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Emergency Room Use by Undocumented Mexican Immigrants

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This study examined emergency room use by undocumented Mexican immigrants and their sources of health care information. Thirty-eight percent of the respondents reported that they would use a hospital emergency room (ER) for primary medical care. ER use rates declined with time spent in the United States. Emergency room use rates varied significantly by region. Respondents receiving information from a church reported less ER use, compared to all others; respondents receiving information from U.S. newspapers reported higher ER use rates. Lack of health care access for undocumented immigrants remains a public health issue as well as a social justice concern.

Key words: Emergency room use, undocumented immigrants, Mexicans, health care services

In 2008, there were approximately 12.7 million Mexican immigrants living in the United States, up from only 760,000 in 1970. Thirty-two percent of all immigrants living in this
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country are Mexican, and of that number, more than half (55%) are undocumented. "Overall, Mexicans comprise about six-in-ten (59%) of the estimated 11.9 million unauthorized immigrants in the U.S." (Pew Hispanic Center, 2009, p. 1).

As citizens, we must be concerned about those in our midst who may need health and human services. This is especially true in the matter of health and should be of special concern with respect to Latinos. While new Latino immigrants tend to be healthier than the general population (the Latino paradox), their health deteriorates in time with acculturation (Zsembik & Fennell, 2005). This is often attributed to the fact that Latino immigrants and their children often lack health insurance and access to health care services (Prentice, Pebley, & Sastry, 2005). In addition, it has been found that many immigrants are unaware of the health and community resources available to them (Yu, Huang, Schwalber, & Kogan, 2005).

The purpose of this study is: (1) to examine patterns of emergency room (ER) use among undocumented Mexican immigrants who choose this rather than usual sources of care; and (2) to describe sources of health care information among these immigrants, as the lack of such information constitutes a major barrier to accessing appropriate care.

Conceptual Framework and Literature Review

As we consider health-seeking behavior of undocumented Mexicans which results in use of an emergency room rather than a clinic or private physician, we use here an ecosystems perspective as a theoretical framework for our analysis (Bronfenbrenner, 1979). In this framework, behavior is seen as resulting from reciprocal transactions between the continually developing person and a multivariate, multidimensional environment. Bronfenbrenner's four transactional levels between person and environment—macro, meso, exo, and micro—here frame the context for health-seeking behavior of Mexican immigrants. While it is not the purpose of this paper to explore each of such factors at each level in depth, they are presented here to facilitate a better understanding of immigrant health-seeking behavior within the context of a reciprocal ecosystems environment.

Macro and Exo Level Factors

At the *macro*, or societal/cultural level, and the *exo*, or distal institutional level, there are many factors that may be viewed as influencing immigrant health behavior. These include economic factors, such as the desire for work, which often results in immigrants working at jobs that have no health benefits (Chavez, Flores, & Lopez-Garza, 1992), and immigration policies. The Immigration Control Act of 1996, among others, denied some benefits to legal immigrants, not just undocumented ones, and precluded legal immigrants from receiving public benefits for five years after they had become legal residents (Berk & Schur, 2001). Other critical factors are social welfare policies, such as The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which has limited access to health care in some states for undocumented immigrants except for treatment of an emergency medical condition and immunizations (National Immigration Law Center, 2005) and the structure of the health care system. Those who do not have the resources to purchase health care insurance are, in most cases, excluded from accessing this system (Berdahl, Kirby, & Torres Stone, 2007). Other factors include societal attitudes towards immigrants, with many viewing immigrants as “undeserving outsiders” and a “problem” (Horton, 2004; Pew Hispanic Center, 2006); institutional discrimination, as “stereotyping, biases, and uncertainty on the part of healthcare providers can all contribute to unequal treatment” (Smedley, Stith, & Nelson, 2003); and cultural attitudes regarding health and illness. As an example of the latter, Borrayo and Jenkins (2003) have asserted that the concept of prevention is meaningless in traditional Mexican culture. There, in order to receive attention, one’s health problem must show symptoms.

Meso and Micro Level Factors

At the *meso*, or proximate institutional level, and at the *micro*, or individual and familial levels, there are also numerous factors affecting immigrant healthcare behavior, including accessibility of healthcare, social support networks, demography, knowledge of available health care resources, individual/familial resources, and perceptions/attitudes regarding care.

