around the country (González Anaya and García Cuéllar 192). Within these medical units, the IMSS helped to oversee approximately 490,000 health consultations, 1,200 births, 4,200 surgeries, and 58,000 emergencies every day (González Anaya and García Cuéllar 192). Through its primary care units, the same study found that the IMSS was achieving a vaccination rate of 96 percent of its beneficiaries, as well as providing an annual average of approximately 30 million checkups and two primary care consultations per beneficiary (González Anaya and García Cuéllar 192).

Under coverage of the IMSS, beneficiaries can obtain multiple kinds of healthcare-related insurance. A form of accident insurance allows workers to be covered for accidents or diseases that they may be exposed to in their jobs, and provides workers with necessary medical care in the case that a worker is temporarily or permanently incapacitated due to a work-related accident

("IMSS"). Maternity insurance covers medical care during pregnancy and childbirth, as well as a maternity leave that extends up to 84 days ("IMSS"). Finally, disease insurance covers medical, surgical, pharmaceutical and hospital care, as well as benefits or money during the illness for the worker and their beneficiaries ("IMSS").

Besides insurance coverage, the IMSS also works to promote overall community health. It does so by providing various social benefits that aim to support health, prevent diseases and accidents, and contribute to the improvement of the population's overall quality of life ("IMSS"). Some of these social benefits include health promotion programs, education on proper hygiene, and cultural and sports activities ("IMSS").

Other than healthcare benefits, the IMSS offers economic benefits, disability, and life insurance (Gutiérrez 2). Pensions are available for those with temporary or permanent disability, and for surviving family members or dependents in case of a worker's death ("IMSS"). Retirement benefits are offered to those over the age of 65 who have completed more than 1,250 weeks of work ("IMSS"). Those affiliated with the IMSS can also receive the benefit of childcare. In 2015, the institution managed 1,399 daycare centers throughout the nation (González Anaya and García Cuéllar 192). Extra benefits are likewise provided to working mothers ("IMSS"). Finally, the institution provides a number of social benefits for its affiliates, providing them with facilities such as supermarkets, theaters, sports centers, funeral parlors, and even four resorts across the nation (González Anaya and García Cuéllar 192).

b. IMSS-Bienestar

IMSS-Bienestar is a welfare-based healthcare program within the IMSS. This program was initiated with a reform of the Social Security Act in 1973, in order to expand care toward the

marginalized and impoverished population of the country. According to the website of the Government of Mexico, the goal of the program is to bring medical, hospital, and pharmaceutical care for those who are not covered by the social security system. The program is especially aimed at those who live in deep rural or marginalized suburban and urban communities ("IMSS"). IMSS-Bienestar is currently present in 19 of the 32 states in the nation, and is funded entirely by the Mexican federal government ("IMSS", Gómez Dantés et al. s225). The program currently oversees operations in 3,622 rural medical units, 140 mobile medical units, and 80 rural hospitals around Mexico. As of January of 2020, IMSS-Bienestar was granting medical services to over 12.3 million people, including 4.4 million people living in indigenous regions in the nation ("IMSS"). Like its parent institution, the program also serves to promote community health among its beneficiaries through education on health topics such as vaccinations, personal hygiene, and nutrition.

c. Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado

Another agency within the social security system of Mexico is the ISSSTE. This institution was created in 1960 with the purpose of providing health insurance to federal government employees (Gutiérrez 3). In 2015, the ISSSTE covered 7.7 percent of the Mexican population ("Derechohabiencia").

Like the IMSS, the main focus of the ISSSTE is to provide medical services to its beneficiaries. The Organization for Economic Cooperation and Development (OECD) found that in 2014, the institution managed almost 1,189 medical units throughout Mexico, including family clinics, general and specialty hospitals, and a National Medical Center (*Improving* 23). In the year 2013, the ISSSTE covered approximately 100,000 health consultations each day,

including an average of 3,000 emergencies, 1,000 surgeries, and 100 childbirths (OECD, *Improving* 23). Similar to the IMSS, the ISSSTE also provides services outside of medical care, such as childcare, mortgage loans and pensions, travel agencies and hotels, discount supermarkets, and facilities for funeral services (OECD, *Public Procurement* 22).

1.2 Universal Healthcare

As previously stated, access to health protection is a right granted to everyone in the nation by the Mexican Federal Constitution. However, before the year 2003, this goal was not fully realized. At that time, the self-employed, the underemployed, and the unemployed of Mexico were not covered by the social security system. This demographic, accounting for approximately 50 percent of the population, had little to no access to pre-paid health insurance (Gutiérrez 3). Some healthcare was provided to these groups by public programs, but the services were generally not comprehensive, as the allocation of funding to support these programs was unspecified and varied in budget. This caused many people of this demographic to have to pay out-of-pocket for basic services and medicine (Gutiérrez 3-4). To reform this system, the government of Mexico formed the Social Protection System in Health in 2003. Within this system, the national health insurance program, named Seguro Popular (SP), was created, with a goal of offering universal access to healthcare (Gutiérrez 4).

By the year 2012, approximately 98 percent of the Mexican population was covered by some kind of health insurance (Conti and Ginja 13). However, due to various criticisms of the system, in January of 2020, SP was replaced by a new universal healthcare program, called the Instituto de Salud para el Bienestar (INSABI) (English: Institute of Health for Welfare). A report from this year by Michael Reich examined the political implications of this reform. In 2018,

under the leadership of a new more liberal president, Andrés Manuel López Obrador (known as AMLO), Mexico began a restructuring of the universal healthcare program, with goals of reaching the people who were still uninsured by SP, offering less costly services, and fighting the corruption of the current health system (Reich 1).

a. Background: Seguro Popular

SP was intended to allow its beneficiaries the rights to equal access to healthcare, comprehensive health services, emergency medical care, and medication necessary for the diagnosis and treatment of diseases (Gutiérrez 4). Some of the benefits that affiliates of this insurance plan receive included public health, outpatient care, dental care, emergency care, hospitalization, and general surgery (Gutiérrez 6). During its existence, SP was funded by the federal government and state governments, and in part by beneficiaries, who were charged based on what they could afford (Gutiérrez 4-5). In 2015, 49.9 percent of the population stated that they were affiliated with the insurance program ("Derechohabiencia").

Some criticisms of SP included that, while it entitled many people to medical service, it did not necessarily provide the specific services that a person might need, as it only covered specific treatments for diseases, medications, and surgeries (Gutiérrez 6). Furthermore, many of the services that SP did cover typically only required low-cost, simple treatments; services that required more expensive and specialized care were generally not covered. This caused many beneficiaries of SP to continue to have to pay out-of-pocket for costly treatments (Gutiérrez 7).

b. Instituto de Salud para el Bienestar

In January of 2020, SP was officially dismantled, and has been replaced by the Instituto de Salud para el Bienestar (Institute of Health for Welfare, INSABI), a new institution that aims to provide public healthcare for those who are not covered by social security. According to the government of Mexico, the goals of this new system include to provide healthcare of a better quality to its beneficiaries, and to focus more purposefully on marginalized communities in the nation by coordinating national and local healthcare facilities under one network ("INSABI"). INSABI also includes a fund that will cover more expensive services that SP failed to provide for, and seeks to ensure sufficient supply of medications and equipment in all of its facilities ("INSABI").

According to the government of Mexico, INSABI will be financed by general taxes of Mexican citizens and will therefore be less expensive than SP overall for its beneficiaries, as they will no longer have to pay for premiums for certain types of medical care (Reich 3). INSABI will also be managed more centrally, with the federal government overseeing the program and the delivery of health services to the nation overall, instead of state governments each managing their own regions, as they did under SP (Reich 5). The new system will also attempt to increase access to healthcare in rural areas by encouraging healthcare workers to move to rural communities (Reich 5).

However, as INSABI is still so new, it is not yet well known how the system will work within states and healthcare units, nor how the program will have enough funding to cover everything it is promising (Ramos-De la Medina and Torres-Cisneros 59). As such, it is not possible to know yet whether INSABI is truly an improvement over SP.

2. Private Healthcare

The private health system in Mexico operates on the free market system, and is available to the people that can afford it, and who are not satisfied by the care provided by public insurance (Gutiérrez 3). Although the majority of the country is affiliated with a public healthcare institution that provides them insurance, many people still choose to receive care at private facilities, as the quality of services can be higher and more efficient. The 2012 National Health Survey in Mexico found that approximately one third of the population, despite being covered by a public institution, reported going to private institutions to receive outpatient care (M. J. Lopez et al. 184). However, this is not true in terms of hospital care, with only 14 percent of people affiliated with a public healthcare institution choosing to receive care at private hospitals (M. J. Lopez et al. 184). In 2019, there were 3,312 privately-owned hospitals in Mexico (OECD, "Hospitals"). Care at these hospitals is paid mainly out-of-pocket (WHO 13).

