



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Medical Care for Undocumented Immigrants

National and International Issues



Teresa L. Beck, MD^{a,*}, Thien-Kim Le, MD^a,
Queen Henry-Okafor, PhD, FNP-BC^b, Megha K. Shah, MD, MSc^a

KEYWORDS

• Undocumented immigrants • Medical care • Health care • Access to care

KEY POINTS

- There are an estimated 30 to 40 million undocumented immigrants (UIs) worldwide, with more than 12 million in the United States.
- Barriers such as language, cost, and fear of deportation prevent many from seeking health care.
- Although some provisions exist in the United States and abroad to address the health needs of this population, most remain uninsured and with limited access to care.
- Medical conditions and issues specific to this population include infectious diseases, mental health, and inadequate prenatal care.

INTRODUCTION

Both nationally and internationally, medical care of undocumented immigrants (UIs) is a growing issue. Although definitions of who is undocumented vary internationally, in the United States UIs include individuals born outside the United States who are not legal residents. This definition includes those who have entered the country without documents or authorization, those who were legally authorized to enter but remain after their visa has expired, and those whose application for immigrant status has not been resolved.¹

Although it is challenging to determine exact figures, recent estimates show that UIs make up roughly 4% of the US population, amounting to approximately 12 million individuals. Most of this group is of Hispanic origin (64%) (See Figure 4 at Henry Kaiser

This article originally appeared in *Primary Care: Clinics in Office Practice*, Volume 44, Issue 1, March 2017.

Disclosure: The authors have no financial disclosures.

^a Emory Family Medicine Residency Program, Department of Family and Preventive Medicine, Emory University School of Medicine, 4500 N. Shallowford Rd, Suite B, Dunwoody, GA 30338, USA; ^b Family Nurse Practitioner Program, Vanderbilt University School of Nursing, Nashville, TN, USA

* Corresponding author.

E-mail address: tbeck@emory.edu

Physician Assist Clin 4 (2019) 33–45
<https://doi.org/10.1016/j.cpha.2018.08.002>

2405-7991/19/© 2018 Elsevier Inc. All rights reserved.

physicianassistant.theclinics.com

Family Foundation, Health Coverage of Immigrants: <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/>) and 90% are adults between the ages of 18 and 40 years. More than 4 million people in the United States are the US-born children of UIs. About half of UIs are of Mexican origin; however, these numbers have declined over the last 5 years, from more than 6 million to 5.6 million as of 2014. California, Texas, and Florida have the largest numbers of UIs, and Nevada has the largest share, making up 8% of the state's population.²⁻⁵

The issue of UIs is not unique to the United States. Internationally, the United Nations Population Division estimates that there are 30 million to 40 million unauthorized immigrants worldwide, and although most are in the United States, proportionally continental Europe has a larger share.⁶ Although UIs have a variety of reasons to migrate, from safety concerns to economic incentives, addressing the health needs of these populations come with unique challenges and solutions. This article provides an overview of challenges in addressing their health needs, existing methods for accessing care, health conditions specific to this population, and potential solutions to consider in both the national and international contexts, specifically in Europe.

CHALLENGES IN HEALTH CARE

Despite the better health status of the younger UI population, this advantage deteriorates over increasing time spent in the United States.⁷ Various factors from socioeconomic status to fear of deportation affect the UI population's health both domestically and internationally and deter UIs from seeking care. The UI population is often of lower socioeconomic status, which adds to the difficulties accessing health care. Given that most of the federal insurance plans are unavailable to the UI population, UIs are susceptible to higher out-of-pocket costs for care. In addition, because of undocumented status, they may not have sick leave days and may have difficulty negotiating time off from work to seek care.⁸

Decreased proficiency in the language of the host country and fear of deportation may also present barriers to health care for UIs. Studies have shown that patients with limited English language proficiency (LEP) are at higher risk of poor health and have decreased access to health care. Patients who have LEP had increased difficulty in understanding their health status as well as accessing preventive services.⁹ Fear of deportation may lead to the avoidance of seeking care and risk of severe health complications,⁸ and this also affects health care for US-born children of UIs. In addition, shame and discrimination are common feelings experienced by the UI population and contribute to poor access to health care globally.⁸

Many of these issues in health care are not unique to the United States. In a study by Chauvin and colleagues,¹⁰ 22% of the UI population in Europe had access to health coverage, and, of those, only about 36% had true access because of barriers such as administrative difficulties, limited language proficiency, and lack of awareness of available services. Of the main reasons for lack of access, administrative difficulties in obtaining health care and finances were cited as the most common. France and Belgium were found to have the most complicated systems for obtaining health care and, for those who had access, the fear of deportation or imprisonment was prevalent.

