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# Evaluating the Role of Health Care in Mexico in Undocumented Immigration to the United States

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Abstract

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MA, University of Texas, 2018

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Dissertation Submitted in Partial Fulfillment

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Abstract

Undocumented immigration has been a major social and political problem for the United States with an estimated 11 million immigrants living presently in an undocumented status. In Mexico, 73% of the population live below the poverty line and face challenges in meeting basic needs let alone purchasing private health insurance. In May 2003, the government of Mexico established the *Segura Popular* (popular healthcare) to extend health insurance to underinsured and uninsured communities to address healthcare access inequities. In depth phenomenological interviews were used to explore the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role of healthcare in their push/pull decision to migrate to the United States. Lee's push/pull theory of migration served as the conceptual lens. Utilizing a convenience purposive sampling design, seven participants were recruited using a social media platform. ATLAS.ti software was used for thematic coding and data analyses. The findings revealed that corruption, pay before care, lack of healthcare facilities and doctors were push factors while the perception of free care in emergencies, cheaper insurance, and quality healthcare services were pull factors. The study findings can have positive social change implications by adding to information regarding the relationship between healthcare access and the immigration push to better guide healthcare policy debate for the Hidalgo County, Texas public health authorities and United States Immigration policy setters.

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# Chapter 1: Introduction to the Study

## Introduction

Healthcare access in Mexico over a decade has faced some challenges. According to Pelcastre-Villauerte et al. (2017), 73% of the population in Mexico live below the poverty line of $10 a day and consequently, they are unable to purchase private health insurance. The provision of healthcare services in Mexico can be acquired through public or private insurance, but most of the services are provided under Popular Insurance, known in Spanish as Seguro Popular (S.P.; Hone & Gómez-Dantés, 2019; Martinez-Martinez & Rodriguez, 2020; Sosa & Sosa-Rubi, 2016).

In May 2003, the government of Mexico established the S.P. to extend quality healthcare insurance to the poor, under-insured, and uninsured, to address inequities in quality healthcare access. Unfortunately, the program failed, and many people still lack health insurance and quality health care services (Hone & Gómez-Dantés, 2019; Sosa & Sosa-Rubi, 2016). Only 42.2% of the poor who lack permanent jobs are covered by the S.P. health insurance in Mexico (Martinez-Martinez & Rodriguez, 2020).

The findings of my study will shed light and provide more information on the role of healthcare in Mexico in undocumented immigration to the United States. The findings of this study can have positive implications in the field of public policy, because it will add to our understanding of the relationship between healthcare and immigration and provide useful information to better guide the debate on healthcare policy. The findings of my study will also reveal how healthcare access in the United States motivates some people from Mexico to immigrate to the United States in an undocumented status to have access

to quality healthcare. This information will open a new door for further research on how quality healthcare in the United States can cause undocumented immigration. In this chapter, I provide an overview of the work by highlighting the background of the study, the problem statement and purpose, and research questions. I also present the theoretical foundation of the study, the nature of the study, and its limitations. Finally, I conclude the chapter with a discussion of the potential significance of the study.

## Background of the Study

Inés Ospina (2019), Macías-Rojas (2018), Orrenius and Zavodny (2019), and Roberts (2017) explained that undocumented immigration had become a major political, social, and economic problem in the United States over the decade. According to Heslin (2018) and Hoekstra and Orozco-Aleman (2017), approximately 12 million undocumented immigrants are living in the United States, making it difficult for the government to track the population and implement social intervention policies.

Access to quality healthcare is a problem in Mexico. Pelcastre-Villauerte et al. (2018), Guerra et al. (2018), Hone and Gómez-Dantés (2019), Martinez-Martinez and Rodriguez (2020), Sosa and Sosa-Rubi (2016) explained that about 55% of the population in Mexico lack access to quality healthcare insurance even after the implementation of the S.P. program. According to Sosa and Sosa-Rubi and Hone and Gómez-Dantés, healthcare access in Mexico increased because of the implementation of S.P however, there remains several people who are uninsured or underinsured because of lack of financial resources and effective management of the S.P. by the government. My study will explore the role of healthcare in Mexico in undocumented immigration to the

United States. It will provide in-depth information on lived experiences of undocumented immigrants to better understand the role of healthcare in undocumented immigration to the United States. Also, this information can better guide debates on healthcare public policies.

## Problem Statement

In the United States, undocumented immigration has been a major social and political problem (Robert, 2017). Historically, the long border between United States and Mexico has been the focus of American government in curbing undocumented immigration (Inés Ospina, 2019). Nearly 11 million undocumented immigrants are living in the United States (Heslin, 2018; Hoekstra & Orozco-Aleman, 2017). According to Passel and Cohn (2019), in 2017, there were 10.5 million undocumented immigrants in the United States, including 4.9 million Mexicans (47 %), marking the first time that undocumented immigrants from Mexico fell below half of the total undocumented immigrants (Passel & Cohn, 2019). There are many reasons people immigrate to the United States. According to Macías-Rojas (2018) and Robert (2017), the primary reasons people immigrate to the United States include: employment, fleeing political persecution, reuniting with family, and the desire to live in a free society.

Due to the social, political, and economic issues, such as an abundance of narcotic drugs, pressure on social programs, and pressure on jobs associated with undocumented immigration, Congress, in 1996, passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) to reduce the undocumented immigration (Macías-Rojas, 2018). The probability rate of arrest and apprehension of undocumented immigrants has

increased from 40% in 2000 to 55% by 2015; approximately 304,000 undocumented immigrants were apprehended along the U.S.-Mexican border in the 2017 fiscal year (Orrenius & Zavodny, 2019). Another effect of undocumented immigration is that American citizens are divided on the issue of undocumented immigration and the divisions are along party lines (Robert, 2017).

The nature of health insurance in Mexico and its challenges, such as being expensive, lack of quality healthcare services, and inaccessibility, have been recently studied (Hone & Gómez-Dantés, 2019; Martinez-Martinez & Rodriguez-Brito, 2020; Rivera-Hernández et al., 2019; Sosa & Sosa-Rubi, 2016). There is an existing body of information on healthcare in Mexico, but that research does not significantly focus on ineffective health insurance in Mexico and its relation to undocumented immigration in the United States. This study will fill this gap by contributing to the body of information needed to address the problem by providing an evidence-based approach to inform public policy.

According to Pelcastre-Villauerte et al. (2017), in Mexico, 73% of the population live below the poverty line and face challenges in purchasing private insurance. The provision of healthcare services in Mexico can be acquired through public or private insurance, but most of the services are provided under S.P. (Hone & Gómez-Dantés, 2019; Martinez-Martinez & Rodriguez, 2020; Sosa & Sosa-Rubi, 2016). In May 2003, the government of Mexico established the S.P. to extend quality healthcare insurance to the poor, under-insured, and uninsured, to address inequities in quality healthcare access. This was done through the 1983 amendment of Article 4 of the Mexican Constitution to

provide universal health care for every citizen (Guerra et al., 2018). Unfortunately, the program failed, and many people still lack health insurance and quality health care services (Hone & Gómez-Dantés, 2019; Sosa & Sosa-Rubi, 2016).

Only 42.2% of citizens that lack permanent jobs are covered by the S.P. health insurance in Mexico (Martinez-Martinez & Rodriguez, 2020). The Mexican Institute of Social Security (IMSS), which provides health insurance for only private companies' employees, only covered 36.4% of eligible enrollees as many of them wanted to move to S.P., which is relatively cheaper than the IMSS (Guerra et al., 2018; Martinez-Martinez & Rodriguez-Brito, 2020). Although there exists evidence that S.P. has increased health insurance coverage among the underserved, Mexico has one of the highest out-of-pocket healthcare expenses among the countries belonging to the Organization for Economic Co-operation and Development (Martinez-Martinez & Rodriguez-Brito, 2020). Despite the improvement in healthcare insurance, inequities in healthcare provision and utilization still exist because of lack of finance, personnel, and bureaucracy of the government (Hone & Gómez-Dantés, 2019; Rivera-Hernández et al., 2019; Sosa & Sosa-Rubi, 2016).

According to Artiga and Diaz (2019), Castaneda (2016), and Kuruvilla and Raghavan (2014), even though undocumented immigrants in the United States are denied healthcare from the Affordable Care Act (ACA) they may obtain low-cost care through community health centers and hospitals that receive federal funding and are required to screen and stabilize patients who need emergency care, regardless of their immigration status. Emergency care is backed by the Emergency Medical Treatment and Active Labor

Act (EMTALA) which was first signed into law in 1986 (Kuruvilla & Raghavan, 2014). Also, in many large medical schools, medical students provide free health care to members of underserved communities, including undocumented immigrants, as part of their training rotations (Castaneda, 2016). All these benefits may encourage some Mexicans to embark on undocumented U.S. immigration to access free or lower-cost quality health care for themselves and their children. Therefore, it is important to address Mexico's inaccessible health insurance to reduce the desire to participate in undocumented immigration for the purpose to access free or lower-cost U.S. health care.

## Purpose of the Study

The purpose of this qualitative study was to understand the role of healthcare quality in Mexico in undocumented immigration to the United States. I used a phenomenological approach to engage immigrants from Mexico to explore detailed and in-depth information on how challenges or problems of health insurance in Mexico could encourage some Mexicans to cross to the United States to benefit from a free or lower cost of health care.

I recruited participants who were legal permanent residents and citizens of the United States but focused on their healthcare access experiences both in Mexico and the United States before they became legal residents. Smart phone interview was used to obtain primary data from the participants using principles of confidentiality to protect their welfare. The respondents were selected by using a convenient purposive sampling strategy (see O'Sullivan et al., 2017; Ravitch & Carl, 2016). My study will include persons residing in Hidalgo County, Texas.

## Research Question

My study intended to answer the following principal research question: What are the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role of healthcare in their decision to migrate to the United States?

## Conceptual Framework

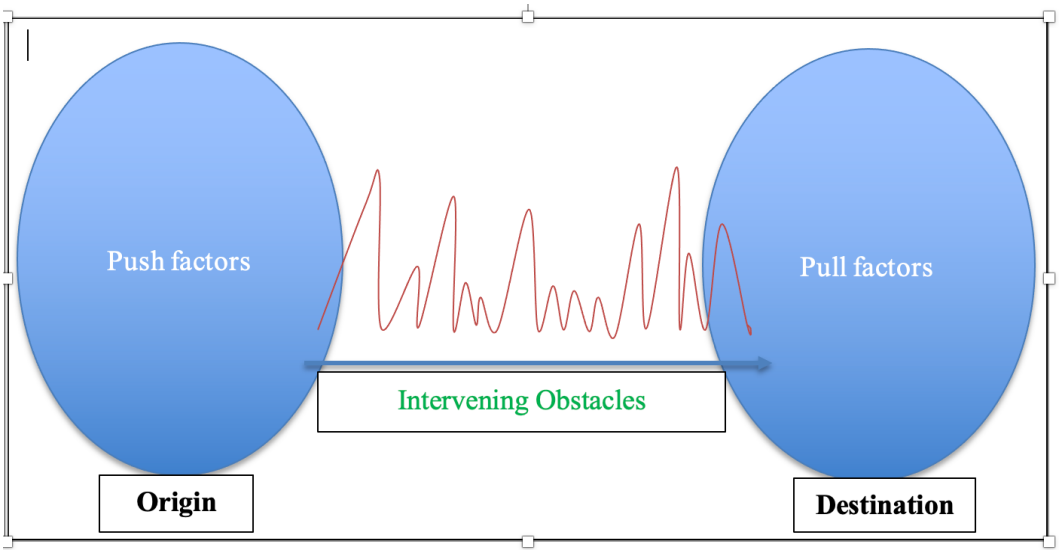
Lee's (1996) push and pull theory of migration served as my conceptual framework. According to Lee, social migration is premised on the push and pull factors with intervening obstacles in the middle. For the push factors, Lee referred to undesirable conditions such as poor healthcare, poverty, fear of political persecution, and famine that force people to leave their homes for other places. The pull factors are conditions such as good health, peace, good jobs, and prosperity that induce, motivate, and attract people to places (Lee, 1996). While the push factors are associated with the place of origin, the pull factors are related to the place of the destination. Lee stated that the decision of a person to migrate is based on four factors: (a) push factors associated with the area of origin, (b) pull factors associate with the area of destination, (c) intervening obstacles, and (d) personal reasons (Lee, 1996). Lee's push and pull theory of migration is suitable for this study because it focuses on problems of healthcare insurance in Mexico encouraging people to enter the United States as undocumented to have access to free or lower-cost quality healthcare services.

The challenges of health insurance in Mexico may be seen as the push factors and the free and lower cost of healthcare services for undocumented immigrants in the United

States through limited government programs may be seen as the pull factors as explained in Lee's theory. The intervening obstacles may refer to border security, distance, and transportation challenges. The personal factors refer to the individual perceptions of both the push and pull factors. Figure1presents the Lee's model of migration.