Private health insurance in Mexico is based on a self-purchase system, with individuals paying premiums to a private insurer for certain health services. Users of private medical insurance in Mexico usually include foreigners and those in the upper or middle class. Only 3.27 percent of people in Mexico stated that they were affiliated with some private health insurance company in 2015 ("Derechohabiencia").

III. The Health System of the United States

Unlike the rights provided by the constitution of Mexico, there is no legislation in the U.S. that guarantees everyone the right to healthcare. While healthcare is provided through both public and private entities, the healthcare sector of the U.S. is largely privatized. This can clearly be seen through the popularity of private insurance over public insurance, as well as through the increased prevalence of private medical facilities in the nation over public ones (in 2017, OECD reported that there were 4,783 privately-run hospitals in the U.S., as opposed to 1,427 public ones) ("Hospitals"). Nevertheless, public insurance serves a large portion of the most vulnerable population in the U.S., such as those who live below the poverty line (in 2020, The U.S. Department of Health and Human Services set the federal poverty line at an annual income of less than or equal to $12,670 for a single person and $26,200 for a family of four), as well as the elderly and those with disabilities (Azar 3060).

This section of the thesis will discuss health coverage options in the United States, including both public and private healthcare, as well as healthcare options for those without insurance. Furthermore, this section will briefly discuss the Affordable Care Act and its lasting effects on the U.S. healthcare sector.

1. Public Healthcare

Public healthcare in the U.S. is implemented and partially funded by national and state entities. It is most commonly used by those in the nation that meet certain requirements to qualify for it, such as the elderly, the disabled and those with incomes below the poverty line. The U.S. Census Bureau estimated that in 2019, 34 percent of people living in the U.S. were affiliated with some form of public health insurance (Berchick et al. 4). Public healthcare is

covered for the poor, disabled, and elderly through insurance provided by the Social Security Act, and for veterans and their dependents through the U.S. Department of Veterans Affairs.

1.1 Insurance Provided under Social Security

The U.S. Social Security Act was established to create a welfare system for those who needed it, including the elderly, people with disabilities, and those near or below the poverty line, among others. In a 2009 article about the history of this act, Barbara S. Klees et al. state that, when the act was originally passed in 1935, this welfare system did not include programs in health protection (3). However, in 1965, amendments were added to the act that allowed for the creation of such programs, which incited the formation of both Medicare and Medicaid (Klees et al. 3). In their 2007 report on the impact of Medicare on the U.S. health system, Amy Finkelstein and Robin Mcknight stated that the enactment of these amendments represented the "single largest change in health insurance coverage in the U.S. history", to that date (1). Since their enactment, both programs have been expanded over time, including in budget, as well as in who they cover (Klees et al. 4).

a. Medicare

Medicare is a government-funded health insurance program that covers all citizens over the age of 65, as well as certain people under the age of 65 with long-term disabilities (Berchick et al. 1). In 2019, Medicare users accounted for around 18 percent of the nation's population, with the majority of this group being the nation's elderly population (Berchick et al. 4).

Juliette Cubanski et al. from the Kaiser Family Foundation (KFF), a nonprofit organization that focuses on health issues and policies in the U.S., report that Medicare is funded

by a payroll tax (taxes from the payroll of U.S. employees and their employers), general revenues, and partially by the beneficiaries themselves (Cubanski et al.). In 2020, the U.S. Centers for Medicare and Medicaid Services (CMS) published *The Official U.S. Government Medicare Handbook: Medicare and You*, which describes the different parts of the Medicare program. The handbook states that those who qualify for Medicare can choose between two main plans to receive their care: Original Medicare and Medicare Advantage.

Original Medicare is composed of two parts. The first, Part A, covers inpatient hospital care (care that requires an overnight stay), care in skilled nursing facilities, hospice care, and home health care (CMS, *Medicare and You,* 5). According to the official government website for Medicare, Part A typically has no monthly cost for its beneficiaries (CMS, *Medicare.gov*). The second, Part B, covers doctor visits, outpatient care (care that does not require an overnight stay), other forms of home healthcare, durable medical equipment (such as wheelchairs and walkers), and preventative services (such as shots and wellness checkups) (CMS, *Medicare and You*, 5). The CMS estimates that the standard cost for Part B in the year 2020 will be $144 per month (*Medicare.gov*). Original Medicare also offers the opportunity to purchase a plan to cover prescription drugs (known as Part D), the cost of which depends on the drugs needed. Beneficiaries can also purchase other supplemental plans to cover any other required services. Those enrolled in Original Medicare can see any medical provider that accepts Medicare insurance (CMS, *Medicare and You,* 51).

The second plan option is Medicare Advantage. Under this option, that is also called Part C of Medicare, enrollees can choose from several different plans offered by Medicare-approved private insurance companies (CMS, *Medicare and You,* 55). These plans typically involve some combination of services covered in Parts A, B, and D from Original Medicare. Each different

Medicare Advantage plan determines which doctors one can see, which prescription drugs are covered, and whether or not one needs a referral from their primary physician to see a specialist (CMS, *Medicare and You,* 61-64). Most Medicare Advantage plans also offer coverage for other things that are not covered by Original Medicare, such as dental, vision, hearing, and wellness programs (CMS, *Medicare and You,* 56). Costs for Medicare Advantage vary largely, as different plans have different rates. Unlike those who use Original Medicare, those covered by Medicare Advantage must visit specific medical providers that participate within their plan's network (CMS, *Medicare and You,* 55).

b. Medicaid

Robin Rudowitz et al. from the KFF state that Medicaid is a public health insurance program that serves to cover the "poorest and most vulnerable people" in the U.S. This population includes people with low income, the elderly, people with physical and developmental disabilities, children with special healthcare needs, and pregnant women, among others (Rudowitz et al.). Approximately 17 percent of people in the U.S. were affiliated with Medicaid in 2019 (Berchick et al. 4). Rudowitz et al. report that Medicaid is the principal source of long-term care coverage for people in the U.S.

Medicaid is not strictly a federal program; rather, it is structured as a federal-state partnership, meaning that the federal government sets basic parameters for the program, and the state governments are responsible for its implementation within their respective jurisdictions (Rudowitz et al.). Each state has the freedom to determine who is eligible for coverage, which health services are covered, how services are delivered, and how physicians and hospitals are funded by the program. This means that, depending on the state, whether or not a person

qualifies for Medicaid, as well as the cost of their Medicaid insurance, depends on their income and the other resources available to them (Rudowitz et al.). The KFF reported that in 2019, Medicaid financed approximately one-fifth of personal healthcare spending in the nation (Rudowitz et al.). This funding helps to support "hospitals, community health centers, physicians, nursing homes, and jobs in the health care sector" (Rudowitz et al.).

The official government website for the Medicaid program reports that while services and benefits can vary largely by state, there are some services that states are required to provide under federal law. Some of these include inpatient and outpatient hospital services, care in nursing facilities, home healthcare services, rural health clinics, and pediatric and family practitioner services (CMS, *Medicaid.gov*). States have the option to provide further benefits such as prescription drugs, physical therapy, hospice care, dental and optometry services, and psychiatric services (CMS, *Medicaid.gov*).

Medicaid also includes a specific program to cover certain children. The Children's Health Insurance Program (CHIP) serves to provide health insurance coverage for uninsured children of families with incomes too high to qualify for Medicaid, but too low to afford private health insurance (Berchick et al. 7). Children enrolled in this program receive benefits such as wellness checkups, dental care, behavioral health services, and vaccinations. In some states, CHIP also helps to cover healthcare for low-income pregnant women, providing care during the prenatal, delivery, and postpartum phases of pregnancy (CMS, *Medicaid.gov*).

In their 2017 study examining the inequality in the U.S. health system, Samuel L. Dickman et al. reported that, while Medicaid improves overall access to healthcare, specialist care can be difficult to obtain because "the program pays low fees to physicians, who are free to turn away Medicaid patients" (1433).

1.2 Veterans Affairs

The U.S. Department for Veterans Affairs (VA) provides public health insurance to those who served in branches of the U.S. military, including the army, navy, and air force. VA, along with its Civilian Health Medical Program (CHAMPVA), covered approximately 1 percent of the U.S. population in 2019 (Berchick et al. 4).

The official government website for the VA states that benefits and costs under coverage from the VA vary depending on the military service history, disability status, and income level of the beneficiary (VA). Some services are provided free to veterans, such as treatment for illnesses, injuries, or mental health issues related to a veteran's time in service. To receive non-emergency care covered by the VA, beneficiaries have to go to one of the 1,255 healthcare facilities that the VA manages throughout the U.S (VA).

Along with health services for veterans, the VA also provides healthcare for qualified dependents of veterans under CHAMPVA. CHAMPVA is a program within the VA that provides health coverage to surviving family members of veterans with permanent, service-related disabilities or service members that died in the line of duty (VA). Benefits under CHAMPVA include inpatient and outpatient care, durable medical equipment, prescription drugs, and skilled nursing and hospice care (VA).