ACCESS TO HEALTH CARE

The Patient Protection and Affordable Care Act (ACA), passed in 2010, required most US citizens and legal residents to have health insurance, and resulted in the expansion of Medicaid in 32 states. UIs are not eligible for Medicaid or state-based exchanges

under this law.¹¹ Thus, although the number of overall uninsured in the United States has decreased, it is mostly US citizens and legal residents who have gained access to health insurance.¹²

In 1986, Congress approved the Emergency Medical Treatment and Labor Act (EMTALA), requiring hospitals to provide services for active labor and emergency care regardless of insurance and immigration status. In addition to EMTALA, there is emergency care under Medicaid, which is currently the only federal insurance that is available to UIs. Emergency Medicaid covers patients in active labor and those with acute medical emergencies.¹³ It may only be used to stabilize patients and may not cover patients for services after the patient has been stabilized.

Federal provisions available to UIs include prenatal care and care for children funded by Maternal and Child Health Block grants and the Supplemental Food Program for Women, Infants and Children. In 2009, the Children's Health Insurance Program (CHIP) was expanded under the CHIP Reauthorization Act (CHIPRA). In 2015, federal funding for CHIP was expanded to states, which included the standard Medicaid benefit package such as the Early and Periodic Screening, Diagnostic, and Treatment services for medically necessary mental health and dental services, vaccinations and prescription drugs, and access to medical specialists and hospital care and services. Although these resources are available for a vulnerable subset of UIs, there are few resources that exist for sick, nonpregnant adults.¹²

Federally Qualified Health Centers (FQHCs) are community health centers that receive federal grant funding to support care to the uninsured without regard for immigration status. There are approximately 1200 health centers operating around the country, providing primary health care, dental, mental health, and pharmacy services on a sliding-scale basis. In addition, there are many low-cost and free community clinics that rely on private donations and volunteers to provide services to those who cannot afford to pay.¹⁴

ACCESS TO HEALTH CARE IN EUROPE

Europe faces similar challenges regarding access to health care for its UI population. The Platform for International Cooperation on Undocumented Migrants (PICUM) reported that Italy and Spain provided the widest coverage for UI with universal access to health care.¹⁰ Germany, Greece, Sweden, and Switzerland only cover emergency care for UIs.¹⁰ **Table 1** provides an overview of access to care for UIs in Europe.¹⁵

THE NATIONAL DEBATE ON MEDICAL CARE FOR UNDOCUMENTED IMMIGRANTS

There is ongoing political debate in the United States regarding health care services for UIs. Those in opposition maintain that using taxpayer-funded services to support individuals who enter and remain in the United States illegally undermines the legal system. However, some scholars and legislators have argued that it is both unethical and impractical to deny access to health care services for illegal immigrants living in the United States.¹⁶ They view health care as a basic human right and an obligation of a just society to provide health care for everyone. Leading medical professional societies such as the American Medical Association (AMA), American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and the American Nurses Association (ANA) reaffirm the position that all individuals living in the United States, regardless of their immigration status, should have access to quality health care, including the opportunity to purchase insurance. These leaders maintain that providing this population with access to health insurance is an evidence-based way to reduce health care costs.^{17–19}