**Figure 1**

*Lee's Model of Migration*




*Note*. The model explains push factors as undesirable conditions at the original place that discourages people to live there while pull factors at the destination motivate people to move there. The intervening obstacles are conditions people experience or face during movement from place of origin to destination.

## Nature of the Study

My study used a phenomenological approach to examine the "lived experiences" of migrants who experienced ineffective health insurance in Mexico, leading to undocumented immigration to the United States. The study included the recruitment of eligible participants in the United States.

## Definitions

*Affordable Care Act (ACA)*: It is officially knowns as Patient Protection and Affordable Care Act, was passed into law in 2010 to expand the quality and affordable healthcare to the uninsured and underinsured to promote healthcare accessibility (Kuruvilla & Raghavan, 2014).

*Emergency Medical Treatment and Labor Act (EMTALA)*: The Act was signed in 1986 stating that patients in emergency rooms must be treated regardless of their legal status, insurance status, or ability to pay (Kuruvilla & Raghavan, 2014).

*Immigration*: It is the process through which a person or persons become permanent residents or citizens of a different country (Parry, 2019).

*Migration*: It is the movement of people from one location to a particular location because of push and pulls factors (Lee, 1996).

*Push factors*: These are issues that impel an individual to emigrate from his/her country to a different country (Lee, 1996).

*Pull factors*: These are conditions that motivate a person to migrate to a different location.

*Undocumented immigrants*: They are foreign-born individuals living in the United States without authorization (Artiga & Diaz, 2019).

## Assumptions

It is assumed that all research participants will participate willingly and honestly. Another assumption is that all the participants have experienced challenges related to health insurance in Mexico before becoming undocumented immigrants in the United

States. Participant confidentiality will be assured through the informed consent process and interview design; therefore, it is assumed all participants will answer questions truthfully. Finally, based on my background as an immigrant from Africa, I might be biased in reporting some of the findings, but with my professional background, I should be able to eliminate personal biases from the findings.

## Scope and Delimitations

I recruited participants who are now legal permanent residents and citizens of the United States but will focus on their healthcare access experiences both in Mexico and the United States before they become legal residents. This study focused on in-depth interviews of 7 participants. The research results may not reflect the experiences of all undocumented immigrants, but it is assumed that it will represent a representative sample of the target populations' experiences. Hall (2010) interviewed five homeless individuals for a phenomenological study on homelessness, and the results of the interviews indicated that participants' perceptions and experiences represent the entire homeless population in the United States.

My study's main challenge was language barriers. The research participants are Hispanic, and some can only speak Spanish; a language I do not speak. Therefore, an interpreter was used for participants who spoke Spanish for successful interviews. Also, the time and location for interviews may pose an inconvenience, which may affect the quality of the interviews. Another significant concern was the protection of the welfare of the research participants. The confidentiality of the sensitive information provided by the participants is paramount and must be abided by. However, divulging confidential

information of the participants through collection and analysis of data may harm the participants in many ways, including economic, social, and psychological crises. As such, all data will be reported using participant pseudonyms and aggregated themes apart from some identity-protected statements that may help to illuminate individual and collective experiences. My study's purpose and objectives will be explained to the respondents and their informed consent form will be obtained. Also, the SARS-CoV-2 (COVID-19) pandemic may impact participant schedules and appointments, which may affect the study's overall timeline. The final limitation is the transferability and dependability of the research findings as the study is qualitative and employs a non-probability sampling strategy.

## Limitations

I used a phenomenological approach to explore the lived experiences of Mexican immigrants on the role of quality healthcare in their undocumented immigration to the United States. One of the study limitations will be the difficulty in ensuring transferability and dependability of study findings. Even though Lincoln and Guba (1985) and Shenton (2004) explained strategies to achieve transferability and dependability (generalizability) for qualitative research, both admitted it is difficult compared to quantitative research. Secondly, I decided to use a nonprobability sampling technique to select participants. This technique, according to Ravitch and Carl (2016), lacks randomness and enhances the biases of the researcher. However, Moustakas (1994) argued that the nonprobability technique can be used in qualitative research because qualitative research focuses on discovering and providing in-depth information on a topic

to provide a better understanding but not how often something happens. In addressing this, I used a nonprobability purposive sampling to explore my topic. I also used triangulation, member checking, and peer debriefing strategies

## Significance

My study focused on the role of healthcare in Mexico in undocumented immigration to the United States. The findings will enlighten people about the role of healthcare in undocumented immigration to the United Sates. The findings will also have positive implications for social change in the field of public policy since it will add to our understanding of the relationship between healthcare and immigration and provide useful information to better guide the debate on healthcare policy.

## Summary

In Chapter 1, I presented the background of the topic. I also detailed the problem statement, purpose, and nature of the study in this chapter. I concluded Chapter 1 by outlining the research questions, presented the conceptual framework, explained some technical terms and research assumptions, outlined the scope and limitations, and finally discussed the significance. Chapter 2 contains an in-depth literature review on undocumented immigration, healthcare challenges in Mexico, and the conceptual framework. Chapter 2 also presents a literature review on the research method and approach. In Chapter 3, I presented information on the design of the research, role of the researcher, selection of research participants, and instrumentation. This chapter also covered procedures for data collection, data analysis plan, ethical procedures, and issues of trustworthiness.

# Chapter 2: Literature Review

## Introduction

My study focused on exploring the research question: What are the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role of healthcare in their decision to migrate to the United States? This chapter presents an approach for reviewing the literature. It includes an outline of the historical, philosophical, and theoretical perception that entails immigration, undocumented immigration, migration, and healthcare. The review of the literature starts with an overview of the historical account of immigration, its effects, and policies put in place to reduce undocumented immigration. The second section will present scholarly literature relating to healthcare and its challenges in Mexico as well as healthcare for undocumented immigrants in the United States. This chapter will also include a review of the literature regarding the conceptual framework for the study. The final section will address the literature review related to the approach and methodology.

## Literature Search Strategy

For an intensive understanding and illustration of the theoretical and abstract frameworks of the topic matter, the following databases were conjointly utilized: EBSCO, ProQuest, ERIC, Google Scholar, and Healthcare Periodicals. I used the following keywords in the search: *immigration, undocumented immigration, undocumented immigration, migration, healthcare insurance, migration theories, and push-pull theory*. I used relevant information from research articles, dissertations, books,

seminars, and organizations websites and the scope of publication year ranges from 1985 to 2020.

## Historical Account of Immigration

Immigration is the process of moving to a new country to reside there permanently (Connor, 2013; Parry, 2019). People who moved to a new country are called immigrants, but these persons are called emigrants from the old country they moved away permanently (Conner, 2016). Connor (2016) stated that the United Nations (UN) estimated there to be 232 million international migrants in the world, which is slightly more than 3% of the world's population. This percentage would be estimated to represent the world's fifth-most populous country if all the world's migrants were living in a single country (Connor & López, 2016).

According to Massey (1999), the modern history of international migration can be divided into four periods: (a) the mercantile period, from 1500 to 1800 in which immigration was dominated by Europe as a result of colonization and economic growth; (b) the industrial period, which began from early 1800 to 1925 when more than 48 million persons left Europe to the Americas and Oceania with a concentration of 85% to five countries [Argentina, Australia, Canada, New Zealand, and the United States], with the United States receiving 60 % of the 85% immigrants; (c) period of limited migration, occurring in the 1930s where the receiving countries, most notably the United States, had passed restrictive immigration laws because of the Great Depression; and (d) the period of postindustrial migration in the 1960s during which immigration became a global issue where sending countries like United Kingdom, France, Sweden, Italy, and Portugal as

well as the United States witnessed an overflow of immigrants from the developing countries into their boarders.

Another history of mass movement of people occurred in Cuba in 1980 and 1994 (Martinez et al., 2015). In 1980, because of political and economic pressure on Cubans, about 10,000 Cubans invaded the Peruvian Embassy seeking asylum and the Cubans responded by opening port of Mariel to persons wishing to leave the country (Martinez et al., 2015. They took the opportunity to decongest the prisons by expelling imprisoned homosexuals and other prisoners. As a result of this mass immigration, more than 125,000 Cuban refugees arrived in Miami, Florida. Again, in August 1994, about 35,000 Cuban fled to Florida following the rafter crisis (Martinez et al., 2015).

**Immigration in the United States**

The United States has more immigrants than any other country in the world (Budiman, 2020; Connor & López, 2016). Between 1880 and 1910 about, 17 million European immigrants entered United States (Parry, 2019). More than 1 million immigrants arrive in the United States each year (Budiman, 2020). As of 2015, the UN stated that the immigrant population in the United States is about 46.6 million (Budiman, 2020; Connor & López, 2016). This represents 19% of the international immigrants. The immigrant population in the United States is nearly four times that of the world's next largest immigrant destination – Germany, with an estimated immigrant population of 12 million (Budiman, 2020; Connor & López, 2016). According to Budiman (2020), in 2020 immigrants constituted approximately 13.7% of the U.S. population, 4.8 % in 1970, with

one of the largest migrations in the late 1800's to fuel the U.S. industrial age. It is estimated in 1890 that14.8% of the U.S. population, 9.2 million people, were immigrants.

Budiman (2020) further explained that only 77% of the immigrants in the United States have followed legal processes and the rest are undocumented. It is important to stress that since the formation of the federal Refugee Resettlement Program by the Refugee Act in 1980, about 3 million refugees have admitted into the United States, more than any other country in the world (Budiman, 2020; Connor & López, 2016).

***Where Do U.S. Immigrants come from?***

The United States of America is being described as the land of immigrants according to Massey (1999), Parry (2019), and Robert (2017). Every year, about 1 million immigrants arrive in the United States from all parts of the world; Mexico, China, India, Philippines, El Salvador, Europe, Canada, Caribbean, Middle East, North Africa, and sub-Saharan Africa (Budiman, 2020; Connor & López, 2016; Massey, 1999). For the estimated 46.6 million immigrants of the United States, Mexico is the highest sending country. In 2018, about 11.2 million (25%) immigrants living in the United States were from Mexico, 6% each from China and India, 4% from the Philippines, 13% from Europe and Canada, 10% from the Caribbean, 8% from Central America, 7% from South America, 4% from the Middle East and North Africa, and finally 5% came from sub-Saharan Africa (Budiman, 2020). In recent years new immigrant arrivals in the United States have declined due to increasing immigration controls (Budiman, 2020; Orrenius & Zavodny, 2019).

### *Undocumented Immigration*

Most people have immigrated to the United States legally, but some have settled in the country without permission. According to Martinez et al (2015), the term undocumented immigrant is applicable under the following conditions: (a) legally entered the country but remained in the country after their visa or permit expired; (b) received negative remarks on their refugee or asylee application but remained in the country; (c) experienced changes in their socioeconomic position but could not renew residence permit but remained in the country; (d) used fraudulent documentation to enter the country; and (e) unlawfully entered the country. Many of these people were desperate for a job, a better life, or family reunification (Artiga & Diaz, 2019; Macías-Rojas, 2018; Parry, 2019)

Robert (2017) explained that undocumented immigration has been considered one of the major social, economic, and political problems in the United States. According to Robert, polls conducted over the last 15 years revealed most Americans believe that U.S. borders are not secured, and that the federal government could do more to reduce undocumented immigration. As a result of this perception, border security has remained the most controversial focal point of concern in the United States (Inés Ospina, 2019; Roberts, 2017).

Nearly 11 million undocumented immigrants live in the United States (Heslin, 2018; Hoekstra & Orozco-Aleman, 2017). Budiman (2020) stated that from 1990, the population of undocumented immigrants increased from 3.5 million to a high record of 12.2 million in 2007. However, by 2017, Passel and Cohn (2019) estimated the

undocumented immigrant population had decreased by 1.7 million, accounting for 10.5 million of which 4.9 million were estimated to be Mexicans. This constitutes 47% of undocumented immigrants from Mexico in 2017, the first time the undocumented immigrants from Mexico fell below half of the total undocumented immigrants (Passel & Cohn, 2019). Budiman added that the 10.5 million undocumented immigrant population constituted 3.2% of the overall U.S. population in 2017. Between 2007 and 2017 there was a decrease of the Mexican undocumented immigrants by 2 million leading to an overall decline of the undocumented immigrants from 12.2 million to 10.5 million in the United States (Budiman, 2020; Passel & Cohn, 2019).

***U.S. Public Perception of Undocumented immigrants***

According to Gramlich (2019), a survey was conducted in June 2018 to obtain opinions about immigrants in the United States. In this survey, only 45% of Americans said most immigrants are in the country legally, but 35% incorrectly said that most of the immigrants are in the country in an undocumented status. In another survey conducted before the 2018 midterm elections among registered voters who planned to vote for Republican and Democratic Parties, 75% of registered voters who planned to vote for the Republican candidate said undocumented immigration was a serious problem in the country against 19% among voters who planned to support Democratic candidate (Gramlich, 2019). Gramlich also stated that 69% of Republicans agreed that expanding the wall along the U.S Mexican border is a major restrictive measure to reduce undocumented immigration, but 70% of Democrats indicated that measure would not be effective in reducing undocumented immigration.