2. Private Healthcare

Private insurance usage in the U.S. is much more common than that of public insurance, with the U.S. Census Bureau estimating that approximately 66.1 percent of people in the nation used some form of private health insurance in 2019 (Berchick et al. 4). Those that receive private insurance primarily do so through an employer, although some choose to purchase insurance

plans directly from insurance companies, and the family members of certain U.S. service members can receive coverage through the TRICARE program. The costs and benefits for private health insurance vary greatly, depending on the plan that one chooses.

2.1 Employer-Based Insurance

Employer-based health insurance is a health insurance plan provided to the beneficiary by their employer or workers union (Berchick et al. 1). David Blumenthal reports in a 2006 article in the *New England Journal of Medicine* that this type of insurance originated in the 1930s to fill the need for health insurance for the people, as the U.S. government, under President Roosevelt, decided not to enact universal healthcare during this time (82). Another 2006 study by Alain Enthoven and Victor Fuchs about the history of employer-based insurance reported that the popularity of employer-based insurance continued to rise in the nation after World War II, but began to become less prevalent in use after the 1980s (1538). However, despite its subtle decline, employer-based coverage remains the primary method of receiving healthcare in the U.S., accounting for approximately 54 percent of coverage over the U.S. population in 2019 (Berchick et al. 4).

An article by the KFF about employer-based insurance in the U.S. reports that this type of insurance is typically funded jointly by the employers and their employees ("2019 Employer Health"). The individual costs for employer-based insurance vary greatly based on the plan a person chooses, as well as the insurance company from which the employer purchases coverage. The Employer-Health Benefits Survey conducted by the KFF in 2019 reported that the average annual cost for employer-based health insurance was $7,188 for coverage for a single person and

$20,576 for coverage for a family, where the employers paid for approximately 75 percent of these costs, and the workers themselves paid the rest ("2019 Employer Health").

2.2 Direct-Purchase Insurance

Direct-Purchase insurance, also called individual health insurance, is healthcare coverage purchased directly from an insurance company or a federal or state marketplace (Berchick et al. 1). This type of insurance is typically used by those who are not satisfied with, or not covered by, employer-based insurance or public insurance. Approximately 10.2 percent of people living in the U.S. used some form of direct-purchase insurance in the year 2019 (Berchick et al. 4).

In a 2019 report by the KFF over health coverage in the individual market states that federal regulations specify that all direct-purchase plans must be "comprehensive", meaning that they must cover doctor visits, hospitalizations, prescription drugs, and maternity care, as well as preventative services such as immunizations ("ACA Open Enrollment"). Costs tend to vary based on a person's age, as well as the number of people for whom coverage is being purchased ("ACA Open Enrollment").

2.3 TRICARE

TIRCARE is a privately-owned health insurance program for the family members of active-duty, retired, or deceased service members, National Guard soldiers, Reservists, or Medal of Honor recipients (VA). The U.S. Census Bureau estimates that TRICARE provided 2.6 percent of the U.S. population with coverage in 2019 (Berchick et al. 4). According to the program's official website, beneficiaries of TRICARE can enroll in one of several different plans

that the program offers, depending on who they are and where they live (TRICARE). Costs and benefits depend on the plan under which one is covered.

3. Healthcare Options for the Uninsured

As no current legislation in the U.S. guarantees the right to healthcare for all, many people living in the nation find themselves without health insurance. The U.S. Census Bureau estimated that approximately 9.1 percent of people living in the U.S., or almost 30 million people, did not have health insurance in 2019 (Berchick et al. 4). Dickman et al. found that, compared to those with health insurance, those that were a part of the uninsured population in the U.S. were far more likely to "forgo needed medical visits, tests, treatments, and medications because of cost" (1432).

To help alleviate the cost of medical services for the uninsured population, the U.S. federal and state governments often provide some form of financial support. This is done by refunding medical facilities for "uncompensated care". Tessa A. Coughlin et al. from the KFF found that in 2013, the cost of this uncompensated care, the majority of which was given in hospitals, provided to uninsured individuals in the U.S. amounted to approximately $84.9 billion. This cost was deferred by around $53.3 billion through funds from the federal and state governments, as well as a small contribution from private sector (Coughlin et al.).

4. The Affordable Care Act

A major piece of legislation that has greatly affected healthcare in the U.S. is the Patient Protection and Affordable Care Act (ACA). The ACA, colloquially known as Obamacare, was officially enacted in March of 2010. The official U.S. government website *HealthCare.gov* states

that the ACA had three main goals: to “make affordable health insurance available to more people”, to “expand the Medicaid program”, and to “support innovative medical care delivery methods designed to lower the costs of health care generally” (CMS, “Affordable Care Act”).

The passing of the ACA worked to expand access to both public and private health insurance in the U.S. A 2010 article by Keith J. Mueller provides a comprehensive summary of the ACA. The act encouraged businesses to provide a health insurance option for their employees (Mueller 2). It also required that all individuals have some form of health insurance (except in special circumstances), and it enacted protections for consumers that made it easier for people to retain their health insurance, such as prohibiting insurance companies from excluding those with pre-existing conditions from receiving coverage (Mueller 12).

Other than expanding coverage, the ACA also worked to promote wellness and improve health quality and the health system in the U.S. The act increased funding and implemented programs to encourage preventative services, such as immunizations and disease screenings, and required insurance companies to cover certain preventative services (Mueller 74). It promoted an increase of research on effective and safe medical treatments to ensure better quality of health services (Mueller 66-68). Finally, it promotes the development of the healthcare workforce by reforming the medical education system and increasing scholarship and loan opportunities for students entering the healthcare field (Mueller 53).

The ACA also expanded Medicaid so that the program covered a greater percentage of impoverished citizens. However, the Supreme Court ruled in 2012 that states were allowed to opt out of this expansion, which many chose to do (Dickman et al. 1433). However, a study by Luojia Hu et al. reported that impoverished populations in states that followed this expansion

ended up having greater financial wellbeing than those than in states that did not expand Medicaid (27).

Overall, while it did not eradicate uninsurance, the passing of ACA did help to greatly diminish the amount of uninsured people in the U.S. Before the passing of the ACA, approximately 50 million people in the nation did not have health insurance; however, by the year 2016, the ACA had helped the number drop to 27 million (Dickman et al. 1432).

Today, while the Trump administration has worked to repeal it, and while many people in the U.S. seem to be convinced of its termination, the ACA remains a prevalent figure in the regulations of the U.S. healthcare industry. A 2020 study by Helen Levy et al. that examines which parts of the ACA are still currently enacted reports that, since its introduction, the majority of the provisions within the act have been successfully implemented, and only a small amount of provisions have been repealed (60-61).

IV. Comparison of Systems

While the health systems of Mexico and the U.S. are overall very different, both have their respective benefits and disadvantages. This section will include a brief comparison of some of the major factors of the health systems of both Mexico and the U.S., including how they function, how they are financed and how much they cost, the available resources in each system, and the effects of each system on overall health and other factors. Finally, this section will give a brief summary of how each nation is responding to the current coronavirus pandemic.

1. Function, Spending and Costs, and Resources

The foundations of the health systems of the two nations are based in different values, which has caused them to have very different methods of implementation. As previously discussed, federal legislation in Mexico deems healthcare a human right, and thus mandates that the Mexican government provide healthcare to all living in the nation. As such, the majority of healthcare in Mexico is publicly funded and provided. The U.S. currently has no such legislation. Therefore, as no overarching public institution exists, healthcare in the country is largely run and insured by private entities, and public healthcare is only provided to certain disadvantaged demographics.

How might this difference in foundation and function affect the health systems in each nation? According to a 2013 study by Alan Maynard on the differences between private and public health systems, each system has its benefits and disadvantages. Private systems, like that of the U.S., typically offer more complete and effective treatments, but only provide services to those that can afford them (Maynard 1103). Public systems, like Mexico, provide care based on need; however, they are more limited by cost in the services they can provide (Maynard 1103).

The privatized system in the U.S. also means that many are vulnerable to having no insurance at all, whereas in Mexico, INSABI promises to cover healthcare for anyone not already covered by a state program (Reich 2).

Healthcare spending likewise varies in each nation. According to data collected by OECD on healthcare spending from 2019, the U.S. devotes much more of its Gross Domestic Product (GDP, defined as the total value of goods and services produced in a nation) to healthcare spending that many other countries, including Mexico. OECD found that in 2019, Mexico spent 5.5 percent of its GDP on healthcare (approximately $1,123 U.S. dollars per person per year), compared to 17 percent (approximately $11,072 U.S. dollars per person per year) in the U.S. ("Health Spending"). The U.S. spends a much larger portion of its GDP on healthcare than not only Mexico, but also most other nations. A 2018 study by Irene Papanicolas et al. concluded that this is because, compared to most other high-income nations, the U.S. charges much more for procedures and pharmaceutical drugs, gives much higher salaries to its doctors and nurses, and spends more on healthcare administration (1024). The privatized nature of the U.S. healthcare industry allows for less regulation on cost for healthcare services, and therefore generally higher prices for constituents.