Table 1
Health care access to undocumented migrants in 7 European countries

Country	Undocumented Migrants as Percentage of Population	Main Vehicle for Covering Undocumented Migrants	Benefits	Additional Notes
United Kingdom	1.2	NHS	Emergency care and certain infectious diseases with public health hazard. NHS requires hospitals to confirm the ability to pay of patients not covered by the NHS	Cost must either be covered by the patient or taken out of the hospital's budget, which creates a barrier
France	0.6	AME	Full range as provided in the public system	Undocumented migrants without AME eligibility are entitled to emergency care, pediatric care, and maternity care
Germany	0.6–1.8	Separate tax-funded scheme in which providers can receive reimbursement for the costs of emergency treatment	All emergency care Several categories of planned care, only accessible with a medical card	Undocumented migrants face a high barrier when applying for a medical card in the welfare office because the office must report the individual to the authorities, which could lead to deportation
Italy	0.3–1.6	Undocumented migrants can apply to a local national health service office for a temporary (ie, 6-mo) health card	Health card entitles bearer to urgent care, essential care, preventive care (including maternity care), and diagnosis/treatment of infectious diseases	There are local differences in interpretation of the law and willingness to provide services. There are reports of many people without access
Netherlands	0.4–1.4	Separate tax-funded scheme in which the government pays providers for undocumented migrant care at 80% of normal fees for costs that cannot be recovered from the patient	Full range as provided in the public system	The requirement that patients be billed and the limited number of contracted providers for services provided on referrals may create barriers to care

Spain	0.8	Undocumented migrants are covered by the national health service if they have registered as residents of the municipality	Full range as provided in the public system	The requirements for registration with a municipality (valid passport, a proven residency) and police having access to registers constitute the greatest barriers
Switzerland	1.0–1.3	Undocumented migrants are required to purchase insurance in the statutory health insurance system provided by private insurers. There are income-related subsidies	Full range as provided in the public system	High premiums, cost-sharing requirements, and administrative procedures may seriously hamper undocumented migrants' ability to purchase insurance. Undocumented migrants mostly rely on basic health care provided by the cantons

Abbreviations: AME, State Medical Assistance; NHS, UK National Health Service.

Data from Country-specific reports from the Nowhereland Project and the Platform for International Cooperation on Undocumented Migrants (PICUM). PICUM submission to the UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families: day of general discussion on the role of migration statistics for treaty reporting and migration policies. 2013. Available at: http://www.ohchr.org/Documents/HRBodies/CMW/Discussions/2013/DGDMigrationData_PICUM_2013.pdf. Accessed February 14, 2016.

Another argument, from a cost perspective, is that many UIs will benefit from preventive care and early treatment of chronic diseases before they advance to life-threatening and costly complications.^{20,21} Proponents of this strategy advocate for improving health literacy and vaccination rates, and offering health screenings to the UI population to try to prevent long-term adverse health outcomes and control cost. Moreover, UIs may harbor infections such as tuberculosis (TB), which, when undetected, can easily be transmitted to the general public, thus posing a public health risk.²²

In contrast, some have argued that treating UIs creates more expenditures for the United States while saving their countries of origin the costs of providing health care.²³ Furthermore, they argue that sharing inadequate health care resources with UIs will reduce the availability of those scarce resources for US citizens. In the last 2 decades, several states have attempted to advance legislation designed to deny UIs access to publicly funded health services. One such initiative was California's Proposition 187. This law, later deemed unconstitutional, required health care professionals to verify immigration status and report UIs to authorities.²⁴

In addition, some believe that continued unabated treatment of UIs is an incentive for persistent violation of the immigration laws and threatens national security in the post-9/11 era.²⁵ Proponents of this argument suggest that denying health care to UIs will discourage others from attempting to immigrate without proper documentation.²⁴

COMMON MEDICAL CONDITIONS IN UNDOCUMENTED IMMIGRANTS

There are significant gaps in the literature on the health status of the UI population. Immigrants in general, and the undocumented in particular, report lower levels of cancer, heart disease, arthritis, depression, hypertension, and asthma than do the native born.²⁶ Factors thought to contribute to lower rates of reported chronic diseases include the young immigrant population and the process of migration, which, especially in cases of undocumented individuals, positively selects for those healthy enough to make the often arduous journey (ie, the so-called healthy immigrant effect).^{7,26} In addition, little is known about the long-term health of the children of UIs, particularly related to the adverse effects of inadequate prenatal care and the stressors related to undocumented status, which has been shown to negatively affect children regardless of their own legal status.¹²