In addition to the structural barriers encountered at the macro and meso levels, the immigrant in this country may face

other issues relating to accessibility, for example, lack of transportation to healthcare facilities and lack of childcare, which would deny a parent the opportunity to use such facilities. New immigrants often do not know of health and community resources that may be available to them (Yu et al., 2005). Newcomers have to learn how to navigate a complex health-care system from which they are often excluded (Chavez et al., 1992; Smedley et al., 2003). New immigrants are often better able to access health systems with social support (Derose, 2000).

Individual demographic characteristics, such as length of residence in the United States, immigration status, and language ability, all contribute to access to care, or lack thereof, for Latino immigrants. Thamer, Richard, Casebeer, and Ray (1997) found that the longer one resides in the United States, the more likely one is to have health insurance. Similarly, LeClere, Jensen, and Biddlecom (1994) found length of residence to be a significant factor in whether and how often a person saw a physician in the last year.

Language ability can also be a significant barrier to accessing care, as many facilities have no Spanish-speaking translators and many new immigrants are not bilingual in English (Hu & Covell, 1986). Ku and Matani (2001) state that language problems are cited by Latino parents as the leading barrier to child health services. In addition, many Latino patients, even those with proficiency in English, have difficulty communicating in English when they are ill (Documet & Sharma, 2004).

Studies have shown that immigrants are more likely to be uninsured than U.S. born persons (Mohanty et al., 2005). This is particularly true for Hispanics, who have the highest percentage of uninsured of any immigrant group (Dey & Lucas, 2006). In particular, immigrants who are not U.S. citizens are more likely to lack health insurance, although the number decreases with length of time in U.S. In the case of immigrant families, U.S.-born children are eligible to receive SCHIP (State Children's Health Insurance Plan), but often undocumented parents are less likely to enroll their children in such programs (Ku & Matani, 2001).

Undocumented immigrants not only tend to lack health insurance, but also report more difficulty in obtaining health care

than others (Hubbell, Waitzkin, Mishra, Dombrock, & Chavez, 1991). In many hospitals, doctors' offices, and clinics, eligibility requirements often screen out undocumented immigrants (Smedley et al., 2003). Some studies have shown that immigrants are fearful to access health services because they are afraid they will be asked their immigration status and denied service, or even worse, be deported (Berk & Schur, 2001).

In addition, some immigrants may mistrust the medical system and their treatment by healthcare providers. Many Latinos feel that they receive lesser care, have been discriminated against in the health care system, and have been treated with disrespect based on their ethnicity and English-speaking ability (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004; Schur, Berk, Good, & Gardner, 1999).

Given these myriad, interacting forces affecting immigrants' lives, it is readily apparent that decisions to seek primary medical care, or routine care from other usual sources of care, are not isolated events but rather take place in a dynamic, sociopolitical/cultural context. Within this context, we wanted to know where Mexican immigrants choose to receive health care, particularly at what rate they would choose an ER as the source of medical care, rather than other sources of primary care or other types of care. The authors focused on emergency room use because health care obtained in this way is a public concern due to its high cost and also due to the consequent overcrowding of emergency rooms with non-emergency issues, placing great strains on hospital systems. A secondary aim of the study is to describe where immigrants obtain information about health care resources and how such information sources may impact the choice of care setting.

Methods

This study is a secondary analysis of the Mexican Migrant Worker Survey conducted by the Pew Hispanic Center (Pew Hispanic Center, 2005). The survey comprised a convenience sample of nearly 5,000 Mexican migrants in the United States who were interviewed while applying for a "Matrícula Consular," an identity document issued by Mexican diplomatic missions. As the immigrants had no legal papers

authorizing them to be in the United States, they were assumed to be undocumented or unauthorized. Data were collected at consulates in seven large American cities known to have high numbers of Mexicans: Los Angeles, New York, Chicago, Atlanta, Dallas, Raleigh, and Fresno, from July 12, 2004, to Jan. 28, 2005. In each location, data collection was conducted for five to ten business days, depending on the estimated size of the target population in each city.