The two nations furthermore differ in costs of healthcare per household. INEGI reported that the median household income in Mexico in 2018 was 32,318 pesos per quarter (approximately $5,986.20 U.S. dollars per year). The average household spent approximately $155.24 U.S. dollars per year on healthcare in the same year, amounting to 2.6 percent of total income spent on healthcare ("Derechohabiencia"). For the U.S., the U.S. Census Bureau reports that the median household income in 2019 was $68,703 (Semega et al. 1). Due to the private nature of their health system, costs for healthcare per household vary largely based on the type of

insurance used and health status of household members; however, a 2019 article by the KFF estimated that the average household spent approximately 11 percent of their income on healthcare ("The Real Cost"). This would amount to approximately $7,557.33 U.S. dollars spent on healthcare for the median household income in 2019.

The two systems have some similarities and differences in their amounts of healthcare resources. In 2018, OECD reported that Mexico had an average of 2.4 doctors per 1,000 people, while the U.S. had 2.6 ("Doctors"). The U.S. also has a significantly higher number of nurses, with OECD reporting in 2018 that the nation averaged 11.9 nurses per 1,000 people, as compared to 2.9 in Mexico ("Nurses"). Overall, the U.S. also has more available hospital beds, with OECD reporting that the U.S. had 2.9 per 1,000 people in 2017 and that Mexico had 1.0 per 1,000 people in 2018 ("Hospital Beds").

2. Overarching Effects

The health systems of each nation also affect the overall health of their respective populations. PAHO's *Health in the Americas+* documents significant aspects of health and healthcare of most nations in the Americas and the Caribbean. One of these aspects includes a summary of data from 2010-2016 that details basic indicators of health in each nation, including average life expectancy at birth, infant and maternal mortality (defined by the World Health Organization as death of the mother while pregnant or within 42 days of termination of a pregnancy), and immunization coverage ("Maternal Mortality").

The U.S. has lower rates of both infant and maternal mortality rates than Mexico, with the U.S. reporting an infant mortality rate of 6 per 1,000 live births in 2013 and a maternal mortality rate of 23.8 per 100,000 live births in the same year (PAHO 233). Mexico reported an

infant mortality rate of 12.5 per 1,000 live births in 2013 and a maternal mortality rate of 38.9 per 100,000 live births in 2014 (PAHO 177). Maternity leave is also different for the two nations. Mexico law mandates a minimum of 12 weeks paid leave (Vilar-Compte et al. 383). Legislation in the U.S. ensures that new parents under most employers can take up to 12 weeks of leave without losing their jobs; however, during this leave employers are not required to give pay (Berrigan et al. 2).

The average life expectancy at birth in the U.S. was reported to be 78.8 years in 2014, and in Mexico was found to be 77.2 years in 2016 (PAHO 177, 233). Finally, for immunizations, 87 percent of the population in Mexico was vaccinated against 14 diseases in 2015 (PAHO 179). In the U.S., while there was no data given for the entire population, it was reported in 2015 that over 90 percent of infants between the ages of 19 and 35 months were vaccinated against diseases such as polio, measles, mumps, and rubella (PAHO 234).

It is important to note that these reported variations in population health in the U.S. and Mexico may be caused by a multitude of environmental, social, and economic factors. Therefore, while the function of their respective health systems may have some impact on each nation's population health, it should not be assumed that they are the sole determinant for the reported population health outcomes.

Beyond the health of their people, a noteworthy societal factor that the health systems may have an impact on is the level of and access to education the nation. In Mexico, a 2017 study by Carlo Alcaraz et al. reported that access to free health insurance through Seguro Popular may have had a positive impact on education, as while the program was in place, the nation saw an overall increase in enrollment rates in primary and secondary schools as well as children's standardized test scores (146). For the U.S., a 2014 study by Michael Lovenheim et al. that

focused on access to healthcare in in low-income and underserved communities concluded that an increase of healthcare access through the establishment of school-based health centers in these areas could significantly reduce high school drop-out rates and thereby raise the level of education in the nation (29).

3. Coronavirus Responses

During the time in which this thesis is being written, the coronavirus, or COVID-19, has been the most important issue among world news and public discourse. This major health concern has greatly affected the responsibilities of health systems of every nation around the world. As the pandemic has progressed, Mexico and the U.S. have had varying levels of success in their overall responses to the health emergency.

The first case of COVID-19 in Mexico was reported on February 28, 2020. The Mexican government initially took some measures to prevent the spread such as closing schools, encouraging social distancing, and cancelling sporting events and large gatherings (Caldera-Villalobos et al. 2). However, the government did not allocate the appropriate amount of Personal Protective Equipment (PPE) to hospitals at the beginning of the exponential spread of the pandemic in the nation, causing many healthcare workers to contract the disease from lack of proper protection (Caldera-Villalobos et al. 2).

As a more recent response to the pandemic, the Mexican federal government has implemented what has been deemed a "stoplight system." According to the official website for the U.S. Embassy in Mexico, this system was put into effect in the nation on June 1, 2020 to regulate non-essential social and economic activities in each state ("COVID-19 Information"). Every two weeks, the severity of the virus in each state is determined through an assessment of

the state's case numbers and virus-related hospitalization rates. Based on the findings, each state is assigned one of four colors (red, orange, yellow, and green) that regulates what non-essential activities can take place. For example, red states can only carry out activities considered that are considered essential (including grocery shopping, medical treatments, and maintenance of critical public and social services), whereas green states are permitted to carry out all economic and social activities, with appropriate precautions ("COVID-19 Information"). As of November 24, 2020, the majority of states in Mexico are orange and yellow, with only two red states (Chihuahua and Durango) and two green states (Campeche and Chiapas) ("COVID-19 Information").

Some individual states and cities in Mexico have implemented further restrictions outside of those mandated by the stoplight system, such as imposing curfews, or requiring people to wear masks outside of their homes ("COVID-19 Information"). The Mexican federal government has also been encouraging people in the nation to practice prevention measures including frequently washing hands, wearing masks, and practicing social distancing ("COVID-19 Information").

The number of cases in Mexico is still following a steady increase and has seen a recent spike in case numbers similar to other nations. According to the Coronavirus Resource Center at Johns Hopkins University, as of November 30, 2020, Mexico has had 1,107,071 cumulative cases, 105,655 deaths, and 818,397 recoveries (Center for Systems Science and Engineering). The incidence rate in Mexico (percentage of the population that has contracted the virus) is approximately 0.8 percent, but the case-fatality rate (percentage of virus-related deaths among those that contract it) is about 9.5 percent, which is currently the highest in the world (Center for Systems Science and Engineering).

The first case of COVID-19 in the U.S. was reported on January 20, 2020 (Harcourt et al. 1266). Similar to Mexico, the U.S. also faced a shortage of PPE in the initial stages of the pandemic (Kamerow 1). The U.S. federal government has received much criticism on its overall handling of pandemic prevention (Gerstein 171). In April of 2020, the Center for Disease Control (CDC) began to issue guidelines for citizens to follow, including avoidance of large public gatherings and encouraging citizens to wear masks (Gostin et al. 837). While the CDC has continued to recommend methods to slow the spread of the virus and the federal government has provided a phased plan to reopen the country, legislative implementation of preventative measures has been left predominantly to the discretion of state and city governments. Some states and cities have passed mandates requiring their citizens to wear face masks in public and restricting social gatherings, but others have not. Many have found it difficult to enforce these regulations among the general public (Gostin et al. 837).

Initial interventions in the U.S. helped to slow the spread temporarily; however, case numbers have increased drastically in recent months as regulations have been lifted. The Johns Hopkins Coronavirus Resource Center reports that, as of November 30, 2020, the U.S. has had 13,525,889 cumulative cases of COVID-19 (one of those cases, as of October 1, being the President himself), 267,844 deaths, and 5,065,148 recoveries (Center for Systems Science and Engineering). Currently, the number of cases in the U.S. represents around 21.4 percent of cases worldwide, despite the U.S. accounting for less than 5 percent of the total world population (Center for Systems Science and Engineering). The incidence rate in the U.S. is nearly 4.0 percent, and the case-fatality ratio is approximately 2.0 percent (Center for Systems Science and Engineering).

The health systems of both the U.S. and Mexico impact not only the overall health of their corresponding populations, but also other factors including education. While neither one is better than the other, their different foundations and basic values give each strengths and drawbacks for their constituents.

V. Mexican Immigrants in the U.S. Health System

As they move to the U.S., Mexican immigrants need to find new places in which to receive healthcare. This can be a difficult process, as there are many factors that can affect their access to healthcare, as well as various obstacles that may bar them from receiving it. This section of the thesis will focus on the transition into and the experience of Mexican immigrants in the U.S. health system. This analysis will center on healthcare utilization by Mexican immigrants, such as access to medical care and types of insurance used. This section will furthermore discuss the social and legislative barriers to receiving proper healthcare for legal and undocumented immigrants, as well as those protected under the DREAM Act. Finally, this section will include a brief proposal of how this utilization of healthcare in the U.S. might be improved, and how the barriers to receiving proper healthcare might be diminished.