Most of the emergency health care services used by UIs are for childbirth. A study of emergency Medicaid expenditures for undocumented and recent immigrants in North Carolina between 2001 and 2004 found that more than 82% of health care spending was related to childbirth and complications of pregnancy. Of the remaining health care expenditures, one-third was spent on the treatment of acute injuries and poisoning, possibly related to exposure to pesticides or other toxins in the workplace.²⁷ These uses of health care services reflect not only the young age of most UIs but also the type of work that they perform.²⁸ Beyond pregnancy and acute injury, chronic renal failure, cerebrovascular disease, and heart disease were major contributors to emergency Medicaid use.²⁷

Various factors associated with undocumented status are thought to erode the health advantage of the undocumented at a faster rate than their documented counterparts. Specifically, limited access to quality health care; increased vulnerability caused by low income and occupational status; and the stressors associated with undocumented status, such as fear of deportation, have been implicated.²⁹ In addition,

UIs with chronic and infectious medical conditions are negatively affected because of poor access to care.³⁰⁻³²

Perinatal health of undocumented women and their US-born children is a specific area of concern. Consistent with much of the health literature, several studies have found that undocumented women engage in few health risk behaviors while pregnant and seem to have low rates of low-birth-weight or preterm babies.³³⁻³⁶ However, the beneficial effects of better health behaviors during pregnancy are counteracted by the effects of lower rates of prenatal care among UIs. Poor (and late) prenatal care has been associated with higher risk for adverse perinatal outcomes.^{36,37}

In addition, stressors related to undocumented status, such as fear of deportation or experiences of discrimination and stigma, may adversely affect the physical and emotional health of UIs, with potential consequences for their US-born children.^{38,39} Findings from a qualitative study of 85 immigrant families experiencing the arrest of at least 1 parent by immigration authorities, showed an increase in the children's behavioral problems, speech and developmental concerns, and declines in school performance.⁴⁰

There is a public health concern over UIs bringing infectious diseases into the United States. Legal immigrants and refugees are required to have a medical examination for migration to the United States, while they are still overseas. This examination is the responsibility of the Centers for Disease Control and Prevention (CDC), which provide instructions to the panel physicians who conduct the medical examinations. The procedure consists of a physical examination, an evaluation (skin test/chest radiograph examination) for TB, and a serologic evaluation for syphilis. Requirements for vaccination are based on recommendations from the Advisory Committee on Immunization Practices.⁴¹

Individuals who fail the examination because of certain health-related conditions are not admitted to the United States. Such conditions include drug addiction or communicable diseases of public health significance, such as TB, syphilis, gonorrhea, leprosy, and a changing list of current threats such as polio, cholera, diphtheria, smallpox, or severe acute respiratory syndromes.⁴² There is a growing concern that UIs crossing into the United States illegally could bring any of these threats. The most prevalent infectious diseases are hepatitis B, latent and active TB, filariasis, intestinal helminth infections, malaria, intestinal protozoa infections, hepatitis C, other nonparasitic infections, sexually transmitted diseases, and human immunodeficiency virus.⁴³

Little is known about the mental health issues of UIs. However, the literature suggests that UIs have a unique risk profile that may contribute to different mental health outcomes compared with their documented counterparts. Themes specific to UIs include failure in the country of origin, dangerous border crossings, limited resources, restricted mobility, marginalization/isolation, stigma/blame and guilt/shame, vulnerability/exploitability, fear and fear-based behaviors, and stress and depression.⁴⁴

One study compared the diagnoses and mental health care use of undocumented Latin American immigrants (15%) with those of documented (73%) and US-born Latin Americans (12%) treated in this clinical setting. The undocumented Latin Americans were more likely to have a diagnosis of anxiety, adjustment, and alcohol abuse disorders. The UIs also had a significantly greater mean number of concurrent psychosocial stressors compared with documented immigrants and US-born groups, and they were more likely to have psychosocial problems related to occupation, access to health care, and the legal system.⁴⁵ Other studies have shown increasing rates of substance abuse, binge-eating, and conduct disorders among UIs residing longer in the United States.⁷