Potential participants were identified in the consulate waiting rooms where they received announcements regarding the survey and its content, the nature of the questions and the length of time needed to fill out the survey, as well as a detailed explanation of the anonymity and confidentiality of their responses. Data were collected with a self-administered questionnaire in Spanish. Because the targeted sample is characterized by a high rate of illiteracy, special attention was paid to the potentially illiterate or semi-literate people in the sample by emphasizing that reading and writing were not a prerequisite to participation and that interviewers were available to provide assistance and to conduct as much of the survey as necessary. In return for filling out the questionnaire, respondents received a telephone card to be used to call Mexico.

The Pew Hispanic Center made the data publicly available after the surveys were completed. These data were downloaded from the Center's website. The dependent variable in this study was the binary variable of choosing ER for medical care. The independent variables were age, sex, education, income, employment status, length of residence in U.S., number of children, and having family in the same town. In order to learn more about the health-seeking behavior of this undocumented population, researchers here utilized descriptive statistics to ascertain demographic characteristics of the sample. Inferential statistics were used to determine the correlates and predictors of choice for health care and sources of health care information. We also described the sources of information regarding health care and investigated whether information sources independently affect the choice of setting for medical care.

The sample characteristics in this study are comparable to estimated characteristics of undocumented Mexican migrants living in the United States (Passel, Capps, & Fix, 2004; Suro,

2005). The survey captured a distinctively young and recently arrived segment of the Mexican-born population living in the United States: nearly half of the sample was aged between 18 and 29 years, or had been in the country for five years or less. In addition, respondents showed a higher level of educational achievement than the adult population of Mexico at large (Suro, 2005).

Of the sample of 4, 836, the majority were male (58.7%) and 41.3% were female. Slightly over 50% of the sample were 29 years of age or younger. About a third had not completed high school, while 59.5% were either secondary/technical school graduates or high school graduates. About six percent (6.3%) were college graduates. These findings are similar to those of Cuecuecha (2005), who found that Mexico was losing its middle-range educated workers, not its uneducated campesinos.

Almost fifty percent of the immigrants (45.9%) had been in the country for five years or less, while twenty percent (20.9%) had been in the country for more than fifteen years. Related to this residency is fluency in English, with over fifty percent (54.8%) of the respondents able to speak "only a little" or no English, as compared to 13.6% who said they spoke "a lot" of English.

A majority of the respondents were married (55.9%) and had three or more children in the United States (54.7%). Most of them lived in a town or city where they had relatives (67.1%). Of those who worked, 76% worked full-time. And unlike findings in other studies, the majority of them (59.5%) stated that they had health insurance.

Respondents were asked, "Which of these would you be most likely to use if you were seeking medical care?" Responses included: (i) hospital emergency room; (ii) clinic; (iii) private doctor; and (iv) consult with a friend. Multiple responses were allowed. The dichotomous dependent variable of the current study, emergency room (ER) use for medical care, indicated all respondents that choose hospital ER for medical care. Potential predictors of ER use included gender, age, education, level of English, marital status, number of children in the U.S., presence of relatives in town/city, working full-time, time in the U.S. and the city where the data was collected. In addition, analyses controlled for presence of health insurance.

Respondents were asked about the two most important sources from which they receive medical and health information. Analyses included a binary variable indicating that the respondent received such information from church, a second binary indicator for receiving information from medical care providers, and two other binary indicators for receiving information from Mexican and U.S. newspapers.

For purposes of analysis, an acculturation index was created from three variables found to be associated with acculturation: English-speaking ability, time in the U.S., and level of education. A number of acculturation scales have used these proxy measures and these scales have been tested and validated to some degree (Arcia, Skinner, Bailey, & Correa, 2001; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005). Those with better facility in English (self-reported), longer residence in the U.S., and higher levels of education were assumed to be more acculturated.

The proportion of immigrants choosing ER for medical care was tabulated across covariates, and chi-square tests were used to identify bivariate associations between the outcome measure and the potential predictors. Multivariate logistical regressions were used to model the relationship between ER use and explanatory variables. Estimates were converted to odds ratios. Because the acculturation index is a composite of time in the U.S., education, and level of English, two separate models were estimated. The first model included the acculturation index and did not control for items that make it up, in order to avoid multicollinearity. The second model controlled for the items that compose the acculturation index individually, and excluded the index. Data management and statistical analyses were conducted using Stata software (StataCorp, 2006).

