

Undocumented migration and the social right to health: A blurred trajectory in the United States and Mexico

Migración indocumentada y derecho social a la salud: Una trayectoria difuminada en Estados Unidos y México

Yetzi Rosales^{a*}  <https://orcid.org/0000-0003-1169-9411>

^a Conacyt, El Colegio de la Frontera Norte, Departamento de Estudios de Población, Monterrey, Nuevo León, Mexico, e-mail: romy@colef.mx

Abstract

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*Corresponding author: Yetzi Rosales, e-mail, romy@colef.mx

This paper analyzes the social right to health of a group of Mexicans deported in the context of their migration between Mexico and the US. Based on 20 semi-structured interviews with deportees living in the city of Monterrey, Nuevo León, it explores the search for medical care and access to healthcare services during a migratory trajectory conformed of three stages: destination, interception and return. The results emerge from a dual experience, first, as irregular immigrants in the United States and, later, as deportees in Mexico. The right to health was partially exercised in both national contexts with health systems and policies that exclude, either on purpose or by omission, irregular immigrants and deportees. The period of residence or absence, as well as family networks, acted as antagonistic factors encouraging or inhibiting access to health, according to the migratory stage analyzed. This right was typically exercised during medical emergencies caused mainly by accidents.

Keywords: irregular immigration, deportation, medical care, Mexico, United States.



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Resumen

Este artículo analiza el derecho social a la salud en un grupo de mexicanos deportados en el marco de la migración entre México y Estados Unidos. Con base en 20 entrevistas semiestructuradas con deportados residentes en la ciudad de Monterrey, Nuevo León, se exploró la búsqueda y acceso a servicios de salud

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durante una trayectoria migratoria conformada por tres etapas: el destino, la intercepción y el retorno. Los resultados emanan de una doble vivencia, primero, como inmigrantes irregulares en Estados Unidos y, después como deportados en México. El derecho a la salud se ejerció parcialmente en ambos contextos nacionales con sistemas de salud y políticas que excluyen, a propósito o por omisión, a inmigrantes irregulares y deportados. El tiempo de residencia o ausencia, así como las redes familiares actuaron como factores antagónicos favoreciendo o inhibiendo el acceso a la salud según la etapa migratoria analizada. Este derecho se ejerció típicamente durante emergencias médicas causadas principalmente por accidentes.

Palabras clave: inmigración irregular, deportación, atención médica, México, Estados Unidos.

Introduction¹

This article contributes to the literature on the social right to health and undocumented migration between Mexico and the United States. The concept of social rights is taken up here based on the compensatory justice it entails for underserved social groups. While these types of rights have their origins in the arena of work and social security, their aims have permeated other spheres of social life related to access to education, healthcare, culture, housing, nutrition, etc. The fulfillment of this right is theoretically backed by the presence of a social state whose function is to protect and guarantee preferential treatment for the neediest groups, i.e., those in situations of vulnerability and exclusion due to the capitalist economic system (Prieto, 1995).

In certain national contexts, the concept of social rights has expanded as a result of the increase in population flows across borders. The relationships between nation states and residents born outside their territories has meant that citizenship, as membership or adscription to a social contract, is gradually ceasing to be a single and indispensable requirement to be a bearer of social rights. In the current migration situation, receiver countries have included in their legislation—with certain reservations—the granting of rights to foreigners in accordance with the clauses contained in international migration agreements signed for this purpose.²

Access to social rights by migrants has been documented largely alluding to the “immigrant” population—that is, from the point of view of the host country. However, changes in the evolution and directionality of migratory flows requires that we also turn our gaze to populations who return to their country of origin after long periods of time. This reasoning invites an analysis of migration from a longitudinal perspective, addressing the trajectory from irregular immigration in the host country through the

¹ This article is part of the research project: *Las ciudades santuario como fronteras emergentes. Dinámicas transnacionales y espacios vividos de mexicanos indocumentados en Estados Unidos*, financed by Conacyt.