THE EUROPEAN EXPERIENCE

The European immigrant population comes from many different countries, with a heavy concentration from countries in Africa, the Middle East, and the former Soviet Union. The most commonly reported health care problems in this undocumented migrant population include mental health, infectious and sexually transmitted diseases, and reproductive health. Concerns about human trafficking, particularly of women and children, for commercial sexual exploitation or forced labor or slavery are more prominent in Europe.¹⁵

POTENTIAL SOLUTIONS

Despite the contentious debate over the ACA, a consensus has emerged that strengthening primary care will improve health outcomes and restrain the growth of health care spending. Supporting evidence comes from studies of primary care as an orientation of health systems and as a set of functions delivered by a usual source of care.⁴⁶ Although methodological concerns exist, many observational studies in the United States have found that regions with higher primary care physician-to-specialist ratios have better health outcomes, including lower mortality; fewer emergency department visits, hospitalizations, and procedures per capita; and lower costs.⁴⁶

International comparisons between industrialized countries also suggest that countries with higher ratings of primary care orientation experience better health care outcomes and incur lower health care costs than countries with lower degrees of primary care orientation.⁴⁶ These findings suggest that reducing barriers to primary care for UIs may ultimately improve the quality and cost of delivering health care for all countries struggling to manage their growing immigrant populations.

MODELS FOR OFFERING COMPREHENSIVE CARE

Several US cities and states with large immigrant populations have attempted to address their health care needs by providing access to primary care. New York City has the nation's largest public health system, composed of the Health and Hospitals Corporation (HHC) and Community Health Care Association of New York State, whose members include FQHCs and migrant health programs. These organizations provide much of the health care for uninsured and undocumented patients. Both systems rely on Medicaid (and, to a lesser extent, Medicare) reimbursements. They also depend on federal Disproportionate Share Hospital funding and other sources of state Indigent Care Pool funding. In addition to primary and preventive health care, HHC ambulatory centers offer uninsured patients access to on-site pharmacies and referrals to medical specialists and diagnostic and other services located in HHC medical centers.⁴⁷

California offers a Medi-Cal health insurance plan that provides a full range of low-cost health care options for uninsured Californians, with some benefits provided regardless of immigration status. In addition, Kaiser Permanente offers a Child Health Program for uninsured California children younger than 19 years who do not have access to Medi-Cal or other coverage, regardless of immigration status. My Health LA (MHLA) is a no-cost health care program that offers comprehensive health care for low-income, uninsured Los Angeles county residents, regardless of immigration status or medical condition. It offers care through 164 community clinic medical home sites, where patients receive primary and preventive health care services and some diagnostic services. Los Angeles County Department of Health Services facilities also provide county clinic medical home sites, plus emergency, diagnostic, specialty, inpatient services, and pharmacy services. Healthy San Francisco (HSF) is a low-

income program for San Francisco County residents regardless of employment status, immigration status, or medical condition. Unlike MHLA, HSF charges a participation fee and point-of-service fee to all patients except for those at less than 100% of the federal poverty level and those who are homeless.⁴⁷

The Harris County Health System, which includes the city of Houston, Texas, offers Access Care, a financial assistance program open to uninsured and undocumented Harris County residents, and provides access to discounted health care at more than 20 community clinics, a dental clinic, and surgical and other subspecialty clinics. The Harris Health System has a dialysis clinic as well as a long-term care facility.⁴⁷

In Massachusetts, all immigrants are eligible for some form of health coverage. There is 1 application for all available programs, including the insurance marketplace. Mass Health Limited is the state version of emergency Medicaid. It is available to UIs and some immigrants who are PRUCOL (Permanent Residence Under Color of Law), defined as aliens who are living in the United States with the knowledge and permission of the federal government, and whose departure the agency does not contemplate enforcing.⁴⁷

In Nevada, the nonprofit Access to Healthcare Network (AHN) offers medical discount programs, specialty care coordination, a health insurance program, nonemergency medical transportation services, a pediatric hematology/oncology practice, and a toll-free statewide call center. AHN has 35,000 members, more than half of whom are presumed to be undocumented.⁴⁷

ADDRESSING BARRIERS TO CARE FOR UNDOCUMENTED IMMIGRANTS

A study by Hacker and colleagues⁸ identified 5 areas to address barriers to care for UIs: advocacy for policy, insurance options, expansion of the safety net, training of providers, and education of UIs on navigating the system (Table 2).