Baranowski (2012) and Krogstad (2020) stated that 74% of U.S. adults said they favor granting permanent legal status to immigrants who came to the United States as undocumented. Baranowski added that a survey was conducted among 686 participants about perceptions of undocumented immigrants from Mexico. The findings revealed that Latinos have more positive attitudes towards undocumented immigrants than White Americans. Also, participants with higher education endorsed respect for undocumented immigrants from Mexico more compared to participants with lower or without education (Baranowski, 2012). Finally, participants who live within 200 miles of the U.S.- Mexican border have less tolerant attitudes towards undocumented immigrants from Mexico than participants who live far away from that region.

**Effects of Immigration**

There has an overwhelming pressure on healthcare infrastructure in the United States and one of the causes is the rapid growth of undocumented immigrants (Muschek, 2015). Muschek added that the U.S. federal government spent about $29 billion to take care of undocumented immigrants in the 2010 fiscal year. Out of this expenditure, $10.7 billion was spent on providing healthcare for undocumented immigrants (Muschek, 2015).

Undocumented immigration has led to an increase in population and an overwhelming pressure on social welfare programs in the United States (Macías-Rojas, 2018; Muschek, 2015; Orrenius & Zavodny, 2019). Kerwin (2018) stated that, between 1997 and 2018, the budget of the U.S. DHS has increased from $1.935 billion to $21.1 billion in efforts to enhance border security and control undocumented entries. This

spending, including expenditure on the healthcare of immigrant children, drains the federal coffers (Kerwin, 2018). According to Rueben and Gault (2017), when all the costs of public goods are distributed to everyone in the United States, immigrant adults are estimated to be more dependent on state and local budgets than native adults. There was a $2,950 gap difference in budget impact between immigrants and individuals born in the United States between 2011and 2013.

Borjas (2019) mentioned that from 1990 to 2014 the U.S. Gross Domestic Product (GDP) would have been 15% less without the contribution and hard work of immigrants. Borjas further explained that when the immigrants' population increases by 1%, the economy of the United States grows by 1.15%. This means that an increase in immigration has been seen as a great contributor to the economic growth in the United States. In 2016, foreign-born alone constitutes 16.6% of the labor force in the United States contributing meaningfully to generating national wealth and output (Borjas, 2019). According to Desilver (2019), in 2014 27.6 million immigrants were present in the U.S. workforce of 161.4 million and out of the 27.6 million immigrants, 19.6 million came to the United States legally; an estimated 8 million are undocumented (Desilver, 2019). Immigration has been considered as source labor for the United States. In 2014, 33% of farmworkers were immigrants, 45% of private households were immigrants, and 36% of the textile and manufacturing industries employed immigrants (Desilver, 2019). Gubernskaya and Dreby (2017) added that, generally, family-based immigration has a positive impact on the economy of the United States compared to negative effects.

**Healthcare and Undocumented immigrants**

Flavin et al. (2018) mentioned that 52% of people in the United States believe that expenditure on immigrants' healthcare is a great burden on the economy and 67% of the public hold the belief that undocumented immigrants should not qualify for social services including healthcare. In the light of this, federal policies have been put in place to deny undocumented immigrants' access to public healthcare insurance, Medicare, and Medicaid (Artiga & Diaz, 2019; Castaneda, 2016; Flavin et al., 2018; Kuruvilla & Raghavan, 2014). The ACA, which was enacted in March 2010 by Congress to expand access to quality healthcare, categorically denied undocumented immigrants from being covered (Artiga & Diaz, 2019; Castaneda, 2016; Flavin et al., 2018; Kuruvilla & Raghavan, 2014). However, undocumented immigrants may obtain low-cost health care through community health centers, and hospitals that receive federal funding must screen and stabilize patients who need emergency care for free regardless of their immigration status. Emergency care is backed by the Emergency Medical Treatment and Active Labor Act (EMTALA) which was first signed into law in 1986 (Kuruvilla & Raghavan, 2014). Also, in many large medical schools, medical students provide free health care to the poor including undocumented immigrants as part of their training rotations (Castaneda, 2016).

Allyn (2019) stated that California is the first U.S. state to provide state government-subsidized health benefits to young undocumented immigrants. California, since 2016, has allowed children less than 18 years to benefit from state taxpayer-backed healthcare regardless of their immigration status (Allyn, 2019). Allyn added that the low-

income undocumented immigrants aged 25 or younger are being covered by California's Medicaid program.

**Recent Efforts to Prevent and Reduce Undocumented Immigration**

Due to the sociopolitical and economic issues, such as an abundance of narcotic drugs, pressure on social programs, and pressure on jobs associated with undocumented immigration, Congress, in 1996, passed the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) to prevent or reduce the undocumented immigration (Macías-Rojas, 2018). Orrenius and Zavodny (2019) stated that about 304, 000 undocumented migrants were arrested along the U.S. – Mexican border in 2017. This is the lowest rate of apprehension since 1971. Robert (2017) corroborated that successful undocumented entries in the United States have been reduced by 90% between 2005 to 2015 (from 2 million to 200,000) as a result of enhancing border security ranging from added personnel to fencing to motion camera detection and the use of aerial surveillance.

The campaign of President Trump during the 2016 elections focused on the negative effects of immigration included safety, narcotic abundance, rape, and job security, and called for the need to extend the U.S.-Mexican southern border (Pierce, 2019). According to Pierce (2019), many enforcement measures were undertaken by the Trump Administration to reduce undocumented immigration included if not all: (a) National Guard deployment to the U.S. – Mexican border. As of March 2019, about 2,100 National Guards troops were still stationed at the border; (b) on April 6, 2018, the Trump Administration declared a zero-tolerance policy on undocumented immigration resulting in thousands of children being separated from their families; (c) active-duty

military deployment to the border in October 2018; and (d) increasing border patrol staffing. In January 2017, President Trump ordered hiring 5,000 additional Border Patrol officers and by the end of 2018, there were 21,370 officers authorized by Congress (Pierce, 2019).

On April 29, 2019, the Associated Press reported that Acting Defense Secretary Shanahan instructed that additional 230 troops be deployed to the southern U.S.-Mexican border to help Customs and Border Protection (CBP) officers intensify efforts to secure the border against undocumented entries. This deployment, approved by the Acting Defense Secretary Shanahan, cost the federal government an estimated $7.4 million. This money could have been used to address other social and economic challenges (Pierce, 2019).

## Healthcare

Baltagi et al. (2017) investigated a relationship between healthcare expenditure and individual income among 167 countries between 1995 and 2012. Their findings revealed that healthcare is an essential service rather than a luxury and that the prices of healthcare services of countries depend on the level of the country's income distribution. Lower-income level countries tend to have a higher income elasticity of demand for healthcare services (Baltagi et al., 2017). The cost of healthcare over the years has increased in the United States and in developing countries alike deterring many people from accessing healthcare.

During the 67th meeting of the UN General Assembly in New York, all member-countries passed a resolution in support of universal healthcare systems (Hynes, 2013).

The tenets of the resolution emphasized and encouraged member-countries to provide and deliver affordable and quality-driven healthcare services to all individuals to help to achieve the UN Committee's goals (Hynes, 2013). Hynes added that the resolution directed member-states to roll out health care policies that do not require healthcare consumers to pay for important medical services because expensive out-of-pocket payments can deny poor people quality healthcare access. The UN Committee admitted challenges facing universal healthcare accessibility but stated that universal healthcare is worth pursuing as it is the foundation of sustainable development and a means for poverty reduction. About 150 million people each year face difficulties to pay their medical bills worldwide and many must sell their assets or go into debt to offset their healthcare bills (Hynes, 2013).

Murtaza (2020) used the Lee's push/pull model to explain that United States has been on top in the world for receiving immigrants since 1970. The immigrants are motivated to migrate to the United States because of availability of healthcare facilities, services, and economic opportunities (International Organization for Migration, 2020; Justice for Immigrant, n.d; Murtaza, 2020). Murtaza further explained that Mexico is the second largest country of origin for immigrants after India. To collaborate Murtaza, the report of IOM in 2020 stated that 11.8 million Mexicans migrated out of Mexico and 17.5 million Indians left for abroad in 2019. Using Lee's push and pull theory, Murtaza demonstrated that people migrated from different places like Africa, South America, and Asia because of lack healthcare services and facilities to the United States for quality healthcare services and better life.

**Healthcare Access in Mexico**

Many countries, including Mexico, still face challenges for ensuring universal health coverage following the UN's resolution and the Group of Twenty's (G20) declaration and commitment to providing universal health coverage (Hone & Gómez-Dantés, 2019). Mexico has been in the spotlight related to its effort to expand quality universal healthcare among its citizens. Hone and Gómez-Dantés (2019), Martinez-Martinez and Rodriguez-Brito (2020), Rivera-Hernández et al (2019), and Sosa and Sosa-Rubi (2016) identified these challenges to include difficulty in examining the term "universal," providing "quality healthcare" services, not just access, what type of medical services to provide, lack of political consensus, and lack of resources. According to Pelcastre-Villauerte et al. (2017), in Mexico, 73% of the population live below poverty and face challenges to get insured.

According to Hone and Gómez-Dantés (2019), over the years, Mexico has been advancing healthcare as a social right, expanding healthcare to the uninsured, and has invested in infrastructure. The provision of healthcare services in Mexico can be acquired through public or private insurance, but most of the services are provided under Popular Insurance, known in Spanish as *Seguro Popular* (S.P.; Hone & Gómez-Dantés, 2019; Martinez-Martinez & Rodriguez, 2020; Sosa & Sosa-Rubi, 2016). In May 2003, the government of Mexico established the S.P. to extend quality healthcare insurance to the poor, underinsured, and uninsured, to address inequities in quality healthcare access. This was done in line with the 1983 Amendment of Article 4 of the Mexican Constitution to provide universal health care for every citizen (Guerra et al., 2018).

Unfortunately, the program failed, and many people still lack health insurance and access to quality health care services (Hone & Gómez-Dantés, 2019; Sosa & Sosa-Rubi, 2016). Only 42.2% of the poor that lack permanent jobs are covered by the S.P. health insurance in Mexico (Martinez-Martinez & Rodriguez, 2020). The Mexican Institute of Social Security (IMSS), which provides health insurance for only private companies' employees, covered only 36.4% of eligible enrollees as many eligible enrollees sought to be covered under S.P., which is relatively cheaper than the IMSS (Guerra et al., 2018; Martinez-Martinez & Rodriguez-Brito, 2020). However, the S.P. is not resourceful to insure them.

Although there exists evidence that S.P. has increased health insurance coverage among the poor, Mexico has one of the highest out-of-pocket healthcare expenses among the countries belonging to the Organization for Economic Co-operation and Development (Martinez-Martinez & Rodriguez-Brito, 2020). Despite the improvement in healthcare insurance, inequities in healthcare provision and utilization still exist because of lack of resources, corruption, and inefficiency of the government (Hone & Gómez-Dantés, 2019; Rivera-Hernández et al., 2019; Sosa & Sosa-Rubi, 2016). Lack of resources, such as inadequate health personnel, finance, and healthcare facilities especially in the rural areas have affected accessible healthcare in Mexico (Hone & Gómez-Dantés, 2019; Rivera-Hernández et al., 2019; Sosa & Sosa-Rubi, 2016).

## Conceptual Framework

Lee's push and pull theory served as my research lens. Lee (1996) and Liang (2006) stated that Ravenstein, who has been considered the originator of the theory of

migration and expert in a social movement, defined migration as moving from one location to another location as a resident for pressing issues. There are two basic types of migration; inter-migration (between countries) and intra-migration (within one country; Lee, 1996; Waldinger et al., 2008). Waldinger et al. (2008) emphasized that the theory of migration is broadly perceived on basis of international migration which is driven by a country's economy, healthcare, political, racial, and cultural identities, and tolerance.