² An example of these is the Convention on Migrant Workers, 1949; the Convention Concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers, 1975; the Convention Relating to the Status of Refugees, 1948; and the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, 1990.

return to the country of origin, where migrants also face difficulties in exercising their rights due to a lack of valid identification documents in a certain context.³

This article is particularly concerned with examining the social right to health among migrants, which is exercised differently not only among native and migrant populations but also within the latter category (Chavez, 2012). A series of legal/administrative requirements, in addition to discriminatory attitudes, impose greater obstacles on people who do not possess official documents compared with those who possess visas. International experience has demonstrated that impacts on physical and mental health are often greater when migration occurs illegally given the exposure to more violent social contexts, transit through unsafe spaces, and situations of isolation and exclusion.

As groups in situations of greater vulnerability, undocumented immigrants and deportees present health impacts caused to a large extent by the conditions of the journey, health services provision infrastructure, and restrictive migration policies. From the place of origin until return, the health needs of migrants can worsen over time, above all if they lack resources and social networks that facilitate access to medical care (Aboii, 2014). For this reason, the return phase can mean cumulative harm to their health that places greater demands on the healthcare system due to the worsening of disabilities, chronic illnesses or mental illnesses that are not treated promptly (Martinez-Donate et al., 2017; Wassink, 2018; Zimmerman, Kiss & Hossain, 2011).

The objective of this article is to analyze exercising the right to health among a group of Mexicans during a trajectory that includes three phases of migration and two national contexts. Using a qualitative methodology, retrospective information was gathered from 20 deportees who at the time of the study resided in Monterrey, Nuevo León. Experiences of searching for and accessing medical care were investigated, first, in the United States as a host country with a federal immigration policy that excludes from the healthcare system the population with undocumented status and, second, in Mexico as the return country with a nascent policy on the reception of citizens and a healthcare system that is insufficient for serving the general population.

Social rights and international migration

The definition of social rights is dynamic, given their connection with social demands and reparations for injustices occurring throughout history. These rights, also called “benefits,” aim to diminish social inequalities through the provision of goods and services to sectors of the population that lack the means to acquire them through the marketplace. The application of these rights requires the principle of compensatory or corrective justice that seeks to make up for deficits within a certain social context. The idea behind this is that historic injustices create a debt to populations that are currently in situations of vulnerability, and one way of compensating for such injustices is through special legal protection and the attribution of basic rights that contribute

³ Primarily those who have been deported after living for many years in the United States return without official documents recognized in Mexico. Without this documentation, access to social services is difficult in their own country, even in government shelters.

to those populations achieving optimal human development (Alvarado & Carreño, 2007; Sanderson, 2012). According to Sosa, the emergence of social rights “involved the consecration of a set of confessedly unequal norms in their content —although not in their purpose— with recipients of preferential protection due to their state of greater vulnerability” (Sosa, 2008, p. 12). In instrumental terms, the formulation and fulfillment of these rights create heterogeneous realities in each country based on structural conditions and social policies geared toward regulating the distribution of economic benefits among inhabitants (Prieto, 1995).

In the United States, the notion of social rights has a limited scope due to the nature of its welfare model. This liberal model is grounded in a free market economy and in a segment of the population that has been excluded from the benefits of that system (Navarro, 2006; Sainsbury, 2006). The state provides public assistance for the most impoverished population, while access to social rights for the rest of the population depends on their participation in the labor market, the employment sector and the payment of taxes. According to this logic, the enjoyment of goods and services is made conditional on the purchasing power of individuals or their classification as a social group in extreme poverty (Navarro, 2006).

In this context, the reduced provision of social rights to the general population is even more restricted for those who are not citizens. Being a foreigner in the United States, as in other countries, entails certain disadvantages in terms of the enjoyment of rights that vary according to the mode of entering the country (Sainsbury, 2006). The population that enters as part of a temporary worker program, such as professionals or experts (H1-B and TN) in advanced technology industries or non-agricultural industries (H2-B) can access social services through their work contracts; however, the population that enters without legal permission or whose permission lapses during their stay are excluded despite being part of the most vulnerable and neediest population (Portes, Fernández-Kelly & Light, 2012).

On the other hand, Mexico is a state that has guaranteed social welfare at the constitutional level since 1917. A set of regulations and institutions exist that are aimed at providing a series of social rights, such as work, social security, healthcare, education, housing, nutrition, and in general, care for vulnerable populations.⁴ While these rights are set out in general language in the constitution, in practice, not all individuals exercise them due to the gradual shrinking of the state's functions and the adoption of a regime of dual and liberal welfare. Dualism restricts the enjoyment of the right to social security of the population that meets eligibility criteria based on their sector of employment and corporatism, while the liberal regime—as in the United States—is focused on the instrumentalization of residual policies directed toward persons in extreme poverty (Navarro, 2006; Ordoñez-Barba, 2017).