Results

Thirty-eight percent of the respondents reported that they would use hospital ER for medical care (Table 1). Males were more likely to use ER for care, compared to females (39% vs. 35%). Those youngest (aged 29 or younger) reported higher ER use rates (41%) compared to those aged 30-39 (36%) or older (aged 40+, 31%). Those with one or two children reported the

Table 1. Bivariate Associations between Emergency Room (ER) Use for Medical Care and Respondents' Characteristics

	%	p-value
All	37.6	
Gender		
Male	39.1	0.007
Female	35.2	
Age		
Under 30	40.6	0.001
30-39	36.4	
40+	30.7	
Education		
Did Not Complete High School	36.7	0.283
Secondary/Technical School Graduate	39.3	
High School Graduate	37.0	
College Graduate	35.0	
How much English does the respondent speak?		
A Lot	37.0	0.752
Some	38.5	
A Little	36.7	
None	37.4	
Is the respondent married (including common law)?		
No	38.9	0.069
Yes	36.3	
Number of children in the U.S.		
None	34.5	0.050
1 or 2	39.7	
3 or more	36.6	
Any relatives in town/city?		
No	36.0	0.232
Yes	38.5	
Does respondent work full-time?		
No	38.6	0.856
Yes	38.3	
Time in the U.S. (Years)		
5 or Less	39.0	0.003
6 to 10	40.1	
11 to 15	37.2	
More Than 15	32.7	
Does respondent have health insurance?		
No	36.1	0.023
Yes	39.3	
Market [City]		
Los Angeles, CA	33.1	<0.001
New York, NY	45.7	
Chicago, IL	34.2	
Fresno, CA	36.2	
Atlanta, GA	45.6	
Dallas, TX	37.4	
Raleigh, NC	46.3	
Information Sources (number & % receiving information from)		
Church	32.5	0.043
Doctors or Other Medical Service Providers	36.3	0.231
Mexican Newspaper	36.4	0.762
US Newspaper	41.3	0.065

highest ER use rates (40%), compared to the subgroup with no children, or respondents with three or more children. ER use rates declined with time spent in the U.S., especially for those who have been in the U.S. for more than 15 years. There were no statistically significant bivariate subgroup variations in ER use by education, level of English, presence of relatives in town/city or full-time employment status. Reported ER use rates varied significantly according to the data collection site: lowest rates were observed in Los Angeles (33%); whereas in New York, Atlanta, and Raleigh, rates were above 45%.

Contrary to expectations, and the literature studying non-immigrant or documented immigrant populations, those with some insurance coverage reported slightly higher ER use rates compared to the respondents that lack health insurance coverage (39% vs. 36%). It should be noted that respondents were simply asked "Do you have health insurance?" and there were no inquiries on quality or source of coverage.

Of the 4,836 respondents, 345 of them (7%) reported that they receive health care related information from churches; 1,415 (29%) reported receiving information from medical care providers, 162 respondents (3%) reported Mexican newspapers as a source, and 511 of them (11%) reported U.S. newspapers as a source of information for medical care (these choices were not mutually exclusive). Respondents who receive information from a church reported less ER use, compared to all others (Table 1), whereas respondents receiving information from U.S. newspapers reported higher ER use rates (the difference reached borderline statistical significance, $p = 0.065$).

Observed variations in age remained in the multivariate analyses: the odds of using ER declined with age (Table 2). However, the gender difference was no longer significant once all other covariates were controlled for. The findings on number of children, insurance, education or employment status remained in the multivariate analyses. Variations by location also remained after other characteristics were controlled for: compared to the respondents surveyed in Los Angeles, those surveyed in New York, Fresno, Atlanta or Raleigh had significantly higher odds of reporting ER use. Respondents that use churches or medical providers as a source of information had lower odds of reporting ER use for medical care, whereas those

that use Mexican or U.S. newspapers for information were no less likely to report ER use, compared to those that do not rely on newspapers as an information source.