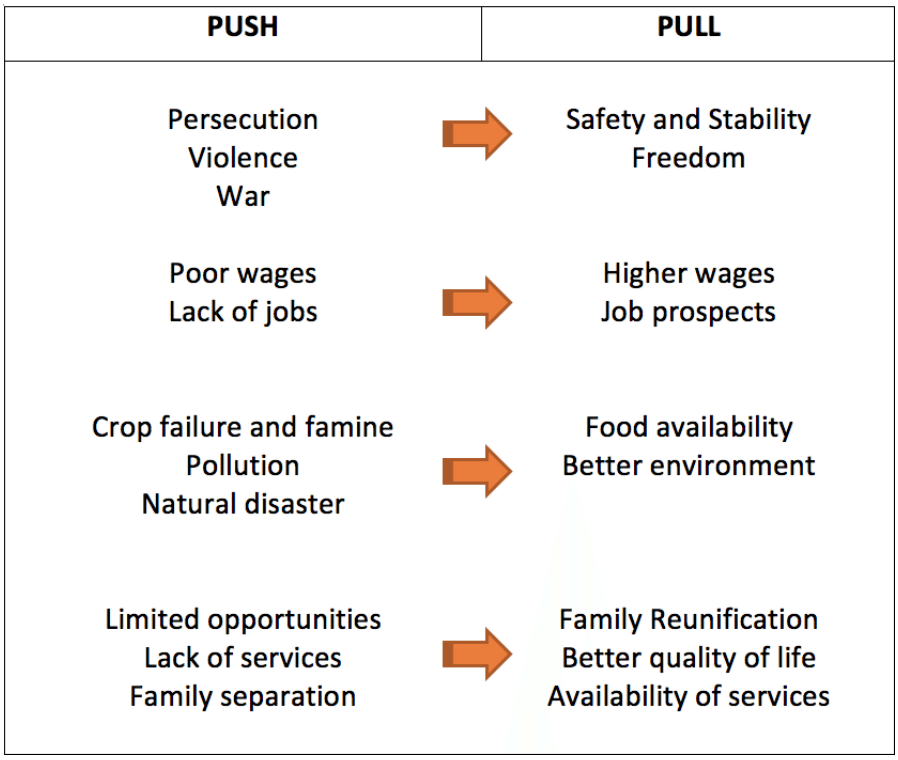
Lee on April 23, 1965, at the Annual Meeting of Mississippi Valley Historical Association, Kansas City, presented an academic paper on migration and why people immigrate or emigrate (Lee, 1996). Lee explained that social migration is premised on the push and pull factors with intervening obstacles in the middle. For the push factors, Lee referred to undesirable conditions such as poor healthcare, poverty, fear of political persecution, and famine that force people to leave their homes for other places. The pull factors are conditions such as good health, peace, good jobs, and prosperity that induce, motivate, and attract people to places (Lee, 1996). While the push factors are associated with the place of origin, the pull factors are related to the place of the destination. Lee stated that the decision of a person to migrate is based on four factors: (a) push factors associated with the area of origin, (b) pull factors associate with the area of destination, (c) intervening obstacles, and (d) personal reasons (Lee, 1996).

Murtaza (2020) investigated causes of international migration and used Lee's push and pull theory as a framework. In this work Murtaza mentioned availability of healthcare services as a pull factor for migration to the United States and lack of quality healthcare facilities as push factor. Wurie (2012) also used Lee's push and pull model to

demonstrate reasons Latinos in Cuba, Mexico, and El Salvador came to the United States. Justice for Immigrants (2017) also used Lee's push and pull theory to illustrate the difference between push and pull factors on international immigration. Faridi (2018) explained that Lee's theory of push/pull is one of the best models of theories of migration. Faridi added that the push/pull theory examined causes of migration both at the place of origin and destination. Faridi further implied that lack of healthcare services may push people out of their places and available healthcare services attract immigrants as a pull factor. Justice for Migrants (2017) illustrated how lack of healthcare services and availability of healthcare services can serve as push and pull factors under Lee's theory (See Figure 2).

**Figure 2**

*Push/Pull Factors of Immigration*



*Note*. Lack of services as push factors refers to lack of quality healthcare services and facilities in original location. From "Root Causes of Migration" by Justice for Immigration, 2017, https://justiceforimmigrants.org/what-we-are-working-on/immigration/root-causes-of-migration/#_edn14. Public Domain.

Problems of accessing healthcare insurance in Mexico may be encouraging people to enter the United States as undocumented immigrants to have access to free or lower-cost quality healthcare services. The challenges of health insurance in Mexico may be seen as the push factors and the free and lower cost of healthcare services for undocumented immigrants in the United States through limited government programs may be seen as the pull factors as explained in Lee's theory. The intervening obstacles may refer to border security, distance, and transportation challenges. The personal factors refer to the individual perceptions of both the push and pull factors.

## Methodology and Approach

I employed a phenomenological approach to explore and examine lived experience of the research participants on the quality of healthcare in Mexico in undocumented immigration to the United States. According to Denzin and Lincoln (2008), Husserl was considered the father of phenomenological approach because he used the approach to conduct many research studies on the behavior and lived experiences of people. Moustakas (1994) phenomenology research makes it possible for a researcher to actively engage participants to explore lived experience on concerning social issues. Moustakas further explained that under phenomenological research, a researcher should focus on personal observations, participants' experiences, and emotions to make meanings. Phenomenological research also focuses on listening, documenting, and

interpreting lived experiences and behaviors in real life (Moustakas, 1994; Patton, 2015; Ravitch & Carl, 2016; Sloan & Bowe, 2014). Moustakas and Ravitch and Carl (2016) summarized phenomenology characteristics to include: (a) focuses on meanings of lived experiences, (b) aligns with qualitative research method, (c) does not predict relationships between variables as in quantitative research, (d) the approach fully engages research participants attention as they account their experiences, and (e) the approach focuses on meanings and not how frequently an event occurs or is repeated.

Wurie (2012) conducted a qualitative study and used the phenomenology approach with 7 participants. The study focused on exploring the lives of Salvadoran families after the implementation of IIRIRA. This study is similar to my study as both focus on exploring lived experience of a particular group of people (immigrants) in the United States. While Wurie's population was the Salvadoran community, mine will target the Mexican immigrants in the United States. Hall (2010) employed a phenomenology approach to understanding the challenges of homeless individuals towards self-independence. Hall also used this approach to elicit lived experience of homeless people as I intend to use it to understand lived experience of immigrants on healthcare insurance challenges in Mexico to undocumented immigration in the United States. Finally, another important literature review on the approach is the work by Davis and Erez (1998). These authors used a phenomenology approach to examine the lived experiences of immigrants towards the multicultural criminal justice system in the United States. I have the same reason to use the phenomenology approach as the authors, but the difference is the target population. For these notions, I used a phenomenology approach to provide in-depth

accounts of Mexican immigrants on healthcare insurance challenges in Mexico to undocumented immigration in the United States.

## Summary and Conclusion

As articulated in chapter 2, undocumented immigration has been an issue in the United States and nearly 11 million undocumented immigrants are living in the United States making it difficult for the government to track the exact population. The growing number of undocumented immigrants over the decades has put pressure on social service and welfare programs and the inflow of narcotic drugs through the southern U.S.-Mexican border. This chapter presented a literature review on focused immigration patterns, specifically undocumented immigration to the United States, and its effects and efforts made to prevent or reduce undocumented immigration by the Trump Administration.

This chapter also covered a literature review of healthcare insurance in Mexico and its challenges. Lee's push and pull theory served as my conceptual lens. The theory posits that people begin to move to different places because of push and pull factors. Lee's push and pull theory is appropriate and aligns with the purpose of the study. The study focused on exploring undocumented immigrants' experience on the role of quality healthcare in undocumented immigration to the United States. Chapter 3 contains information describing my methodological approach to explore the lived experience of undocumented U.S. immigrants. Chapter 3 outlines the research design, sample size, processes for participant selection, instrumentation, the procedure for data collection, plan for data analysis, ethical issues, and issues of trustworthiness.

# Chapter 3: Research Methodology

## Introduction

This study relied on a phenomenological research approach to elicit a detailed lived experience of Mexican immigrants on problems of health insurance in Mexico as a driver for undocumented immigration to the United States. I explored the lived experiences of adults who have immigrated to the United Status in a previous undocumented status to provide an in-depth look at information regarding healthcare access as a driver for their immigration journey. This chapter elaborated on the research questions, interview questions, qualitative methodology, role of the researcher, procedures of data collection, ethical concerns, phenomenology inquiry, validity, reliability, and conclusion.

## Research Design and Rational

### Research Question

The main research question was: What are the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role of healthcare in their decision to migrate to the United States?

### Qualitative Method

I relied on a phenomenological design to investigate the lived experience of Mexican immigrants on the role of health insurance problems in Mexico in relation to its push factors for undocumented immigration to the United States. Denzin and Lincoln (2009), O'Sullivan et al (2017), Patton (2015), and Ravitch and Carl (2016) opined that phenomenological focuses on eliciting and interpreting lived experiences and narrations

while the quantitative method is appropriate for studies that focus on testing hypotheses to understand causal relationships between variables or phenomena. O'Sullivan et al and Ravitch and Carl did further explain that the choice of research method is determined by the nature of the research question. If the research question is exploratory and seeks to provide in-depth information about a problem, the appropriate research method is qualitative (Denzin & Lincoln, 2009; O'Sullivan et al., 2017; Ravitch & Carl, 2016). Based on this and the purpose of my research, the appropriate method I used is the qualitative method.

**Phenomenological Research**

Phenomenology is one of the approaches of qualitative research. It focuses on listening, documenting, and interpreting lived experiences and behaviors in real life (Moustakas, 1994; Patton, 2015; Ravitch & Carl, 2016; Sloan & Bowe, 2014). According to Denzin and Lincoln (2008), Husserl was considered the brainchild behind the phenomenology approach as he used the approach to conduct research on the behavior and experiences of people. Moustakas (1994) explained that under phenomenological research, a researcher should focus on personal observations, participants' experiences, and emotions to make meanings. McNabb (2008) added that phenomenology is utilized in social research to find social meanings of problems, activities, arts, and work. This has justified my intention to use the approach to explore lived experiences of Mexican immigrants on the role of healthcare quality in undocumented immigration to the United States.

## The Role of the Researcher

My interest is to involve communities in identifying social problems related to healthcare and finding solutions to the problems through empirical inquiry. I used interviews to elicit lived experiences of the research participants. My role in the process was to recruit participants, interview them using a semistructured question list, listen and record findings that conveyed their feelings and lived experiences in relation to the role of healthcare insurance in Mexico in undocumented immigration to the United States.

## Participant Selection

All participants reside in Hidalgo County, Texas, United States, and initial recruitment was conducted using a social media platform in which I posted my research interest in English and Spanish on my personal page seeking participants (see Appendix A). The target population was legal immigrants from Mexico who entered the United States in an undocumented immigrant status. I used a convenient purposive sampling technique for recruitment. A convenient purposive technique allows the researcher to select participants who are knowledgeable and have in-depth information about the topic (Ravitch & Carl, 2016; Rubin & Rubin, 2012; Sharma, 2017). Individuals who responded to either the English or Spanish social media recruitment posting were contacted using direct messaging in the social media application and provided further contact details to review study inclusion criteria and informed consenting procedures. Date and time stamping were captured and chronologically utilized for participant selection in the event the interest exceeds required participant threshold. If social media recruitment efforts failed to achieve seven potential participants, I had planned to use a snowball recruitment

strategy to enlist additional participants by asking my participants who have completed the study interview to inform other people about the study and provide them my contact information or direct them to the social media posting for direct messaging. This snowball recruitment strategy was not needed as I was able to recruit and retain all seven participants during the initial recruitment process.

I used a sample size of seven participants. The justification for this can be seen in the research work of Wurie (2012), where he used the same phenomenological research and a convenient purposive sampling technique of a sample size of seven adults to investigate the awareness of the implementation of 287(g) among Salvadoran immigrants to explore the awareness of 287(g) policies among Salvadoran immigrants in the United States. The similarity between my research and Wurie's study is that I also used both qualitative, phenomenological approach, and a convenient sampling strategy with seven participants. Rudestam and Newton (2007) stated that a recommended sample size for phenomenological research should range between five to 30 participants. According to Creswell (2007) the recommended sample size for a phenomenological study is between five to 25, as far as saturation is concerned. Saturation according to Mason (2010) is the amount of quality information a researcher needs to provide a detailed and clearer picture about a topic. Morse contends that a minimum of six participants are required for a proper phenomenological study to be conducted (Mason, 2010). Therefore, my sample size was seven participants. Another reason is that qualitative study focuses on credible in-depth information, but not frequencies and generalizations (Mason, 2010; Ravitch & Carl, 2016).

I understand the vulnerable nature and welfare of the participants. The immigration legal status of the participants makes them vulnerable and revealing this confidential information will subject them to possible legal suits, jail time, and deportation. To protect and keep them safe, I will not reveal any information on their legal status nor reveal any confidential information that may jeopardize participants' welfare. I will assign participant pseudonyms to conceal their identities.

## Instrumentation

I used phone interviews to explore my research question. Smart phone and internet platform interviews were conducted using a qualified Spanish interpreter for participants wishing to conduct their interviews in Spanish. Using a three-way smartphone calling feature, I initiated a call first with my Spanish interpreter and then add the participant to the call. The participant was asked if they wish to conduct the interview in English or Spanish. For those expressing their request to conduct in English, the Spanish interpreter exited the group call. For those wishing to conduct the interview in Spanish, the interview proceeded with the Spanish interpreter present. For interviews conducted using an internet-based connection tool each attendee will be provided a conference access link to join at the prearranged access time. Interviewing is one of the many ways to collect data for qualitative studies (Jacob & Furgeson, 2012; Rubin & Rubin, 2012). Interviewing is the most appropriate tool because my study uses a phenomenology method, which focuses on exploring in-depth human experience with interest phenomenon (Patton, 2015). The semistructured interview gives participants enough time and flexibility to expand their answers and provide detailed information

(Rubin & Rubin, 2012). It also allows the researcher to ask probing or follow-up questions for clarity (Rubin & Rubin, 2012). On these notions, I used a semistructured interview to explore my participants' lived experiences and allow them to provide in-depth information on the topic. But Ravitch and Carl (2016) and Rubin and Rubin (2012) cautioned that researchers using semistructured interviews should remain focused and take control of the process in line with the research question. According to Jacob and Furgeson (2012), interviewing makes it possible for participants to share their stories in detail for quality information.