1. Demographics

In the year 2019, the U.S. Census Bureau reported that of the 60 million people of Hispanic origin living in the United States, 34.8 percent, or almost 20.9 million individuals, were classified as "foreign-born," that is, born in a country other than the U.S. ("Table 8"). Of this demographic, 56.2 percent (almost 11.8 million people) were of Mexican descent ("Table 8"). Finally, the data reports that, of the foreign-born Mexican population, 67.2 percent, or almost 7.9 million Mexican people, were not naturalized citizens (meaning those that have not been granted U.S. citizenship) (U.S. Census Bureau, "Table 8").

It is important to note that the number of non-citizen Mexican immigrants may be significantly higher, as there may be many more living in the U.S. undocumented, and therefore unaccounted for in the official data available to the U.S. government. However, the data

provided on these demographics is still important to consider, as the substantial amount of Mexican immigrants in the U.S. indicates the prominence of this topic and aids in recognizing the significance of the experiences of Mexican immigrants within the health system of the U.S.

2. Access to Healthcare Services

Access to healthcare among Mexican immigrants in the U.S. can depend on many factors, such as one's geographic location, the characteristics of the area one lives in, as well as one's legal immigration status. This section will focus on the utilization of and access to different healthcare services by Mexican immigrants in the U.S. (including basic medical care, mental healthcare, and types of insurance), as well as factors that may affect access to these services. Finally, this section will observe the decision of some Mexican immigrants to seek healthcare in Mexico instead of the U.S.

2.1 Basic Medical Care

Access to and usage of basic medical care differs among all immigrants in the U.S. for various reasons. When observing healthcare access for immigrants in the U.S., the KFF finds that, while specific healthcare programs for immigrants typically offer primary and preventative care, they cannot typically provide more specialized services (Artiga and Diaz). Among Mexican immigrants, utilization of healthcare services differs with documentation status. Vargas Bustamante et al. found in 2010 that undocumented Mexican immigrants were 27 percent less likely than documented immigrants to have had a doctor visit in the previous year, and 35 percent less likely to have a usual source of care ("Vargas Bustamante et al., Variations," 146).

For Mexican immigrants, characteristics of a local population can also have a significant effect on access to healthcare. These characteristics can include languages commonly spoken, as well as ethnicity of other individuals living in the area. Gresenz et al. reported in their 2009 study that Mexican immigrants living in areas with higher concentrations of other Hispanic people found that information about "sources of culturally competent care," (such as bilingual physicians and pharmacy clerks, as well as providers who offered low-cost or charity care) was more easily facilitated and transmitted, which overall improved their access to quality healthcare (1546).

Migration can likewise have a large impact on access to healthcare for immigrants in the U.S. Martinez-Donate et al. found that among Mexican immigrants, rates of utilization of healthcare, as well as the percentage of those that had usual access to healthcare, both decreased when these immigrants moved from their communities of origin to the U.S. Furthermore, more immigrants surveyed reported forgoing necessary medical care in the U.S., most particularly during deportation proceedings, than in their home communities in Mexico (Martinez-Donate et al. 1317-1318). Mexican immigrants that were separated from their spouses or unemployed also typically had less access to healthcare services in the U.S. (Martinez-Donate et al. 1319).

Finally, access of immigrants to basic healthcare services can also have effects on health outcomes. Pérez-Escamilla et al. found that lower access to healthcare often lead to worse health outcomes for Hispanic immigrants. The researchers observed that the lack of access to healthcare and "primary prevention" among Hispanic immigrants can lead to an increase in the number of chronic diseases within the demographic (Pérez-Escamilla et al. 54). Vargas Bustamante et al. predicted that limited access to healthcare among undocumented immigrants could likewise have adverse health outcomes. Undocumented status can discourage doctor visits among these

immigrants for fear of deportation. As such, undocumented immigrants may avoid seeking preventative care for health concerns, which can lead to having to pay for much more costly and dangerous emergent medical treatments if a condition is not treated before it worsens (Vargas Bustamante, “Variations,” 153).

2.2 Mental Health Services

Immigration to a new country can be a traumatic experience, leading to poor mental health outcomes. A 2017 study by Margarita Alegría et al. over the effects of immigration on mental health found that immigration can lead to an increased risk of psychiatric disorders, such as anxiety and depression (148). However, although they may have an increased risk of mental health problems, it is not common among Mexican and other Latin American immigrants to utilize mental healthcare services. In regard to mental and behavioral health, Ortega et al. found in their 2018 study that undocumented Latin American immigrants were particularly unlikely to report experiencing “serious psychological distress”, or to have seen a mental health practitioner within the past year (921). These immigrants were also the least likely of any groups observed in the study to have insurance for mental health treatment, and therefore were the least likely to seek help due to the cost of these treatments without insurance (Ortega et al. 921). Furthermore, a fear of being perceived as “crazy” by others in a community, combined with strong sense of pride, may cause Latin Americans in the U.S., including Mexican immigrants, to repress symptoms of mental illness and refuse to seek help (Barrera and Longoria 8).

2.3 Types of Insurance Used

The 2017 Current Population Survey by the U.S. Census Bureau observed trends of insurance use among foreign-born Hispanic individuals in the U.S. The data from the survey shows that, of the 20.4 million individuals in this demographic, private health insurance was the most popular type used, with 40.3 percent reporting having employer-based insurance, and 15.4 percent using some form of direct-purchase coverage (U.S. Census Bureau, "Table HI09a"). For public insurance use, 21.5 percent of individuals in this group reported being affiliated with Medicaid, 11.7 percent with Medicare, and only 1.6 percent reported using military-provided health insurance (U.S. Census Bureau, "Table HI09a"). Finally, 26 percent of foreign-born Hispanic individuals, or approximately 5.3 million people, did not have some form of health insurance in 2017 (U.S. Census Bureau, "Table HI09a").

Citizenship status was shown to have an effect on health insurance use among this demographic. With the exception of Medicaid, foreign-born Hispanic individuals who were naturalized citizens had higher rates of participation in all public and private insurance options (U.S. Census Bureau, "Table HI09a"). Most notably, the percentage of uninsurance was significantly higher among non-citizen individuals, with 33.9 percent reporting having no health insurance, as opposed to only 12.9 percent of naturalized citizens in this same group.

While this data is based on all foreign-born Hispanic people in the U.S. and not solely those of Mexican descent, it can still be used as a fairly accurate estimate of what health insurance types Mexican immigrants use. As previously stated, people of Mexican descent compose a majority of this demographic. Once again, these statistics may not include all Mexican immigrants residing in the U.S., as there may be many more living in the nation undocumented. It is more difficult to know the exact rates of health insurance for undocumented

immigrants residing in the U.S.; however, it is presumed that rates of health insurance for this demographic are even lower than that of naturalized or documented, non-citizen immigrants. In 2018, the KFF estimated that approximately 45 percent of all undocumented immigrants residing in the U.S. did not have health insurance ("Health Coverage of Immigrants").

2.4 Seeking Healthcare in Mexico

It is not uncommon for residents in the U.S. to travel to Mexico to receive healthcare. A 2019 study by Arturo Vargas Bustamante reported that those that participate in this phenomenon, called "medical tourism," are typically motivated by lower costs of care (most commonly primary and dental care), as well as a wider availability of specialized treatments and medications (12). This is option is particularly popular for those that live close to the U.S.-Mexico border (Vargas Bustamante, "US-Mexico," 12). A large portion of the population that practices medical tourism in Mexico consists of Mexican immigrants living in the U.S. (Vargas Bustamante, "US-Mexico," 2).

A 2008 study by Henry Shelton Brown reported that Mexican immigrants may seek medical services in Mexico in order to save money on healthcare, or to avoid encountering cultural and language barriers in medical facilities in the U.S. (2037). Brown postulates that the decision to receive healthcare outside of the U.S. could partially explain the higher uninsurance rates among Mexican immigrants in the nation, as the utilization of health services across the border discounts the need to enroll in U.S. health insurance programs (2036). However, medical tourism is not a viable healthcare option for all Mexican immigrants in the U.S. Undocumented immigrants are unlikely to participate in the utilization of healthcare services in Mexico, as crossing the border presents too high a risk (Vargas Bustamante, "US-Mexico," 13).

3. Barriers to Receiving Proper Healthcare

When examining access to healthcare, Ortega et al. found that Latin American immigrants were less likely than other groups observed to have a usual source of healthcare other than the emergency department, or to have visited a doctor within the last year (922). This underutilization of healthcare could be due to various barriers that immigrants face when seeking out healthcare in the U.S. Specifically for Mexican immigrants, these barriers might include language, cultural differences, potential misunderstandings caused by differences in expectations of the system as opposed to the reality of the system, as well as legislative obstacles to obtaining insurance and receiving care as an immigrant in the U.S.