Table 2 Recommendations for improving barriers	
Category	Description
Advocacy/legal change	<ul style="list-style-type: none"> • Expand health care access to all, regardless of status • Make UIs documented and give full rights to health care
Insurance	<ul style="list-style-type: none"> • Allow all residents to have access to state-funded limited network health plan and paid or subsidized insurance options, or provide insurance to all workers regardless of status
Expansion of the safety net	<ul style="list-style-type: none"> • Expand the capacity of public, nonprofit, and free clinics to render care to the population • Provide health and education in nonprofit social service or faith-based organizations • Enhance support for safety-net providers through state-funded vehicle
Training providers	<ul style="list-style-type: none"> • Train providers to better understand the needs of their immigrant patients • Train providers and update them on legal mandates within the country
Education and outreach to UIs	<ul style="list-style-type: none"> • Outreach to specific immigrant communities to educate on the current laws and the system, especially education regarding rights to health care • Provide culturally appropriate navigators in health care environments

POTENTIAL SOLUTIONS IN EUROPE/INTERNATIONAL CONTEXT

Nearly all industrialized countries provide some form of government-supported health care to all of its residents, including those who are undocumented (see [Table 1](#)). Although countries in the European Union have significantly fewer UIs, their models may offer insights on the options and challenges of addressing this health care dilemma facing the United States.

SUMMARY

Medical care for UIs is a complex area involving challenges for accessing care, barriers in financing care, and unique medical conditions. Fear, stigma, cost, and cultural barriers often prevent UIs from seeking medical care. UIs make up a small but substantial portion of the population in the United States and internationally, and there is an emerging interest in finding solutions to address their health care needs. In the United States, cities with large numbers of immigrants have models that provide health care to their uninsured regardless of immigration status, and could potentially be expanded to other areas of the country experiencing increasing growth of their immigrant populations. International approaches may also inform on policies to address the health care needs of UIs.

REFERENCES

1. Internal Revenue Service. Immigration terms and definitions involving aliens. Available at: <https://www.irs.gov/Individuals/International-Taxpayers/Immigration-Terms-and-Definitions-Involving-Aliens>. Accessed February 14, 2016.
2. Passel JS. Unauthorized migrants: numbers and characteristics. Background briefing prepared for Task Force on Immigration and America's Future. 2005. Available at: <http://www.pewhispanic.org/files/reports/46.pdf>. Accessed April 29, 2016.
3. Artiga S, Damico A, Young K, et al. Health coverage and care for immigrants. 2016. Available at: <http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/>. Accessed February 14, 2016.
4. Hoefler M, Rytina N, Baker B. Estimates of the unauthorized immigration population residing in the United States: January 2011. 2012. Available at: https://www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2011.pdf. Accessed April 28, 2016.
5. Krogstad JM, Passel JS. 5 facts about illegal immigration in the U.S. 2015. Available at: <http://www.pewresearch.org/fact-tank/2015/11/19/5-facts-about-illegal-immigration-in-the-u-s/>. Accessed April 29, 2016.
6. Platform for International Cooperation on Undocumented Migrants (PICUM). PICUM submission to the UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families: day of general discussion on the role of migration statistics for treaty reporting and migration policies. 2013. Available at: http://www.ohchr.org/Documents/HRBodies/CMW/Discussions/2013/DGDMigrationData_PICUM_2013.pdf. Accessed February 14, 2016.
7. Teruya SA, Bazargan-Hejazi S. The immigrant and Hispanic paradoxes: a systematic review of their predictions and effects. *Hispanic J Behav Sci* 2013; 35(4):486–509.
8. Hacker K, Anies M, Folb BL, et al. Barriers to health care for undocumented immigrants: a literature review. *Risk Manag Healthc Policy* 2015;8:175.