I formulated my interview questions (see Appendix B) to align with my research question based on the existing interview question from existing scales and studies and the tips provided by Jacob and Furgeson (2012). I also reframed some focus group interview questions of Betancourt et al. (2015) for Somali refugees to create the first, second, and third questions. I also revised interview questions on accessible healthcare in Mexico (Martinez-Martinez and Rodriguez-Brito,2020) to formulate question 2 and 3. I formulated question 4, 5,6,7, and 8 based on Lee's push and pull theory, the work of Murtaza (2020), and Wurie (2012).

The first question of the interview questions intended to gather information about the background of the respondents. Jacob and Furgeson (2012) explained that the background questions help the researcher to warm up participants and facilitate the selection process. The information I obtained help me to determine whether participants have met selection criteria based on age and birthplace or country of origin. The second and third questions dealt with accessibility of health insurance in Mexico and its

challenges. Question four covered the benefits of healthcare in the United States and how they motivate immigrants as pull factors. The fifth question sought information about how participants came to the United States because of cheaper and accessibility to healthcare. The final question centered on the differences between health insurance accessibility in Mexico and health insurance accessibility in the United States.

Interview questions should be open-ended and clear to understand (Ravitch &Carl, 2016; Rubin & Ruin, 2012). The questions should not be leading respondents to specific responses, nor should clues about possible responses be embedded within them (Rubin & Rubin, 2012). The construction of the interview questions should not contain words that may trigger passions, inflate emotions, or disrespect respondents (Rubin & Rubin, 2012). The other data sources I included are declassified information from the website of U.S. DHS regarding undocumented immigration on the southern border. This created an opportunity for triangulation of all the sources of data for valid and credible data (Shenton, 2004).

## Procedures for Data Collection

Following the recruitment process above, I emailed an informed consent in both English and Spanish wherein the purpose of the research is explained in more detail to include participants' rights and the voluntary nature of their participation to include the right to withdraw from the interviews at any time and the right to skip any question they feel uncomfortable answering. Participants could schedule the interview for their convenience after they agree to participate.

According to Rubin and Rubin (2012), recording and transcribing or taking notes of interviews help the researcher minimizes biases and produces credible findings. I sought permission to audio record and transcribe the interviews for credible data. I used the Call Recorder smartphone application to digitally capture telephone interviews for transcription. For interviews being conducted using internet connectivity tools, I used the embedded recording features in the digital product to produce data transcripts. For confidentiality purposes when using an internet-based connecting tool, participants were advised that they may keep their video cameras off. For those participants who decline to be audio recorded either during smartphone or interview-based connections, I took detailed notes throughout the interview process. Participant pseudonyms are used for confidentiality purpose.

## Data Analysis Plan

I used the Call Recorder application to record and transcribe phone interviews and I used embedded voice recording features of internet-based connection tools for interviews conducted using these interfaces. I took interview notes for those sessions in which audio recording was declined. Transcription of interviews helps the researcher to have a vivid understanding of what transpired during interviews and captures exactly what each participant says (Rubin & Rubin, 2012). Following transcription construction, I used ATLAS.ti software for coding and data analyses. According to Rubin and Rubin (2012), coding is one of the first key elements of qualitative data analysis and interpretation. The ATLAS.ti software is one of the leading software qualitative data analyses (QDA) tools and it provides researchers with a broad scope of informative

details related to their phenomenon of interest (Boston University, n.d; Predictive Analysis Today, 2016a). ATLAS.ti also allows researchers to gain in depth information and to see content patterns bringing meaning to information (Boston University, n.d; Predictive Analysis Today, 2016a).

## Ethical Consideration

My participants are considered vulnerable immigrants and, as such, issues of privacy and confidentiality are very important. All participants are anticipated to be in a legal U.S. resident status at the time of interviews. Participants may choose to discuss or describe their immigration journey; however, I had not explored specific information regarding immigration status in my interview questions. Informed consent was used to describe participant rights. Creswell (2007) stated that a researcher should explain the purpose of a study to participants to gain their trust. Participants were assigned pseudonyms for confidentiality. To achieve this, I allowed participants to choose unique alphabets other than their real names to conceal their identities. If the selected alphabet has already been adopted by another participant in a concluded interview, I ask the present interview participant to select another alphabet. Creswell added that the true names of participants should not be used to enhance their privacy and confidentiality. I explained to each participant my study's purpose and remind them that participation is voluntary, and any participant is free to quit at any stage of the investigation. According to Ravitch and Carl (2016) and Rubin and Rubin (2012), it is unethical to lie to participants about a study's purpose or force any person to participate in research. My interview questions were constructed as open-ended questions and were not expected to

demean or trigger respondent emotions. Data protection is the process of ensuring the security of information obtained from participants to guarantee their safety (Rubin & Rubin, 2012) To ensure data protection, I removed all information or cues on interview transcript that might reveal participants' identity. I only shared the redacted findings and analysis with the Walden University's faculty members. I securely stored the contact information of participants, data, and study analyses on electronic files in Dropbox with a backup file stored on an encrypted flash drive. I secured the flash drive in my locker I will keep and protect the data for at least 5 years as required by Walden University. At the conclusion of the required 5-year storage period, I will destroy electronic data using a disc wipe software and all information contained on paper will be shredded.

**Member Checking**

I provided each participant an opportunity to member-check their transcriptions to ensure information has been clearly captured and to validate that confidentially has been maintained. According to Guba and Lincoln (1985), the member checking technique allows research participants to check and confirm their answers for credibility and true representation. After each interview, I gave 30 minutes to each participant to check all their answers to make sure it is what they want to say. For participants who do not wish to participate in member checking their transcripts will be accepted as final and used for analyses. Wurie (2012) used member checking technique to enhance and strengthen data credibility.

## Issues of Trustworthiness

The credibility of qualitative data is equally important as it is in a quantitative study (Shenton, 2004). For the data of qualitative research to be trustworthy, the information obtained in the field should be credible, transferable, dependable, and confirmable (Shenton, 2004). Credibility is the process of revealing what exactly happened in the field (Shenton, 2004). To obtain credible data, a researcher should use the triangulation strategy, member checking, peer debriefing, and observation (Shenton, 2004). Lincoln and Guba (1985) and Shenton (2004) explained triangulation as using many sources of data collection to check inconsistencies. Apart from the interviews, I will access data from the websites of U.S. DHS, Mexico Health Department, and U.S. BPC to check insistencies for credible data. I used a colleague student at Walden who is interested in the topic for peer debriefing. I posted the announcement on Walden students' dissertation groups on Facebook for interested person. The person sent me a private message on Facebook messenger accepting to debrief my findings. We are not acquainted. The person signed a confidentiality agreement and focused mainly on checking my personal biases and perceptions. The debriefing process started soon after interviews were conducted and ended after data analysis. I emailed the interview notes or transcripts to the person. I used the member checking technique and according to Shenton, member checking allows participants to make corrections to reflect what they wanted to say to make sure the information provided is true.

To achieve transferability which refers to where the findings of one study can be used in different settings (Lincoln & Guba, 1985; Shenton, 2004), the researcher should

allow participants to provide detailed information about the topic to generalize findings (Lincoln & Guba, 1985; Shenton, 2004). This is in line with my selected phenomenological approach. To achieve dependability, which refers to findings being consistent and can be replicated (Lincoln & Guba, 1985; Shenton, 2004) semistructured interviews were used to allow participants provide detailed information about the topic. Finally, the last requirement to ensure data trustworthiness according to Shenton (2004) is confirmability. This is where the researcher should be neutral to prevent biases and provide an audit trail of all for the research (Lincoln & Guba, 1985; Shenton, 2004). The triangulation method also enhances the confirmability of a study (Lincoln & Guba, 1985; Shenton, 2004) which I employed.

## Summary

Chapter 3 presented information on the design of the research, role of the researcher, selection of research participants, and instrumentation. The study's design is phenomenology. Convenient sampling is used to select research participants. Recruitment of participants was done on social media. Interviews were conducted using phone and other internet-based electronic tools. ATLAS.ti software is used for data coding and analyses. This chapter additionally described my study's ethical procedures and issues of trustworthiness for recruitment, interviewing, coding, and analyses.

The Chapter 4 presents findings of my in-depth interviews, data analyses, and evidence of trustworthiness of the data collected. The chapter also presents characteristics and information about the research participants. In this chapter, the responses provided by the research participants are categorized into themes for easy analysis and understanding.

# Chapter 4: Research Findings

## Introduction

The study's purpose was to understand the role of healthcare quality in Mexico in undocumented immigration to the United States. A phenomenological research approach was used to explore lived experiences of the research participants. This chapter presents information about the research participants, their experience with undocumented immigration to the United States, and healthcare in both Mexico and United States. The chapter also presents research findings and data analysis.

## Setting

All the interviews were conducted via phone. In total, seven participants were interviewed; five participants agreed to speak to me in English while two participants opted to do the interview in Spanish through the interpreter. Each interview lasted about 45 minutes and additional 30 minutes for member checking was needed once individual transcripts were transcribed, cleaned, and formatted for sharing with the interviewed participant.

After I received IRB approval (0986362; 05-26-22), I recruited all the seven participants using a social media platform. I posted my recruitment announcement (Appendix A) on my personal page wall. The people who had interest to participate responded to the posting through direct messaging to my user account name. I then provided them criteria for recruitment and the informed consent. Each of the seven recruited participants completed the research interview in its entirety. I made no changes

to the informed consent after IRB approval as I did not change participants' recruitment process, data collection methods, analysis, and data storage.

## Demographics

All seven study participants lived in the Hidalgo County, Texas, United States. All the participants are adults who experienced healthcare both in Mexico and United States. All participants speak English and Spanish and used to have jobs in Mexico. Out of seven participants only two people did their interview in Spanish. To ensure confidentiality, I used pseudonyms for all participants interviewed.

### John

At his interview time, John was living in Hidalgo County, Texas. He is in his mid 40s and currently a truck driver in the United States. He came to the United States from Mexico. He was truck driver too in Mexico. He had health insurance in Mexico and currently has health insurance in the United States. John sent me a message to take part in the study after reading the recruitment posting I posted on my social media page (Appendix A). During the interview phone call, he declined the interview be audio-recorded and agreed the interview to be conducted in English. John was polite and clear during the entire process.

### Juan

At his interview time, Juan was living at Hidalgo County, Texas and working as car mechanic. He is in his early 40s. He immigrated to United States from Mexico in his early 30s at Tamaulipas closer to the southern border. Juan was a car mechanic in Mexico. He was fully insured at the time of this study. Juan sent me message after he read my recruitment posting I posted on my social media page. He turned down my

request to audio-record his interview. He requested the interview to be conducted in Spanish through the interpreter. His interview was done in Spanish. Juan was nervous when he answered the interview phone call, but he became calm and relaxed when I started building rapport and asking questions about his favorite food and car for the first 5 minutes. He was comfortable, articulate, and audible in Spanish language. His interview lasted about 45 minutes.

**Maria**

At her interview time, Maria was residing at Hidalgo County, Texas and working as a nurse. Maria is in her late 40s. In Mexico she was living at Reynosa a city closer to the Mexican-U.S. border. She came to the United States in her early 30s. She was a nurse in Mexico. Maria who saw my recruitment post in Spanish on my social media page and sent me a message expressing interest to participate. Before her phone interview started, Maria explicitly stated he wants the interview to be conducted in Spanish and should not be recorded. Maria was happy throughout the interview process and was straight forward in her responses. She was clear. Her interview lasted about 50 minutes.

**Rosa**

At her interview time, Rosa was residing at the Hidalgo County, Texas. Rosa was a teacher in Mexico before coming to the United States and she had health insurance. She is in her early 40s and teaches in middle school in the United States. She immigrated from Palau Coahuila. Rosa replied to my recruitment post on my social media page and sent me message expressing her interest in the study. During the phone interview call, she agreed that the interview should be conducted in English but should not be recorded. She

was clear and detailed in her responses to the interview questions and answer all the questions. Her interview lasted for about 30 minutes.

**Perez**

He is in his mid 70s. At his interview time, Perez was living in Hidalgo County, Texas. He was born in Mexico, but he immigrated to the United States in his early 40s. He was a welder in Mexico for more than 40 years. He had health insurance in Mexico. Perez was working as a welder when he arrived in the United States, but now he is retired. Perez sent me a message after he read my recruitment post on my social media page. Before the interview started during the interview phone call, Perez opted for English interview, but turned down my request to record the call. He was so emotional and provided examples for probing questions. He remained calm throughout the interview and provided concise and clear responses. His interview lasted for about 50 minutes.