3.1 Language

One of the most recognizable obstacles to receiving proper healthcare for Mexican immigrants in the U.S. is the language barrier. Although Spanish is the second-most spoken language in the U.S., there is still a sizable shortage of healthcare facilities that have options for Mexican non-English speakers in the U.S. Pérez-Escamilla et al. found that Hispanic people with lower "language acculturation" (defined here as the level of familiarity one has with the spoken language of a culture other than their own; in the case of the U.S., this term would pertain to familiarity with English) were less likely to possess health insurance or a usual source of healthcare (54). Brooks et al. mentioned that the language barrier can cause issues along many steps of the healthcare process, including misunderstandings when gathering a patient's medical history, as well as uncertainty in a patient about a diagnosis, procedure, medication, or treatment

(32). If important health matters are miscommunicated between a provider and a patient, the results could potentially be very harmful.

The language barrier may cause those with a low English proficiency to forgo seeking healthcare entirely. Brooks et al. found that this avoidance of healthcare can lead to higher rates in chronic diseases and poor health outcomes (33). For Mexican immigrants (as well as Hispanic immigrants in general), this issue is more common in areas with lower rates of other Spanish speakers. Gresenz et al. found in their study that Mexican immigrants living in regions with more Spanish speakers, as well as more Hispanic immigrants, reported having overall better access to healthcare (1555). The researchers postulated that this phenomenon occurs because areas with higher levels of Spanish speakers will likewise have a greater availability of Spanish-speaking healthcare providers, as well as stronger social networks among Spanish speakers and Hispanic immigrants in these areas that help to facilitate information about where to find these providers (Gresenz et al. 1556). However, for Mexican immigrants with a low English proficiency that do not live in areas with these characteristics, obtaining proper healthcare may be more of a challenge.

3.2 Cultural Differences

Differences in culture can likewise become barriers in receiving proper healthcare for Mexican immigrants. Barrera and Longoria report that failing to "accurately 'read relevant cultural cues'" of patients of racial and ethnic minority groups is a common mistake among health practitioners in the U.S. (3). For Mexican immigrants, cultural barriers may include differences in the perception of pain and illness due to social and religious values, as well as differences of opinions on appropriate methods of treatment.

Gender roles may play an important part in the presentation of illness and willingness to seek care in Mexican culture. Some sectors of Mexican culture highly value a social norm called *machismo*. Meaning "manliness" in English, *machismo* pertains to the cultural principles behind how a man should present himself to the outside world (Barrera and Longoria 4). One of these principles includes not showing feelings of pain or admitting to weakness. A 2006 study by Mary Sobralske et al. observed that *machismo* may cause Mexican men who observe it to not seek healthcare unless they are physically incapacitated and unable to go about their normal lifestyle and care for their families (349). Because they are socialized to not admit to pain, men of Mexican culture who observe *machismo* may downplay their health concerns. When seeking healthcare in the U.S., this can be particularly problematic, as a healthcare provider may be unaware of the importance of *machismo* in Mexican culture and thereby may not deliver the best care possible.

Belief in the divine and supernatural may also play a large part in the perception of illness among religious and superstitious individuals in Mexican culture. Faith and prayer may be very important among these people in maintaining or regaining health (Sobralske 349). Others may believe in *fatalismo*, or fatalism, which is the idea that adverse situations are due to supernatural forces that are outside of one's control. In the context of healthcare, this may include the belief that poor health outcomes, such as injuries and illnesses, are not preventable (Barrera and Longoria 3). Those who observe *fatalismo* may avoid seeking healthcare for fear that a provider will not understand their perception of the origins of their health concerns.

Another cultural factor that may present an obstacle in the treatment of Mexican immigrants in the U.S. is the belief in folk illnesses and the preference of traditional medicine to treat health concerns. Pérez-Escamilla et al. highlights that the use of ethnomedicine and

traditional healing is a common alternative to biomedicine in Hispanic immigrant communities, observing that these methods of healing are more prevalent in these communities due to the "deeply rooted cultural beliefs about the origin of health and disease" (Pérez-Escamilla et al. 58).

Some sectors of Mexican culture may believe in folk illnesses that are caused by certain feelings or forms of behavior. A few of the most common causes of these folk illnesses include *susto* (shock or fright) *envidia* (envy), and *mal de ojo* (evil eye, which results from receiving excessive admiration or attention from others) (Barrera and Longoria 3; Paniagua 86-87). To treat these illnesses, individuals may visit a *curandero/a* (folk healer) or a *brujo/a* (witch doctor) (Paniagua 87). Pérez-Escamilla et al. found that often, Hispanic patients will combine traditional healing techniques with biomedicine, and consult a traditional healer before seeing a doctor when they are dealing with an illness (59). In a new healthcare setting, many Mexican immigrants who value folk illnesses and traditional medicine may be hesitant to admit to their beliefs and practices to a healthcare provider for fear that they will be judged or not taken seriously for their beliefs (Sobralske 349).

3.3 Expectations of Care and Understanding the System

As previously described, there are many differences in feature and function between the health systems of Mexico and the United States. As such, Mexican immigrants may experience some confusion and conflict when adjusting to using the U.S. health system. Barriers in receiving healthcare may arise due to expectations of healthcare services not being met by Mexican immigrants as they interact with the U.S. health system, as well as misunderstandings among Mexican immigrants over what healthcare options they may have and their eligibility for various health services.

Those who have never before interacted with the U.S. health system may have certain expectations of the system and the healthcare providers within it. Mexican immigrants who are unfamiliar with the health system in the U.S. might be expecting that a country that is generally considered to be highly-industrialized and well-developed should have a health system that reflects these qualities. Many immigrants may not be prepared for the higher costs and bureaucratic nature of the privatized health system in the U.S., particularly if they are expecting universal healthcare options that most other industrialized countries have.

Immigrants entering the U.S. from Mexico may be used to experiencing a specific standard of healthcare, which may be challenged as they adjust to utilizing U.S. healthcare services. Lauren Clark and Richard Redman conducted a study in 2007 that observed the differences in expectations of the U.S. health system between Mexican immigrant mothers who were new to the U.S., and mothers of Mexican descent who were either native to the U.S. or had been present in the country for some time. Clark and Redman found that those who were new immigrants had higher expectations of the U.S. healthcare compared to those who had been in the country for longer periods of time. The Mexican immigrant mothers surveyed generally reported expecting an accessible and affordable system (680). When receiving healthcare, initial expectations of these mothers included receiving timely care and fast-acting treatments, quality time spent with providers, and culturally-competent care (Clark and Redman 682-685). If their initial expectations about the U.S. health system are not met, immigrants may be more likely to avoid seeking healthcare in the future.

The privatized nature of the U.S. health system also typically leads to higher prices for treatments and medications, which could potentially become an issue if Mexican immigrants are not prepared to devote a greater portion of their income to health-related expenditures. The

conduction of medical practice is likewise different between the U.S. and Mexico. This difference can lead to an avoidance of care among Mexican immigrants if they are uncomfortable with the change. A 2011 study by Sarah Horton and Stephanie Cole focused on Latin Americans in the U.S. who chose to receive their healthcare in Mexico. Those surveyed generally reported that the medical care process in Mexico felt much more personalized than that of the U.S., where stricter regulations by insurance companies can cause the treatment process to appear more business-oriented and bureaucratic (1851). This may lead to Mexican immigrants avoiding visiting healthcare providers in the U.S., as they may be dissuaded by impersonal nature of the U.S. health system.

As the health systems of the U.S. and Mexico are so different, many immigrants may not understand what options they have for healthcare or which services they are eligible for, which can lead to avoiding the health system entirely (Pérez-Escamilla et al. 51). The KFF reported that many immigrants that are eligible for public insurance programs in the U.S. still may remain uninsured due to "confusion about eligibility policies" and "difficulty navigating the enrollment process" ("Health Coverage of Immigrants").

3.4 Legislative Barriers

Besides barriers imposed by social and cultural differences in the U.S., there are actual legal obstacles that Mexican immigrants may have to overcome in order to receive proper healthcare. These legislative barriers may include laws that restrict access to care due to their insurance status, as well as their immigration or citizenship status. This section furthermore focuses on specific barriers that may be faced by recipients of the Deferred-Action for Childhood Arrivals Program, or the DREAM Act.

a. Obtaining Insurance and Receiving Care Without It

Lack of health insurance, as previously stated, can lead to less access to and less utilization of healthcare services. Without health insurance, most healthcare services must be paid for by the recipient out-of-pocket, which may defer uninsured Mexican immigrants from seeking healthcare, which can have potentially harmful effects. While the ACA expanded healthcare opportunities for many in the U.S., obtaining health insurance is still an obstacle that many Mexican immigrants may face.