Table 2. Multivariate Predictors of Emergency Room (ER) Use for Medical Care

	MODEL 1		MODEL 2	
	Odds Ratio	p-value	Odds Ratio	p-value
Gender: Female	0.89	0.131	0.90	0.189
Age: 30-39	0.86*	0.061	0.83**	0.038
Age: 40+	0.65***	<0.001	0.65***	0.001
Married	1.00	0.956	0.98	0.811
1-2 children in the U.S.	1.36**	0.021	1.27*	0.086
3+ children in the U.S.	1.18	0.195	1.14	0.330
Working full-time	0.99	0.881	1.02	0.774
Possessing Health Insurance	1.20**	0.010	1.21**	0.010
Residence: New York, NY	1.58***	<0.001	1.67***	<0.001
Residence: Chicago, IL	1.04	0.696	1.10	0.379
Residence: Fresno, CA	1.45***	0.009	1.55***	0.003
Residence: Atlanta, GA	1.74***	<0.001	1.81***	<0.001
Residence: Dallas, TX	1.21*	0.069	1.24*	0.055
Residence: Raleigh, NC	1.80***	<0.001	1.88***	<0.001
Information from: Church	0.75**	0.042	0.76*	0.059
Information from: Medical Provider	0.84**	0.027	0.83**	0.026
Information from: Mexican Newspaper	0.84	0.345	0.84	0.398
Information from: U.S. Newspaper	1.02	0.871	1.00	0.984
Acculturation index	1.00	0.881	...	...
Education: Secondary/Technical Sch.	...	...	1.12	0.349
Education: High School Graduate	...	...	1.00	0.996
Education: College Graduate	...	...	1.19	0.254
English: some	...	...	1.18*	0.088
English: a little	...	...	1.25*	0.070
English: none	...	...	1.04	0.742
Time in US: 6-10 years	...	...	1.07	0.484
Time in US: 11-15 years	...	...	1.01	0.905
Time in US: 15+ years	...	...	0.95	0.754

Reference categories are male, aged 30 or younger, did not complete high school, spent less than 5 years in the US, speaking a lot of English, single, no children in the U.S., working part time, not covered by health insurance, residing around Los Angeles, CA, not receiving information from church, medical providers, U.S. or Mexican newspapers.

***p < 0.01, **0.01 <= p < 0.05, *0.05 <= p < 0.10

The acculturation measure was insignificant in multivariate analyses (Table 2, model 1). In the second model, where components of acculturation were entered independently to the estimation, we observed that level of English was associated with ER use, at a borderline significance level. Those who

rated their level of English "some" or "a little" were more likely to report ER use compared to the respondents that reported speaking "a lot" of English. An important deviation from the bivariate findings was related to time in the U.S.: spending 15 or more years in the U.S. was no longer associated with ER use, once all other covariates were controlled for.

Discussion and Conclusion

For all population groups in this country, some conditions do require ER care, including such urgent care as that required for a heart attack, in which case primary care physicians send the patient immediately to the ER. Other conditions may need immediate attention at night or on weekends. If a person, although having a source of routine care, does not have access to it (due to time, location), she or he may be channeled to the ER. However, some ER visits are "preventable," resulting from untreated or under-treated conditions that may lead to acute events requiring an emergency visit; limited access to routine health care is likely to be the root cause of such visits. In other cases, however, the ER is the immigrant's "preference" because he or she fears discrimination in doctors' offices and clinics, or simply cannot afford such services and perceives ER care as free. While the survey does not inquire as to why the person chooses ER for medical care, the questionnaire is most likely to capture the preference-based visits, thus reflecting the problem of access to care.

One of the limitations of this study, however, was the questionnaire instrument itself. While the question was asked, "Do you have health insurance?" no follow-up question was asked as to type or source of the insurance. Contrary to the literature, a high percentage (60%) of the undocumented immigrants responding to the survey reported having health insurance. As Mexico has universal health care coverage, it is possible that some of those who responded affirmatively, when interviewed in the consulates prior to receiving documentation, may have been referring to coverage in their former homeland. Given that this is a retrospective secondary analysis of an existing survey, it is beyond our capacity to investigate the validity of the insurance coverage variable. Still, we opt to report the findings-related insurance variable, since the literature shows that

it is the most influential factor that impacts health care access in the United States.

Another limitation of the study was that no question was asked about the health status of the respondents or whether they had a regular health care provider. A recent study has found that undocumented Mexicans in New York City who reported having health insurance, but not a regular source of care, were more likely to use the emergency room if they reported more health care needs (Nandi et al., 2008). ER use declines by age, even after controlling for acculturation and other factors. It is likely that older people with chronic conditions are more connected to usual sources of care, and younger people with acute problems are more likely to use ER rather than other providers. Families with one to two children were more likely to use the ER, compared to families with three or more children. It is also possible that families with more children were more informed about the outpatient health care services available for children, or more likely to insure their children with SCHIP, thus less likely rely on the ER for medical care.