**Kiara**

She is in her late 50s. At her interview time, Kiara was living at Hidalgo County, Texas and working as nurse. She moved to the United States from Mexico when her husband had work related accident in Mexico. In Mexico, Kiara used to work in one factory called Maquiladoras. She had health insurance in Mexico because of her job. Kiara read my recruitment post (Appendix A) on Facebook and sent a direct message to me on Facebook. When I called her for the interview, she indicated she wants the interview to be conducted in English, but she declined the request to record the call. Kiara was open, detailed, and audible in her responses. The interview with her lasted for about 30 minutes.

**Juliana**

She is in her mid 40s and at her interview time lives in Hidalgo County, Texas. Juliana immigrated to the United States from Mexico when she was battling with a chronic hepatitis B and had medical issues with her liver. Juliana was a working in a restaurant as waitress. She had healthcare insurance in Mexico. In the United States, Juliana is working as parole officer. She read my recruitment post on my social media page and sent me a message to show interest as participant. During the phone interview, she agreed to speak English and turned down my request to record the call. Throughout the interview she was calm, happy, and clear. The interview call with Julian lasted for about 45 minutes.

## Data Collection

I collected data from seven research participants using the semistructured interview protocol (see Appendix B) to explore lived experience of the participants. All the interviews were conducted via phone. Each interview lasted between 30 to 60 minutes. I scheduled each interview at the convenience and request of each participant. I used 2 weeks to complete the interviews and member checking. Two of the interviews were conducted in Spanish with professional interpreter and five interviews were conducted in English. The settings for this were inside my room in Fort Worth, Texas and Hidalgo County, Texas, for each respondent. All the interview calls initiated well and ended successfully without any network interference or physical interruptions.

I asked each participant all questions on the interview document (see Appendix B) and sometimes asked follow-up questions to clarify information or for in-depth information during interviewing. All the participants separately turned down my request

to audio record the interview calls for privacy reasons. I spent about 40 minutes asking interview questions and taking interview notes on each call. After the interview, I read the responses provided to each respondent to confirm or modify their answers to reflect what they really wanted to say. This member checking process was completed within 30 minutes for each participant. All the participants did the member checking for credible and accurate data. I also used peer debriefing technique to check my own bias in data coding and analysis. I converted the interview notes into a MS Word document for each participant. I stored the data on electronic files in Dropbox (cloud) with backup on an encrypted flash drive, which I stored in a locked cabinet. Some information about the causes of undocumented immigration from Mexico to the United States was obtained from the website of DHS. However, I could not assess or obtain information on the challenges of healthcare accessibility in Mexico on the website of Mexico Health Department. This was the only variation in the data collection plan outlined in Chapter 3.

## Data Analysis

I used ATLAS.ti software to code and analyze the data. After I completed interviews and member checking to confirm participants' responses and make corrections, I converted the interview notes of each participant into MS Word document. I applied the iterative process (Pietkiewicz & Smith, 2014), which required that I and thoroughly and closely read and reread the transcript, highlighting experiences of the participants on challenges of healthcare in Mexico to influence to immigrate to the United States for healthcare access. As I listened to participants and asked follow-up questions during the interviews in addition to reading the interview notes I found some

statements and words that helped me to understand the experiences of the participants about the role of healthcare in Mexico in undocumented immigration to the United States.

Using the ATLAS.ti software, I uploaded each participant's responses and the DHS website's article on undocumented immigration in a form of word document and assigned codes to the statements related to the research question. For the first cycle coding, I used descriptive coding method. Here I described each participant's response with simply words and statements. For the second cycle coding, I used concept coding where I assigned concepts to the descriptive statements in the first cycle coding. Finally, I looked for patterns and similar concepts in participants responses I and grouped those patterns into themes. The Figure 3 below illustrated and summarized the coding process I used. Some of the themes I generated relating to challenges of healthcare in Mexico (push factors) included: (a) paying cash before receiving medical services, (b) corruption, (c) lack of hospitals or clinics at the rural areas, and (d) lack of personnel or doctors. Themes I generated on the pull factors of health insurance in the United States included: (a) cheaper price, (b) perception of free medical services in emergencies, and (c) quality healthcare services.

**Figure 3**

*Coding Process*

| ***Question: Tell me about the problems with health insurance in Mexico.*** | | | |
|---|---|---|---|
| **Participant's Response** | **Descriptive Coding** | **Concept Coding** | **Patterns Emerged from all Participants.** |
| I had 3 kids in Mexico and 2 in the United States before coming officially back to the United States. For the delivery of my 3 kids, I had to make sure everything was paid before the delivery which was really expensive. Also, I live in Reynosa, a place closer to the U.S.-Mexican border. I used to travel about 20 miles to the nearest clinic for medical services. Sometimes patients ride with others on motor bike to clinic for about 30 miles to access quality healthcare. This makes it harder and discourages people to go hospital in Mexico. The roads are also bad | Healthcare in Mexico is based on cash payment before services are provided by the doctors. It is also expensive to access and lack of healthcare facilities. | Cash payment before treatment. Expensive for the poor. Lack of Healthcare facilities. | Cash before care<br>Embezzlement of Healthcare resources<br>Lack of Healthcare facilities<br>Lack of Doctors. |

*Note*. The figure is an output of ATLAS.ti used in the coding. It illustrates the processes followed. This process was repeated for each participant's responses to generate the themes.

I noted discrepant views or cases in the data coding and analysis. Patton (2015) explained that data discrepancy strengthens and shows the in-depth nature of data patterns. I used the discrepant data to understand and validate different reasons people have to immigrate to the United States. I compared the discrepant data to the main data and realized that the discrepant data described availability of jobs as the primary driver of immigration to the United States. This reason opens the gate for more research to appreciate and understand the overall picture of immigration.

## Evidence of Trustworthiness

To achieve data credibility, I followed the plan I outlined in Chapter 3. To ensure the data represent the actual view of the research participants, I used a member checking technique to make sure I read each participant's answers to them. This process provided an opportunity for me to make corrections for the data to be credible and reflect what the participants really wanted to say. I also used triangulation method by comparing data from the interviews to information obtained from the website of DHS about reasons Mexicans immigrate to the United States. I also thoroughly compared data of each participant to ensure consistency and accuracy.

To achieve data transferability, I employed phenomenological research approach and semistructured interviews. This method allowed the participants to provide in-depth information and thick descriptions of their experience about the role of health care in Mexico in undocumented immigration to the United States. According to Shenton (2004) and Patton (2015) phenomenological study and semistructured interviews allow the researcher to obtain detailed information to achieve data replicability and generalizability. I also used a convenient purposive sampling strategy to select participants who have more information about the topic. This helped me to achieve data transferability and applicability of the findings.

I followed the plan explained in Chapter 3 to ensure data dependability. To ensure consistency and reliability of my research findings I consulted my committee chair and committee member when developing the interview questions to make sure all the questions are realistic, aligned with the research question, and consistent with each other

(see Appendix B). Finally, because I used semistructured interviews, I was able to ask the participants follow up questions for clarity and more information to make sure my findings are dependable and consistent.

To achieve data confirmability, I used peer debriefing technique. As I explained in Chapter 3, I posted the announcement on Walden students' dissertation groups on Facebook for interested person. The person sent me a private message on Facebook messenger accepting to debrief my findings. The process started when I completed interviews and ended when I finished data analysis. The peer reviewer double checked interview notes, codes, and interpretations to make sure they are free from my personal bias. Moon et al. (2016) explained that for data to be considered reliable, the researcher must provide a detailed description of the methods, procedures, and processes used in drawing conclusions for potential replication by others. All these procedures are explained in Chapter 3. I also used member checking technique and research reflexibility on my personal beliefs and perception to be neutral and transparent in data collection and analysis to maximize confirmability.

## Results

My research question was: What are the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role of healthcare in their decision to migrate to the United States? I used semistructured interviews to explore lived experiences of the research participants. The data were organized in MS Word document. I used ATLAS.ti software, descriptive and concept coding strategy to code the research data. The themes that merged relevant to the push

factors included: (a) paying cash before receiving medical services, (b) corruption, (c) lack of healthcare facilities at the rural areas, and (d) lack of doctors. These problems as push factors, forced some participants to leave Mexico. The other themes that were generated relating to the pull factors of healthcare insurance in the United States are: (a) cheaper health insurance for healthcare, (b) perceived free medical services in emergencies, and (c) quality healthcare services. The pull factor themes motivated and encouraged some of the participants to migrate to the United States to access quality healthcare. The study's push/pull factor themes and discrepant data are discussed in this section.

**Theme 1: Pay Cash before Receiving Medical Services**

The study's findings revealed that the role of healthcare in Mexico in undocumented immigration to the United States is, that people in Mexico more at times are required to pay upfront for medical services even though they are insured. Based on the comments by the respondents to pay cash before seen by a physician limited access to quality healthcare especially the poor. Five of the seven respondents shared their views. For instance, Juan noted "in order to have health insurance in Mexico you need a job. Health insurance in Mexico is all about money and no doctor will you see you without money even when you have insurance." He added, that in Mexico to have any medical procedure done you need to have the money right there and then. You cannot have any medical procedure done without the money.

Maria stated "I had 3 kids in Mexico and 2 in the United States before coming to the United States. For the delivery of my 3 kids, I had to make sure everything was paid

before the delivery which was really expensive." According to Perez, it is hard to obtain health insurance in Mexico, even if you have insurance everything is expensive. Rosa summarized her experience in Mexico about paying cash before a doctor attend to you. She stated "sometimes my doctor would ask me to buy injections from pharmacy and bring them to the hospital for injection or treatment. It was appalling and disgraceful." Finally, commenting on the challenges of health insurance in Mexico, Kiara explained that "in Mexico my insurance really didn't cover anything, I had to pay everything upfront even for the deliveries of my babies. I was always scared of needing emergency insurance due to the money." She expressed her view that physicians or nurses in Mexico have prioritized money over human life and welfare.

**Theme 2: Corruption and Embezzlement of Public Funds or Resources**

All the 7 participants described how corruption and embezzlement of public resources made it difficult for healthcare access in Mexico. John felt that many people in Mexico have no access to healthcare because some politicians and public administrators used public funds meant for expanding healthcare access for personal gains. He stated "politicians and administrators in Mexico are corrupt to the core. The empty public coffers for personal gains to the detriment of the poor to access quality healthcare." Juan asserted that corruption is the root cause of ineffective health insurance system. He narrated "my friend used to tell me how some administrators in the Health Ministry in Mexico always channel public funds meant to help the vulnerable to access healthcare for personal benefits." He described the situation as a "curse." Maria who shared similar view with Juan on corruption further explained that "everything is already planned out

about making it difficult for the poor to always suffer and the rich corrupt politicians continue to be rich." She felt the situation is unfair and disgusting.

Perez was emotional in describing the impact of corruption on healthcare access. He stated "in Mexico corruption is bad, I don't like talking about it; it's politics. I try to not get involved in them." Even though he was not interested in talking about corruption, he described it as a "sin" against the public and vulnerable as it denied them basic right to have access to quality health care. Expressing her experience Rosa explained that corruption is the main challenge for the people to access health insurance as corruption leads to inadequate funds to expand access to healthcare. Kiara noted "public administrators in charge of managing public funds for public good are rather using the funds to buy nice houses and luxury cars draining the coffers meant to help expand health care to the people at the rural areas and pay physicians." Juliana had a moment to reflect on her experience on corruption as a problem of health insurance in Mexico. She said her father one narrated to her how politicians in Mexico have been using state resources for personal gains. She lamented "One of the biggest problems of insurance in Mexico is corruption." She defined corruption as a situation where a public official uses public resources such a money to satisfy his/her parochial interest while the vulnerable continue to suffer.

**Theme 3: Lack of Healthcare Facilities at Rural Areas**

Four out of seven participants mentioned lack of healthcare facilities in rural areas as one of the challenges of healthcare access in Mexico. Maria stated "I live in Reynosa, a place closer to the U.S.-Mexican border. I used to travel about 20 miles to the nearest

clinic for medical services. Sometimes patients ride with others on motor bike to clinic for about 30 miles to access quality healthcare. This makes it harder and discourages people to go hospital in Mexico." She added that some roads to certain clinics are non-motorable.

According to Perez, inadequate number of health facilities leads traveling long distances to access healthcare discourages some people to go to hospitals to seek treatment. He stated, "healthcare facilities are congested in urban areas or cities, but many rural areas lack clinics and hospitals and even roads leading to the few healthcare facilities in the rural areas are deplorable." He explained further that nurses and physicians do not want to station at rural areas to provide quality healthcare to people who need as every nurse and physician want to work in cities. These challenges increase waiting time to see a nurse or doctor. Perez narrated that 50 years ago he visited a clinic in and waited a long 3 hours in a line to see a nurse. Finally, he and other 3 patients had to go back home without seeing any nurse or attended to.