Citizenship status plays a very important role in options for health insurance and care among all immigrants. Even if an immigrant is a naturalized citizen, they still have limited access to health insurance. Immigrants' participation in the public health insurance programs, Medicare and Medicaid, is very limited by the Personal Responsibility and Work Opportunity Reconciliation Act, as it denies many from receiving public benefits (Parmet and Fischer 633). In their 2020 study over changes in health insurance coverage for immigrants over time, Jessica Cobian et al. report that current this legislation restricts recent immigrants (with the exception of refugees and those seeking asylum) from being eligible for Medicaid until they have been in the nation for five years (2). The official U.S. website for the federal health insurance marketplace states that some "lawfully present" immigrants who are non-citizens (meaning immigrants that are permanent or temporary residents, have valid visas, or are permitted by some form of legislation to remain in the U.S.) can be eligible for some forms of public healthcare coverage, such as the CHIP program under Medicaid, and can also purchase some forms of private insurance (CMS, "Coverage for Lawfully-Present Immigrants").

Mexican-immigrants residing in the U.S. undocumented do not have the options that lawfully-present immigrants do, and therefore face many more legislative challenges in obtaining

health insurance and care in the U.S. Parmet and Fischer reported that many undocumented immigrants of all nationalities work in sectors of the U.S. economy that do not provide health insurance, such as the agricultural and service industries (633). In addition to this, the KFF finds that, even if insurance is offered by their employers, many immigrants are not able to afford it, as they work low-income jobs (Artiga and Diaz). Undocumented immigrants can purchase private health insurance; however, many may not be able to afford it (Artiga and Diaz). Public insurance is likewise difficult, if not impossible, for undocumented immigrants to obtain. As of 2019, the KFF reported that undocumented immigrants are not eligible to enroll in Medicare, Medicaid, or health coverage options through marketplaces provided by the ACA (Artiga and Diaz).

Without insurance or proper documentation status, undocumented Mexican immigrants may have very limited options when receiving healthcare. In the U.S., the Emergency Medical Treatment and Active Labor Act permits that anyone, regardless of citizenship status, can receive emergent medical care in a hospital emergency department. However, rights under this act are still very limited, as "the right it offers ends when a patient is stabilized," that is, when a patient no longer needs emergency care (Parmet and Fischer 633). In the U.S., there are some state and locally-funded health programs that will provide care to immigrants, regardless of immigration status; however, healthcare options for undocumented immigrants of all nationalities are overall very limited throughout the nation ("Health Coverage of Immigrants").

b. Dreamers

The Deferred-Action for Childhood Arrivals Program (DACA, or the DREAM Act) gives certain rights to undocumented immigrants who came to the U.S. as children, and allows young-adult immigrants with temporary work authorization to avoid deportation from the country for a

certain amount of time (Raymond-Flesch et al. 324). However, reprieve from deportation does not change documentation status, and therefore leaves many individuals protected under the act (known as Dreamers) in need of healthcare services without the means to obtain them. As of March 31, 2020, the U.S. Citizenship and Immigration Services estimated that 80.4 percent of Dreamers (approximately 517,460 individuals) were from Mexico, making this issue very prominent in the Mexican immigrant community (USCIS).

Raymond-Flesch et al. found that Dreamers generally had lower healthcare utilization rates and worse health outcomes than non-Dreamers in the U.S. (327). Many Dreamers forgo healthcare solely because they have not been educated on what healthcare options they may have. Dreamers face challenges in navigating healthcare, determining their eligibility for services based on their undocumented status, and finding culturally-sensitive care. Furthermore, many may hesitate to seek healthcare due to the fear that a health issue may interfere with their ability to maintain their immigration status (Raymond-Flesch et al. 327).

4. Ideas for Improvement

As Mexican immigrants face so many challenges in access to healthcare in the U.S., there are many ways that the overall situation could be improved. These methods could include increasing the availability of Spanish-speaking healthcare providers and medical interpreters, mandating a more comprehensive cultural education among students in health professions, and passing legislation that improves access to affordable healthcare and insurance options.

The simplest method to overcoming the language barrier is through education. The most effective manner to decreasing this barrier would be to promote the education of foreign languages among students of healthcare professions. Brooks et al. suggested creating incentives

for bilingual healthcare providers, such as scholarships for training and an increase in hiring (32). Brooks et al. furthermore recommended that access to medical interpretation should be more readily available throughout the U.S. to reduce disparities in medical care for those with lower English proficiency (32). The researchers suggested in their study that more professional medical interpreters should be made available in the U.S., and that healthcare professionals should receive training in how to competently work with them, as well as how to use video-based interpreting when an in-person interpreter is unavailable (Brooks et al. 32).

Barriers created by cultural disparities could likewise be dismantled through comprehensive education of healthcare professionals. In 2019, Marty Jacob Brock et al. conducted a review of cultural immersion in the education of healthcare professionals in the U.S. The researchers found that experiences of cultural immersion had a positive impact on the learning experiences and cultural awareness and sensitivity of students of healthcare professions (Brock et al. 6). Brock et al. stress that including cultural immersion in the education of students in health professions will better prepare them to be "culturally-competent healthcare professionals," which could lead to better patient care overall among healthcare facilities in the U.S. (6).

Finally, access to healthcare for Mexican immigrants in the U.S. could most significantly be improved through changes in legislation. According to the National Family Planning and Reproductive Health Association (NFRRHA), provisions in the ACA give states the option to offer low-income residents a basic health program under Medicaid (Rich 2). However, currently, only New York and Minnesota have implemented this program (CMS, *Medicaid.gov*). NFRRHA suggested that the implementation of basic health programs in more states could decrease uninsurance rates among immigrants in the U.S. by offering a more affordable insurance

alternative (Rich 2). The organization also recommended removing the five-year bar on enrollment in Medicaid programs for immigrants in the U.S. (Rich 5). Access to healthcare specifically for undocumented immigrants could be significantly improved if legislation were passed allowing them to participate in low-cost insurance options offered by the ACA. Steven Camarota et al. estimated in their 2019 study that allowing qualified undocumented immigrants to receive health insurance benefits offered under the ACA would cost the U.S. approximately $10.4 billion per year (3).

Other than legislation promoting insurance enrollment, the U.S. could also implement policies that reallocate government funding to support healthcare programs that offer services to those who are uninsured, as well as non-citizen and undocumented immigrants. NFRRHA suggested implementing policies that promote the development of a culturally-competent healthcare workforce, as well as those that encourage the creation of healthcare centers that will provide services for immigrants, regardless of their legal status (Rich 5). The creation of such legislation could improve access to healthcare as well as health outcomes for Mexican immigrants.

VI. Conclusion

The health systems of the U.S. and Mexico are very different in form and function, and therefore have differing effects on the health of their populations and features of their respective societies. Specifically in the U.S., while there are many demographics that might face challenges in obtaining healthcare, immigrants in particular must overcome many barriers in order to have proper access to healthcare. For immigrants from Mexico, these barriers come in the form of social and cultural differences that may deter them from seeking healthcare, as well as legislative obstacles that prevent them from participating in certain healthcare programs. However, the challenges that these immigrants face do not have to be a permanent issue, as there are many ways that the experience of Mexican immigrants in the U.S. health system could be improved.

1. Limitations

Within this thesis, there are some limitations on the research discussed, specifically when discussing the experience of Mexican immigrants in the U.S. health system. As previously mentioned, while many previous studies have provided data on Hispanic and Latin American immigrants in the U.S. health system, there are not as many that explicitly study Mexican immigrants in this setting. As such, some generalizations had to be made when discussing the experience of Mexican immigrants with healthcare in the U.S. While people from Mexico do compose a large proportion of all Hispanic and Latin American immigrants in the nation, it is still important to note that as the information provided in some studies summarizes the experience of all Hispanic and/or Latin American immigrants, the particular experience of Mexican immigrants may be somewhat different. Furthermore, as previously mentioned, it is not entirely known the number of undocumented Mexican immigrants currently residing in the U.S.

Because these immigrants go undocumented, it is more difficult to obtain quantitative data on their usage of healthcare services, and so the predictions made about them from the sources in this thesis may not have complete accuracy.

2. Future Research

There are various ways that the topics covered in this thesis could be expanded upon in future literature. As national health policies are continuously changing in both nations observed, there is always need for more current research analyzing the effects of new legislation and institutions on health systems and population health. Specifically in the case of Mexico, future research might focus on the effectiveness of INSABI as the new universal healthcare program in the nation. It will be interesting to see how INSABI functions compared to SP in the years to come. In the U.S., where there is no universal healthcare option, literature could be published offering policy suggestions to help reduce the number of uninsured people in the nation. Considering the current circumstances, it is also expected that research will soon be performed examining how COVID-19 may affect the future performance and functioning of health systems in both the U.S. and Mexico.

As previously stated, while there are various studies that focus on Hispanic immigrants overall in the U.S. health system, there are not as many that center on solely Mexican immigrants. Future research could focus more specifically on the specific experiences of Mexican immigrants in U.S. healthcare. Finally, while there are many works suggesting ways that the U.S. health system could be improved for all immigrants, there are not as many suggesting specific ways in which these improvements might be practically implemented. Future research might expand upon this topic.