9. Sentell T, Braun KL. Low health literacy, limited English proficiency, and health status in Asians, Latinos, and other racial/ethnic groups in California. *J Health Commun* 2012;17(Suppl 3):82–99.
10. Chauvin P, Parizot I, Simonnot N. Access to healthcare for undocumented migrants in 11 European countries, vol. 70. Paris: CLUMIC; 2009. p. 93–102. Available at: <http://www.epim.info/wp-content/uploads/2011/02/Access-to-healthcare-for-Undocumented-Migrants-in-11-EU-countries-2009.pdf>. Accessed February 11, 2016.
11. Medicare.gov. Affordable Care Act. 2012. Available at: <https://www.medicaid.gov/affordablecareact/affordable-care-act.html>. Accessed February 11, 2016.
12. Wallace SP, Torres J, Sadegh-Nobari T, et al. Undocumented immigrants and health care reform. Final report to The Commonwealth Fund 2012.
13. Congressional Budget Office. The impact of unauthorized immigrants on the budgets of state and local governments. 2007. Available at: <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/12-6-immigration.pdf>. Accessed February 11, 2016.
14. Centers for Medicare/Medicaid Services. CMS issues proposed changes in conditions of participation requirements and payment provisions for rural health clinics and federally qualified health centers. 2008. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2008-Fact-sheets-items/2008-06-26.html>. Accessed April 29, 2016.
15. Gray BH, van Ginneken E. Health care for undocumented migrants: European approaches. *Issue Brief (Commonwealth Fund)* 2012;33:1–12.
16. Fowler N. Providing primary health care to immigrants and refugees: the North Hamilton experience. *CMAJ* 1998;159(4):388–91.
17. Kline M. National immigration policy and access to health care: American College of Physicians - a position paper 2011. 2011. Available at: https://www.acponline.org/acp_policy/policies/natl_immigration_policy_access_healthcare_2011.pdf. Accessed April 22, 2016.
18. Stream GR. American Academy of Family Physicians: STRONG MEDICINE for America. 2013. Available at: <http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/LT-ReidMcConnellImmigrationReform-062113.pdf>. Accessed April 22, 2016.
19. Godfrey T. Nursing beyond borders: access to health care for documented and undocumented immigrants living in the US. 2010. Available at: <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Access-to-care-for-immigrants.pdf>. Accessed April 22, 2016.
20. Kuruvilla R, Raghavan R. Health care for undocumented immigrants in Texas: past, present, and future. *Tex Med* 2014;110(7):e1.
21. Chernin G, Gal-Oz A, Schwartz IF, et al. Care of undocumented-uninsured immigrants in a large urban dialysis unit. *BMC Nephrol* 2012;13:112.
22. Seybolt LM, Christiansen D, Barnett ED. Diagnostic evaluation of newly arrived asymptomatic refugees with eosinophilia. *Clin Infect Dis* 2006;42(3):363–7.
23. Phillips CB, Benson J. Better primary health care for refugees - catch up immunisation. *Aust Fam Physician* 2007;36(6):440–2, 444.
24. Schuck PH. The message of 187: facing up to illegal immigration. *Am Prospect* 1995;(21):85–92.
25. Flechner SM, Leeser D, Pelletier R, et al. Do the right thing. it will gratify some people and astonish the rest. *Am J Transpl* 2015;16(3):1039–40.