At Tamaulipas, closer to the Mexican-U.S. border, Juan explained that unavailability of healthcare facilities such as clinics and hospitals denied some people to access healthcare. He said he used to traveled long distance for about 3 hours on motor bike to the nearest hospital to seek treatment. Juan posed an important question in explaining his answer. He stated, "imagine what happens to patients who lived in my area but who do not have motor bikes or cars to travel to the nearest hospital?". Finally, in addressing the question concerning challenges of healthcare access in Mexico, Juliana explained that she used to travel about 6 miles on foot to the nearest hospital to access

healthcare. She stated “I went through hell” because of inadequate number of hospitals and clinics in Mexico and lack of means or transportation to go to the clinic or hospitals.

**Theme 4: Lack of Doctors**

In explaining challenges of healthcare access, three out of seven participants narrated their experience about lack or shortage of healthcare personnel affected their access to healthcare in Mexico. In accounting her experience, Kiara stated “not having enough doctors and nurses at hospitals and clinics is another problem making it harder on people to access healthcare in Mexico. This results in long hours to see physicians and nurses when you visit a facility. I remember on about three instances I had to wait in line for more than 2 hours to see a doctor. It was terrible.”

Juliana explained that healthcare access is essential but lack of nurses and physicians in Mexico has denied many people to access quality healthcare. She stated that during the time she was diagnosed with hepatitis B she would go to a public hospital for checkup and the doctor would not show up or she could wait for about 3 hours, because the doctor had private hospital to attend to patients in that hospital. According to Juliana it is because of lack of doctors in public healthcare facilities that made her experienced what she explained, and it is a challenge for accessing quality healthcare in Mexico.

Finally, Rosa also shared her experience about lack of doctors in public hospitals as a problem of healthcare access in Mexico. She narrated “before I immigrated to the United States, there was doctor in my community’s government hospital in Mexico. The hospital only had nurses who are not trained to do surgeries and other complicated medical conditions.” She explained further that lack of specialists in hospitals

discourages people to visit hospitals when they are sick and that complicates medical conditions needing more attention and money for treatment.

The themes that were generated as pull factors of immigration to the United States from Mexico for healthcare access are discussed below: it was a probing question put before all participants.

**Theme 1: Perceived Free Access to Healthcare in Emergencies**

During the interviewing four out of seven participants explained their experience as undocumented immigrants about free access to healthcare in emergencies is a pull factor for immigration to the United States from Mexico. Kiara accounted that:

> I knew as an undocumented I could go by the hospital anytime and I would be given healthcare access without insurance if my medical condition is critical. And I would not pay anything to see a doctor in emergency which is not possible in Mexico.

She added “If I’m honest I feel safer in the United States than Mexico.” She also added:

> My husband had a lot of health problems and while living in Mexico we couldn’t afford anything. We decided to move to the United States because of him, he had more access to healthcare here through the help of some organizations. He passed away about 3 years ago due to a work accident, he wasn’t denied healthcare access due to no insurance. He was even transported via a helicopter to another city end up to this date we have not been charged a single dime for it.

Maria also said

> When I came to the United States before I become legal permanent resident, I had 2 surgeries as emergency and did not pay nothing. I also had my two daughters here; I wasn't expected to pay anything for them as well. On the contrary I was given health insurance and for my baby while I was pregnant. Both of my kids had access to free Health insurance which was a great benefit. In the United States the healthcare services are more quality than services in Mexico. They have better medicines and doctors and equipment.

Rosa also explained that when she arrived in the United States from Mexico:

> I was able to see that in the United States health insurance access was way easier. I did not have health insurance here yet due to being illegal, but I went the hospital anytime and I would be given healthcare access without insurance in life threatening situations. And I would not pay anything to see a doctor under emergency which is not possible in Mexico.

Finally, during the interview process Juan also shared "I moved to the USA because of job and healthcare access. Health insurance in the United States is more accessible. If I need to go to the hospital, I don't have to worry about having to pay before being seeing a doctor. I was admitted to emergency room when I had car accident. I did not pay any money before I was attended to. There is quality healthcare."

**Theme 2: Cheaper Health Insurance for Healthcare**

Three of the participants explained that undocumented immigrants in the United States buy health insurance at cheaper rates compared to documented immigrants and citizens. According to Maria, it is not expensive for undocumented to buy health

insurance as some non-profit organizations help undocumented to acquire insurance. She noted “many healthcare centers here funded by the federal government offered health insurance at cheaper rates to the poor including the undocumented immigrants. After my surgeries as an undocumented I bought health insurance at rate of $40 a month at Hidalgo Health Center which is more expensive for documented immigrants and citizens who work.”

Juan narrated that accessing healthcare is cheaper for undocumented immigrants in the United. She stated “there are independent charity organizations like Kaiser Permanente Bridge Program which made me to apply for low-cost medical services. You don’t need a social security number to apply. I applied and was approved. I paid $35 a month just for primary healthcare services”. The enrollment helped me a lot to access healthcare at lower prices when I was undocumented.

Finally, in the interview Rosa shared her experience that as an undocumented, accessing health care insurance is cheaper and easier for her. She explained that some health facilities and hospitals receiving some federal funding provide health insurance at cheaper rate to poor person including undocumented immigrants who cannot afford to pay for higher rates. She continued “for instance when I arrived in the country as undocumented the Catholic Church, I attend, provided me the necessary financial help to acquire health insurance and later I bought insurance at cheaper rate of $40 a month until I become documented.” Healthcare services were also provided by newly trained doctors at San Antonino hospital at lower cost or free to poor people and undocumented immigrants according to Rosa.

**Theme 3: Quality Healthcare Services**

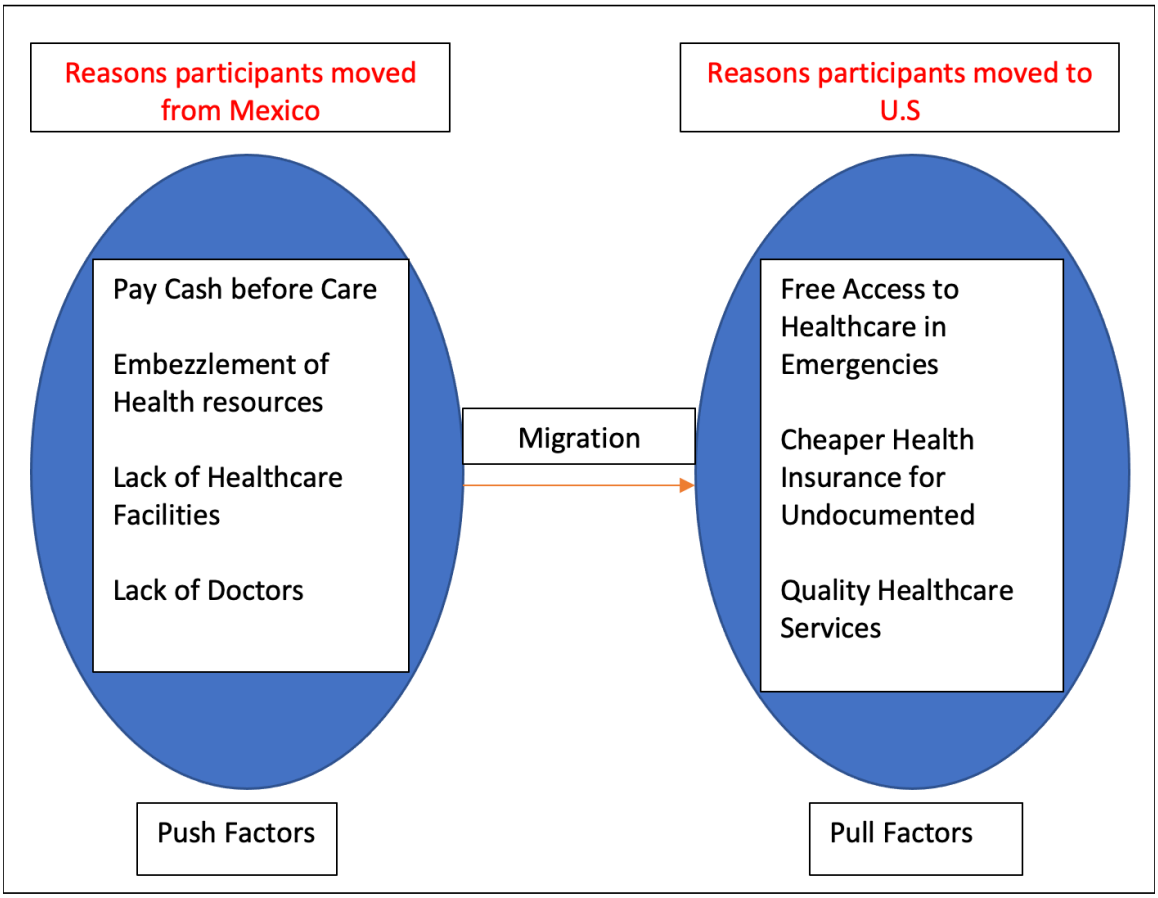
All seven participants agreed and stated that there are better quality healthcare services in the United States than in Mexico. However, four out of seven participants admitted that the availability of the quality healthcare services in the United States influenced their decisions to relocate to the United States. Maria is noted to have explain that there are better doctors, machines and medicines in the United States compared to Mexico and everyone is interested in accessing what is better. She added that she had two surgeries as an undocumented immigrant in the United States and had seen better equipment, doctors, and medicines in the whole process. According to her Mexican hospitals and healthcare facilities lack some of these equipment, specialized doctors, and medicines.

Kiara also indicated that quality of healthcare services is better in the United Sates than Mexico because of the technology gap between Mexico and United States. Rosa also mentioned that she migrated to the United States because she believed there are better doctors and medicines in the United States and that is proven when she visited hospital for the first time as undocumented immigrant. She said, “the doctors were nice and kind to me and would speak soft words to me and give me hope all the time but in Mexico sometimes doctors would be treating me like trash and don’t care about I feel”. Finally, Juan also mentioned that she moved to the United States because of healthcare access. She explained that United States has more sophisticated and modern medical machines and tools and more specialized doctors than Mexico. She narrated “I feel safer and confident in the quality of healthcare I received in the U.S. than in Mexico even

though sometimes it is more costly than Mexico. However, in all U.S. is better than Mexico in terms of quality of healthcare access. Figure 4 below summarized themes of the research findings by illustrating reasons some of the participants migrated from Mexico to the United States.

**Figure 4**

*Push/Pull Factors of Migration*




*Note*. The figure illustrates reasons some of the participants migrated from Mexico (push factors) and reasons they migrated to the United States (pull factors) for healthcare access.

## Discrepant Data

Discrepant data is normal in research studies and proves quality of data (Miles et al. (2014). During the interviews, three out of seven participants explained that they moved to the United States because of jobs opportunities and reuniting with families, but not because of healthcare access. According to Perez "I immigrated to the United States because of my family". Also, John in answering one of the follow-up questions about why he migrated to the United States said the decision to migrate was family decision and they moved here because of jobs availability. He answered "No, I would not but healthcare insurance is better here. We came here because of availability of jobs." Finally, Juliana also stated that she migrated to the United States to find better job, earn good income to take care of the family. According to the U.S. DHS (n.d.) the primary driver of immigration to the United States is the availability of jobs opportunities and family reunion.

## Summary

The main research question is, what are the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role of healthcare in their decision to migrate to the United States? The main purpose of the research question is for me to explore the lived experiences of participants about the problems of healthcare access in Mexico motivating them to immigrate to the United States to access quality healthcare. To explore those experiences, I composed a semistructured interview script, conducted interviews, and analyzed the data to discover emerging themes.

In responding to the question about problems with health insurance in Mexico, participants mentioned embezzlement of public health resources for personal gains, lack of healthcare facilities at the rural areas, lack of doctors, and pay before care as major challenges. And in responding to the question about the healthcare benefits in the United State which could serve as pull factors, the participants mentioned the perception of free healthcare access in emergencies, cheaper health insurance for undocumented immigrants, and quality healthcare services. He explained why people moved from an area or location to different place. The results from the analysis explained healthcare reasons some of the participants migrated from Mexico to United States. However, the primary leading factors for immigration to the United States are availability of jobs in the United States and reuniting with families.

# Chapter 5: Discussion, Conclusions, and Recommendation

## Introduction

The study's purpose was to understand the role of healthcare quality in Mexico in undocumented immigration to the United States. I used a phenomenological approach to explore detailed and in-depth information from the research participants on how challenges or problems of health insurance in Mexico could encourage some Mexicans to cross to the United States to benefit from a free or lower cost of health care. My conceptual framework is situated on Lee's push/pull theory. The study's focus was to collect data from formerly undocumented immigrant from Mexico to understand healthcare access challenges in Mexico that motivated them to enter United States as undocumented immigrants.