Appendix

1. Previous Literature

There have been research studies and scholarly articles that concern topics similar to those covered in this thesis. Most particularly, several previous works referenced in this thesis have focused on the transition into the U.S. health system of Hispanic immigrants, as well as immigrants from all over the world. These studies examined different factors that contributed to overall access to healthcare among mainly Hispanic and Latin American immigrants in the U.S., as well as possible factors that positively or negatively affected access to receiving proper healthcare. This section will briefly summarize some of the studies most relevant to issues covered in this thesis.

a. Access to Healthcare Overall

Rafael Pérez-Escamilla et al. published a 2010 article in *NAPA Bulletin* titled "Health Care Access Among Hispanic Immigrants: ¿Alguien Está Escuchando? [Is Anybody Listening?]." By reviewing 77 previous studies, the article discussed many factors that affect access to healthcare among Hispanic immigrants living in the U.S. The study mainly centered on access to healthcare among children and women, migrant farm workers, immigrant families with children who are U.S. citizens, immigrants with noncitizen or undocumented status, and Hispanic immigrants with diverse medical conditions. It furthermore discussed some of the barriers to receiving healthcare in the U.S. for these demographics, such as differences in language or in cultural practices.

Pérez-Escamilla et al. concluded that, when compared with other ethnic and racial groups in the U.S., Hispanic immigrants were particularly at risk for low or no access to healthcare. The

researchers recommended creating healthcare and immigration reforms in the U.S. that would focus on improving the physical and mental health of Hispanic immigrants to remedy this current disparity between this group and others.

Similar to this thesis, the article by Pérez-Escamilla et al. reviewed works that discussed different factors that determine health access among Hispanic immigrants in the U.S., including social and cultural barriers, as well as barriers created by the system itself. The authors of this article focused on many different Hispanic groups, whereas this thesis observes the experiences of immigrants specifically from Mexico.

b. Access to Healthcare by Community Demographics

Health Services Research featured an article in 2009 by Carole Gresenz et al. titled "Community Demographics and Access to Health Care Among US Hispanics," which reported on a study to examine the access to healthcare of specifically Mexican American people (a term which here is used to describe those either born in or with ancestors from Mexico) in the U.S. based on the communities in which they were living. The study analyzed the responses of over 8,000 Mexican Americans living in metropolitan areas from a survey conducted from 1996 to 2002. Gresenz et al. concluded that, among both insured and uninsured Mexican immigrants, the local demographic characteristics of an area in which one lived significantly affected their access to proper healthcare. The researchers observed that this influence was generally stronger for more recent immigrants than it was for immigrants that had been in the U.S. for longer periods of time.

While the research by Gresenz et al. focuses on access to healthcare among people specifically from Mexico, which, as previously stated, is a focus of this thesis, the data from this

particular study is not very recent, and therefore this thesis attempts to use these results as important background information, but also attempts to include relevant data on this issue from more recent studies.

c. Access to Healthcare by Migration Phase

A study by Ana Martinez-Donate et al. examined the access to healthcare among Mexican immigrants from different phases in migration to and from the U.S. The study was detailed in an article titled "Access to Health Care among Mexican Migrants and Immigrants: A Comparison across Migration Phases," and was featured in a 2017 edition of *Journal of Health Care for the Poor and Underserved*. The researchers in this study analyzed data from a survey given to approximately 1,500 Mexican-born people who travelled through Tijuana, Mexico, a common hub for people departing to and returning from the U.S., between 2007 and 2015. Those surveyed included Mexican immigrants bound for the U.S, Mexican immigrants returning from the U.S. voluntarily, and Mexican immigrants returning to Mexico via deportation from the U.S. Immigrants from each migration phase reported on their access to and utilization of healthcare in a different part of the migration cycle: in their communities of origin, in their communities in the U.S., and during detention or deportation proceedings. Martinez-Donate et al. concluded that migration and mobility had an overall negative affect on access to healthcare for these immigrants, and recommended that policies be put in place that offer more affordable and portable options for those in need of healthcare and health insurance, so that immigrants would have better access to healthcare once they left their communities of origin.

The article by Martinez-Donate et al. is particularly relevant to this thesis, in that it discusses healthcare experiences of Mexican immigrants in both the U.S. and in Mexico.

However, the study did not examine the potential barriers that these immigrants face, other than migration, which can lead to lower access to healthcare or the refusal to seek out care at all.

d. Healthcare Utilization and Overall Health Outcomes

In 2018, Alexander Ortega et al. published an article in *Medical Care* titled "Health care access and physical and behavioral health among undocumented Latinos in California," that detailed a study that utilized data from the 2011-2015 California Health Interview Survey to analyze access to healthcare, as well as overall physical and behavioral health, among non-elderly Latin American and U.S.-born, non-Latin American white adults. Ortega et al. concluded that, among immigrants from various regions in Latin America, undocumented immigrants had overall worse access to and utilization of healthcare than any other group observed; however, they also had overall better behavioral and physical health than most other Latin American groups surveyed.

The issues covered in the study by Ortega et al. introduce another important topic of discussion for this thesis, as they cover not only access to healthcare, but also how this access to care, or lack thereof, affects overall health outcomes of Hispanic and Latin American immigrants. It also focuses on the important differences to access and use of healthcare between legal and undocumented immigrants, on which this thesis will attempt a further investigation.

e. Cultural Barriers in Healthcare

A study conducted by Irán Barrera and Denise Longoria examined the cultural barriers among Latin American people to receiving mental healthcare. The study was detailed in a 2018 article in *CLEARvoz Journal* titled "Examining Cultural Mental Health Care Barriers among

Latinos." The article comprised the results of multiple other studies to help explain the possible cultural and social factors among Latin American people that may impede them from receiving quality mental healthcare in the U.S., or even from choosing to receive it at all. Barrera and Longoria found that there were multiple factors that contributed to the overall underutilization of mental healthcare options by Latin American people in the U.S. Some of the most notable findings described included fears by Latin Americans of how they would be perceived by others if they sought help, feelings of pride that led to the repression of symptoms, as well as failings of health practitioners themselves, such as the inability to understand cultural values and religious or spiritual beliefs, and the communication barrier created by a difference in languages. The researchers concluded that finding solutions to fix this disparity in mental healthcare was very important.

This study, like this thesis, discusses some of the various barriers to receiving healthcare in the U.S., which is an issue very relevant to when examining use of health services by Latin American groups in the nation. However, Barrera and Longoria focus solely on mental healthcare rather than healthcare overall, and do not specifically analyze the experience of Latin American immigrants, but rather the Latin American population in the U.S. as a whole.

f. Language Barriers in Healthcare

Katherine Brooks et al. published a 2016 article in *Rhode Island Medical Journal* entitled "Patient Perspectives on the Need for and Barriers to Medical Interpretation." The article describes a study that observed the experiences in the U.S. health system of people with limited proficiency in English. Those surveyed included people from Guatemala, the Dominican Republic, Colombia, and Puerto Rico. Participants described the negative effects that a lack of an

available interpreter had on their experience in the U.S. health system, citing various miscommunications that occurred between themselves and the English-speaking medical professionals. Overall, Brooks et al. concluded that patients with limited proficiency in English were less likely to receive proper medical services, which often led to worse health outcomes. The researchers suggested that an increased availability to medical interpretation would help to reduce these disparities.

While the article by Brooks et al. does not specifically discuss Mexican immigrants in the United States, it is relevant to this thesis in that it discusses the language barrier, an aspect that serves as a particularly large barrier to receiving proper healthcare in the U.S. for those who primarily speak Spanish.

g. Legislative Barriers in Healthcare

A study by Wendy Parmet and Simon Fischer examined the federal and state statutes that restrict immigrants' access to health insurance and care before and during the year 2013. The study was published as an article entitled "Human Rights and Immigrants' Access to Care" in a 2013 edition of the journal *Salud pública de México*. In their article, Parmet and Fischer described several pieces of U.S. legislation, including the Emergency Medical Treatment and Active Labor Act and the Personal Responsibility and Work Opportunity Reconciliation Act, that limited access to health insurance and proper medical treatment for noncitizens in the U.S. Overall, the authors concluded that many noncitizens (a term which here is used to describe immigrants in the U.S. without citizenship status, regardless of ethnicity) residing in the U.S. did not have the human right to health, and they recommended that governing bodies in the U.S. officially recognize this right so that healthcare needs might be met for all.

This analysis by Parmet and Fischer brings an important topic of discussion to this thesis. However, while Parmet and Fischer briefly mentioned the Affordable Care Act, they did not observe specific provisions within the act that may affect immigrants' access to health insurance and care. This thesis will attempt to expand upon this topic.

Overall, these works recognize many of the most prominent aspects concerning immigration and healthcare in the U.S. that will be discussed in this thesis. Several of these studies were not published in recent years, which could affect their relevance, as pieces of legislation, such as the Affordable Care Act, have since been passed in the U.S. Furthermore, some of these works described experiences from all Hispanic or Latin American immigrants in the U.S., and others from non-immigrants in the U.S. of Hispanic and/or Latin American descent, whereas this thesis will attempt to narrow its focus to explicitly experiences of Mexican immigrants. However, these sources, provide important framework to generate a further understanding of the overall experience of Mexican immigrants in the U.S. health system.

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