26. Footracer KG. Immigrant health care in the United States: what ails our system? *JAAPA* 2009;22(4):33–6.
27. DuBard CA, Massing MW. Trends in emergency Medicaid expenditures for recent and undocumented immigrants. *JAMA* 2007;297(10):1085–92.
28. Gusmano M. Undocumented immigrants in the United States: use of health care. Garrison (NY): The Hastings Center. Available at: <http://undocumentedpatients.org/issuebrief/health-care-use/>.
29. Heyman JM, Nunez GG, Talavera V. Healthcare access and barriers for unauthorized immigrants in El Paso County, Texas. *Fam Community Health* 2009;32(1): 4–21.
30. Coritsidis GN, Khamash H, Ahmed SI, et al. The initiation of dialysis in undocumented aliens: the impact on a public hospital system. *Am J Kidney Dis* 2004; 43(3):424–32.
31. Achkar JM, Sherpa T, Cohen HW, et al. Differences in clinical presentation among persons with pulmonary tuberculosis: a comparison of documented and undocumented foreign-born versus US-born persons. *Clin Infect Dis* 2008;47(10): 1277–83.
32. Dang BN, Giordano TP, Kim JH. Sociocultural and structural barriers to care among undocumented Latino immigrants with HIV infection. *J Immigr Minor Health* 2012;14(1):124–31.
33. Dang BN, Van Dessel L, Hanke J, et al. Birth outcomes among low-income women—documented and undocumented. *Permanente J* 2011;15(2):39.
34. Kelaher M, Jessop DJ. Differences in low-birthweight among documented and undocumented foreign-born and US-born Latinas. *Soc Sci Med* 2002;55(12): 2171–5.
35. Korinek K, Smith KR. Prenatal care among immigrant and racial-ethnic minority women in a new immigrant destination: exploring the impact of immigrant legal status. *Soc Sci Med* 2011;72(10):1695–703.
36. Reed MM, Westfall JM, Bublitz C, et al. Birth outcomes in Colorado's undocumented immigrant population. *BMC Public Health* 2005;5(1):100.
37. Lu MC, Lin YG, Prietto NM, et al. Elimination of public funding of prenatal care for undocumented immigrants in California: a cost/benefit analysis. *Am J Obstet Gynecol* 2000;182(1):233–9.
38. Potochnick SR, Perreira KM. Depression and anxiety among first-generation immigrant Latino youth: key correlates and implications for future research. *J Nerv Ment Dis* 2010;198(7):470.
39. Suárez-Orozco C, Yoshikawa H, Teranishi RT, et al. Growing up in the shadows: the developmental implications of unauthorized status. *Harv Educ Rev* 2011; 81(3):438–72.
40. Chaudry A, Capps R, Pedroza J, et al. Facing our future: children in the aftermath of immigration enforcement. Washington, DC: The Urban Institute; 2010. Available at: <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412020-Facing-Our-Future.PDF>. Accessed May 18, 2011.
41. Centers for Disease Control and Prevention. Immigrant and refugee health: technical instructions for medical examination of aliens. 2012. Available at: <http://www.cdc.gov/immigrantrefugeehealth/exams/ti/panel/technical-instructions/panel-physicians/medical-history-physical-exam.html>. Accessed May 2, 2016.
42. Centers for Disease Control and Prevention. Immigrant and refugee health: frequently asked questions about the final rule for the medical examination of aliens - revisions to medical screening process. 2016. Available at: <http://www.cdc>.

- gov/immigrantrefugeehealth/laws-regs/revisions-medical-screening/faq.html. Accessed May 2, 2016.
43. López-Vélez R, Huerga H, Turrientes M. Infectious diseases in immigrants from the perspective of a tropical medicine referral unit. *Am J Trop Med Hyg* 2003; 69(1):115–21.
 44. Sullivan MM, Rehm R. Mental health of undocumented Mexican immigrants: a review of the literature. *ANS Adv Nurs Sci* 2005;28(3):240–51.
 45. Pérez MC, Fortuna L. Psychosocial stressors, psychiatric diagnoses, and utilization of mental health services among undocumented immigrant Latinos. *J Immigrant Refugee Serv* 2005;3:107–23.
 46. Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. *Health Aff* 2010;29(5):766–72.
 47. Berlinger N, Calhoun C, Gusmano MK, et al. Undocumented immigrants and access to health care in New York City: identifying fair, effective, and sustainable local policy solutions: report and recommendations to the Office of the Mayor of New York City, The Hastings Center and the New York Immigration Coalition. 2015. Available at: www.undocumentedpatients.org and www.thenyic.org/healthcare. Accessed February 29, 2016.