The study's key findings about challenges of healthcare access in Mexico include embezzlement public health resources, payment before treatment, lack of healthcare facilities at the rural areas, and lack of doctors in public hospitals. The key findings about healthcare reasons which motivated some participants to migrated include a perception of free access to healthcare in emergencies, cheaper health insurance for undocumented compared to documented due to charity and other U.S. government funded programs, and quality healthcare services. The key findings align with Lee's push/pull theoretical framework.

## Interpretation of the Findings

The main research question is what are the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, regarding the role

of healthcare in their decision to migrate to the United States? I used two main interview questions to explore the research question. One main interview question was focused to explore problems of healthcare access in Mexico. The other question centered on the benefits of healthcare in the United States that motivate undocumented immigrants to immigrate to the United States from Mexico. Interpretations of the findings for these questions and the literature reviewed in Chapter 2 are discussed below.

First, most of the research participants (5 of 7) stated that payment in cash before receiving medical services is a challenge to healthcare access in Mexico especially among the poor. The literature reviewed in Chapter 2 about healthcare access in Mexico confirmed this finding. Martinez-Martinez and Rodriguez-Brito (2020) stated that Mexico has one of the highest out-of-pocket healthcare expenses among the countries belonging to the Organization for Economic Co-operation and Development and some doctors requiring patients to make payments before being attended to. This makes it harder for the poor and vulnerable to access healthcare in Mexico. To support this Pelcastre-Villauerte et al. (2017), mentioned that in Mexico, 73% of the population live below poverty and face challenges to get insured or pay their medical bills. Also, all the participants have identified corruption and embezzlement of public resources as another problem for providing quality healthcare for people in Mexico. This is confirmed in the literature reviewed as Hone and Gómez-Dantés (2019), Rivera-Hernández et al. (2019), and Sosa and Sosa-Rubi (2016) contended that presence of corruption and mismanagement of public resources in Mexico is a key challenge to provide and expand healthcare access to the people.

Additionally, the findings revealed that lack of healthcare facilities in rural areas in Mexico makes it difficult for the people living in these areas to access quality healthcare. Most of the participants shared their long travel experiences to find hospital or clinic. The lack of healthcare facilities in rural areas is confirmed by the literature reviewed. According to Hone and Gómez-Dantés (2019), Rivera-Hernández et al. (2019), and Sosa and Sosa-Rubi (2016) lack of healthcare facilities in the rural areas has denied many people especially in rural areas to accessible quality healthcare in Mexico. Finally, on the problems of healthcare access in Mexico, majority of the research respondents identified lack of doctors in the public hospitals. Each of those participants explained how lack of doctors affected them in Mexico. As reviewed in Chapter 2, Hone and Gómez-Dantés, Rivera-Hernández et al., and Sosa and Sosa-Rubi collaborated on lack of healthcare personnel and doctors as a challenge to addressing inequities of healthcare access in Mexico.

To begin with, my study's findings revealed that majority of the research participants immigrated to the United States because they had a perception that they are entitle to free healthcare services in emergencies, despite this fact being untrue for the providers of those healthcare services. According to my findings, participants had information and beliefs that during emergency situations doctors in U.S. hospitals and clinics are required by the federal law to treat patients regardless of their background or immigration status. This finding coincided with the literature reviewed. Kuruvilla and Raghavan (2014) clearly stated that hospitals that receive federal funding in the United States must screen and stabilize patients who need emergency care for free regardless of

their immigration status and ability to pay. Emergency care is backed by EMTALA, which was first signed into law in 1986. Castaneda (2016) stated that in many large medical schools, medical students provide free health care to the poor including undocumented immigrants as part of their training rotations. However, according to Sawyer (2017), the perceived "free" care is never free to the provider. American College of Emergency Physicians (n.d.) added that emergency physicians on average provide $138,300 of EMTALA charity care each year and incur on average $25,000 EMTALA-related-bad debt in 2001 per the research conducted by American Medical Association (AMA) in May 2003. Further, the American Hospital Association (2021, February 28) has estimated that approximately $660 billion dollars in the past 20 years has been spent in EMTALA and other unfunded care resulting in upwards shifts of pricing to cover costs directly impacting consumers and business alike.

The findings also revealed that healthcare insurance is cheaper for undocumented immigrants in the United States. Some of respondents shared their experiences of acquiring lower-cost health insurance from some community healthcare services and non-profit organizations. This information is confirmed by the literature in Chapter 2. According to the literature some community health facilities, churches, and non-profit organizations help undocumented immigrants to get health insurance at lower cost (Artiga & Diaz, 2019; Castaneda, 2016; Flavin et al., 2018; Kuruvilla & Raghavan, 2014). Also as already stated, in some larger medical schools' medical students provide free medical services to the vulnerable including undocumented immigrants (Castaneda, 2016).

Finally, some of the participants also mentioned that the healthcare services in the United States are of higher quality than services provided in Mexico. They explained that United States has better medical equipment and specialized doctors than Mexico. And this has influenced their decision to move to the United States. This finding is not confirmed by the literature reviewed.

By and large, these findings are aligned with the conceptual framework for this study (Lee's push/pull theory). Lee articulated that migration is caused by both push and pull factors with intervening obstacles (Lee, 1966). The push factors according to the findings are the challenges for healthcare access in Mexico. They are: (a) payments are made before treatment, (b) corruption or embezzlement of public resources for personal gains, (c) lack of healthcare facilities, and (d) lack of personnel or doctors in public hospitals. The pull factors according to the findings are conditions in the United States that promote access to quality healthcare to undocumented immigrants. They are: (a) perceptions of free access to healthcare in emergencies, (b) cheaper health insurance for undocumented immigrants, and (c) more quality healthcare services. The intervening obstacles included hunger and fear of being shot or arrested.

## Limitations of the Study

One of the study limitations is that majority of the interviews were not audio recorded. This might have affected the quality of data collected, due to the difficulty presented by listening to participants and taking notes simultaneously during interviews (Ravitch & Carl, 2016; Rubin & Rubin, 2012). Secondly, I used a nonprobability sampling technique to select the research participants. This technique, according to

Ravitch and Carl (2016), lacks randomness and enhances potential researcher. However, Moustakas (1994) argued that the nonprobability technique can be used in qualitative research because qualitative research focuses on discovering and providing in-depth information on a topic to provide a better understanding but not how often something happens. In addressing this, I used a nonprobability, convenient purposive sampling to explore detailed and in-depth data. I also used triangulation, peer debriefing, and bracketing strategies to check my personal bias to strengthen the credibility and trustworthiness of the research findings. Finally, I used member checking technique to double check and confirm answers participants provided to ensure the answers captured were the correct answers participants wanted to provide to achieve data credibility.

## Recommendations

There are two recommendations that emerged. The study was only conducted in Hidalgo County, Texas. The study can be replicated in other neighboring counties and states to study the overall impact healthcare benefits have on undocumented immigration to the United States. According to the literature reviewed in Chapter 2, California is the first state in the United States to provide state government-subsidized health benefits to young undocumented immigrants (Allyn, 2019). This is an avenue for future research. Another possible research area in the future is to widen scope of the study to include other countries such as El Salvador, Cuba, East Africa, and West Africa as number of immigrants in those areas keep increasing (Justice for Migrants, 2017 & Murtaza, 2020).

## Implications

Finding ways to identify challenges for healthcare access in Mexico, the findings will enlighten people about the role of healthcare in Mexico as a push for undocumented immigration to the United Sates. The findings will also have positive implications for social change in the field of public policy since it will add to our understanding of the relationship between healthcare and immigration. It will also provide useful information to the Hidalgo County local health department officials and United States Immigration policy setters to better guide their debate and policies on healthcare policy. Also, the U.S. Government needs to spend more time and resources to disabuse persons of the information that emergency healthcare is "free". The findings also revealed that the primary factors leading of immigration to the United States are jobs availability and reuniting with families and this information should help guide policies and debate on immigration.

## Conclusion

The study's purpose was designed to understand the role of healthcare quality in Mexico in undocumented immigration to the United States. The main research focused on exploring the lived experiences of formerly undocumented Mexican immigrants living in Hidalgo County, Texas, United States. A phenomenological approach was used. A convenient non-probability sampling techniques was used to select all the research participants. The conceptual framework was Lee's push/pull theory of migration.

Based on the findings, majority of the research participants stated they moved to the United States as undocumented immigrants to access quality healthcare. The research

findings are in line with Lee's push factors of migration as the healthcare challenges in Mexico served as the push factors. There are (a) payments are made before treatment, (b) corruption or embezzlement of public resources for personal gains, (c) lack of healthcare facilities, and (d) lack of personnel or doctors in public hospitals. The study's findings on Lee's pull factors for the participants migration to the United States include (a) a perception of free access to healthcare in emergencies, (b) cheaper health insurance for undocumented immigrants, and (c) quality healthcare services. The implication of the findings for social change is to enlighten us about the relationship between healthcare access and migration and provide useful information for Hidalgo County local health authorities and United States Immigration policy setters to better guide debate on public healthcare policies. The U.S. government would be well served to spend time to clear some misconception that emergency healthcare is "free". Finally, the information that availability of jobs and family reunion as primary pull factors of immigration to the United Sates should be used by immigration legislators in the United States to help guide debate on immigration policies.

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# Appendix A: Facebook Recruitment Invitation

Hello,

My name is Abdul Ganiyu Mohammed, and I am a Doctoral student at Walden University in the School of Public Policy and Administration. For my dissertation, I am researching the role of quality healthcare in undocumented immigration to the United States. The results of the findings may add useful information to better guide the debate on healthcare policy. Participation is completely voluntary. Interviews will be conducted by smart phone or other inter-based video tools. The estimated duration of an interview is 60 minutes. Interested persons should send me direct message. Thank you.

Hola,

Mi nombre es Abdul Ganiyu Mohammed, y soy un estudiante de doctorado en la Facultad de Políticas Públicas y Administración de la Universidad de Walden. Para mi disertación, estoy investigando el papel de la atención médica de calidad en México en la inmigración indocumentada a los Estados Unidos. Los resultados de los hallazgos pueden aportar información útil para orientar mejor el debate sobre la política sanitaria. La participación es completamente voluntaria. Las entrevistas se realizarán mediante teléfonos inteligentes u otras herramientas de video basadas en Internet. La duración estimada de una entrevista es de 60 minutos. Las personas interesadas deben enviarme un mensaje directo. Gracias.

# Appendix B: Interview Questions

Thank you for agreeing to participate in today's interview. Would you like to conduct the interview in English or Spanish? [await participant response]

[repeat above text here, in Spanish]

Please feel comfortable and be as transparent as possible, because all information you will provide will be confidential and your identity will be not revealed. The purpose of the interview is to collect data and use it to analyze and address societal issues. The interview will be audio-recorded and transcribed. It will last approximately 60 minutes. If you agree to participate in this interview, please say "I agree". Are there any questions before we start?

[repeat above text here, in Spanish]

1. Let us begin; please tell me little about your background and family.
2. Tell me about your job in the United States.
3. Describe to me the nature of your last job in Mexico and how it helps you to take care of your family.
4. Tell me about your own experience with political persecutions in Mexico.
5. Describe your experience with natural disasters in Mexico.
6. Tell me more about your experience with health insurance accessibility in Mexico.
7. Tell me about the problems with health insurance in Mexico.
8. Explain how healthcare benefits in the United States motivated you to immigrate to the United States.

9. Tell me the difference about your experience between health insurance in Mexico and that of the United States.

Thank you for taking the time to answer all the questions. Please contact me if you have questions.

Gracias por aceptar participar en la entrevista de hoy. ¿Le gustaría realizar la entrevista en inglés o español? [espera la respuesta del participante]

[repita el texto anterior aquí, en español]

Siéntase cómodo y sea lo más transparente posible, porque toda la información que proporcione será confidencial y no se revelará su identidad. El propósito de la entrevista es recopilar datos y usarlos para analizar y abordar problemas sociales. La entrevista será grabada en audio y transcrita. Durará aproximadamente 60 minutos. Si acepta participar en esta entrevista, diga "Estoy de acuerdo". ¿Hay alguna pregunta antes de empezar?

[repita el texto anterior aquí, en español]

1. Comencemos; por favor cuénteme un poco sobre sus antecedentes y su familia.

2. Háble me de su trabajo en los Estados Unidos.

3. Descríbame la naturaleza de su último trabajo en México y cómo le ayuda a cuidar de su familia.

4. Háble me de su propia experiencia con las persecuciones políticas en México.

5. Describe tu experiencia con desastres naturales en México.

6. Cuénteme más sobre su experiencia con la accesibilidad a los seguros médicos en México.

7. Háble me de los problemas con el seguro médico en México.

8. Explique cómo los beneficios de atención médica en los Estados Unidos lo motivaron a emigrar a los Estados Unidos.

9. Cuénteme la diferencia sobre su experiencia entre el seguro médico en México y el de Estados Unidos.

Gracias por tomarse el tiempo para responder todas las preguntas. Por favor contácteme si tiene alguna pregunta.