The finding that younger immigrants tend to use emergency rooms in higher numbers is consistent with the literature, as is the finding that ER use declines with time in the U.S. Younger immigrants may not have as much knowledge about other health resources available, and they are less likely to be working at jobs that offer health care coverage. Therefore, they would be more likely to seek care at a hospital emergency room.

One of the interesting findings had to do with location. As indicated above, this survey was conducted in seven major cities known to have high numbers of Mexicans: Los Angeles, New York, Chicago, Atlanta, Dallas, Raleigh, and Fresno. The highest rates of ER use were found in New York City, Atlanta, GA, and Raleigh, NC. We can only conjecture what the reasons for the differences by area may be. Some of these may be due to issues discussed previously, such as access, fear, and lack of knowledge of resources, particularly in locations where this population has only recently migrated. The areas with the lowest rates of ER use, Los Angeles, Fresno, Dallas, and Chicago, have very large Mexican populations of long standing. The Mexican neighborhoods in these areas may have developed better formal and informal systems of communication

regarding health care resources. In some cases, the Mexican population may have become, over time, better accepted by the population at large and thus be better positioned to access available resources and services than are Mexican immigrants in cities like Atlanta and Raleigh, where this population has much more recently begun to settle.

Another reason for the difference in reliance on ER use may be the structure of health care systems from location to location. Large numbers of Latinos are now moving into rural (non-metro) areas and small towns that often have limited healthcare facilities and personnel, especially bilingual ones (Berdahl et al., 2007). Some dentists and physicians in these areas may be reluctant to participate in Medicaid and in the State Children's Health Insurance Program (SCHIP) (Casey, Blewett, & Call, 2004).

Another factor related to location is transportation. Cities in the U.S., including the ones used in this study, have varying degrees of quality public transportation. Even such public transportation as is available may be difficult to navigate for an immigrant with limited English-speaking ability. And whatever the locale, emergency rooms, as components and functions of hospitals, are often more visible than are neighborhood offices or clinics. The differential use of emergency rooms by location is an area for future study. While our data do not allow us to investigate the reasons for regional variations, our findings suggest that macro and meso factors, such as health care structure and transportation, are highly significant predictors of ER use by Mexican immigrants for health care, and explain a larger proportion of the variation compared to the variables we controlled at the micro level (e.g., language, education).

Another area for future research is the question of sources of health care information. It was found that those immigrants who received information from churches were less likely to use emergency rooms, perhaps because they were provided abundant information on other health care sources, and possibly even assistance in accessing such sources. The majority of Mexican immigrants are Catholics. Catholic social service organizations in the United States have long provided social services to this immigrant group as well as many others. It is possible that these organizations provide the local parishes

with information and assistance regarding other sources of health care for immigrants. As to that percentage most likely to use the ER according to source of information, those persons relying on U.S. newspapers as a source for information on health care, one can perhaps speculate that the information presented through this medium was either not sufficiently specific to resources, or that those reading the information did not feel those resources would be accessible, but more research in this area is needed.

This paper looked at a specific population in the United States, undocumented Mexican immigrants, who are of concern for many reasons. Because of their undocumented status and the realistic fear it may engender among them, it can be a difficult population to find or even to persuade to participate in research studies. Further, the use and overuse of emergency rooms is a complex issue, and one not confined to this one group. Also, in the survey utilized for this study, the survey instrument had some shortcomings, at least for our purposes, including the lack of follow-up questions to those immigrants indicating they had health insurance, and not including other factors of interest at both the macro and micro levels. Even given the shortcomings of the data, the survey did open a window onto a crucial policy question: that is, how many undocumented immigrants use emergency room services and what may be some predictors of that use?

Regardless of immigrant status, and whether one is documented or undocumented, health care access is critical to each individual. And at the societal level this issue confronts both human rights and public health considerations. When public policies leave undocumented immigrants with few choices for health care, they may find that the emergency room becomes their only choice. Further research may help solve the dilemma of how to help ameliorate health care problems of immigrant populations caused by disparate policies and health care systems across the country.

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