Regarding the Mexican population in the United States, the Mexican state has strengthened respect for social rights in that country, justified by the 11.3 million Mexican immigrants residing there (Zong & Batalova, 2018). Since 1990, the policy of outreach with the Mexican diaspora has had the purpose of providing social protection

⁴ The Political Constitution of the United Mexican States establishes the right to education under Art. 3; the right to the protection of health, dignified housing and nutritional food in Art. 4; and the right to dignified work under Art. 123, which also includes the Social Security Law instituted in 1943. Meanwhile, Art. 5 of the Law on Social Development, published in the Official Gazette of the Federation (*Diario Oficial de la Federación*) in 2004, regulates care for vulnerable groups in society.

through a broad consular network. The capacity of consular services varies according to entity due to the different establishment of local allies, but in general, there has been limited coverage of assistance for citizens. Meanwhile, the Mexican state has the duty to guarantee social rights for Mexicans returning to Mexico. In 2011, Chapter 5 was added to the General Population Act regarding the regulation of the repatriated population that was prepared through the Humanitarian Repatriation Program in 2007 and substituted by *Somos Mexicanos* ["We Are Mexicans"] in 2013 and later by the National Plan for Returnees in 2019. The common aim of these programs has been to promote access to social services and facilitate processes of reintegration for returnees in Mexico (Jacobo & Cárdenas, 2018; Organización Internacional para las Migraciones [OIM], n.d.).

In general terms, the governments of receiver countries have responsibilities and powers to regulate entry and exit from the country by foreign persons, as well as their access to social services (González, 2015). The relationship of nation states to international migrants entails the requirement of a legal link that replaces the notion of citizenship to establish a connection with social rights. Specifically, the creation of immigration status constitutes this link by recognizing certain rights based on the type of residency⁵ (Caicedo, 2018).

The state grants permission to enter its territory, as well as a given set of social rights and freedoms, conditional upon the assessment of the behavior of and abilities possessed by the migrant. These types of policies condition access to social rights and stratify migrants according to the type of entry to the country and the social and economic benefits they provide the host country. According to these criteria, the migrant population is categorized into groups of people with and without residency permission, with or without long or permanent residence in the host country, or with or without formal qualifications reassessed according to the regulatory standards of the professions in the host country context. This reassessment puts at a disadvantage those migrants who enter a country without authorization and without the official recognition of the studies they have completed in their country of origin.

Another criterion that has determined the level of social rights granted to migrants is the use of public resources that, upon arrival, are scarce. This argument continues to be utilized for reasons more political than economic both in the United States and Mexico to claim that the migrant population implies a burden on public budgets; however, scientific evidence disproves this idea (Flavin, Zallman, McCormick & Boyd, 2018; Portery & Campos, 2017). Using the argument of limiting public spending, the design of policies fosters the stratification of groups of migrants that have permission to enjoy different levels of access to social rights (Caicedo, 2018). Paradoxically, this "permission," which is socially considered an expression of solidarity, is conveniently granted to migrants who make greater economic contributions to the host country. Beyond the needs of individuals, access to social rights in states with liberal regimes is conceded based on an economic reasoning that excludes undocumented migrants, with their basic needs being greater due to the lack of permission to work.

⁵ According to Caicedo (2014), in Europe, social rights have been extended to the migrant population based on important precedents such as the Convention Relating to the Status of Refugees in 1951 and the Convention on the Rights of the Child in 1989; however, in some countries, access to these rights is based on meeting the requirement of residing for a long time or permanently in the host country.

In sum, a dissonance exists between the sovereignty of states to impose limits on granting social rights to migrants and the universal criteria in defense of equality and nondiscrimination (Caicedo, 2018). Despite the existence of legal frameworks and international treaties that protect the right to health among migrants, access to medical care continues to be limited (Organización Panamericana de la Salud, Organización Mundial de la Salud [OPS-OMS], 2016). The following paragraphs present how this is experienced in the realm of the lived experience of the right to health among a group of deported Mexicans in the national contexts described above.

Methodology

Study type and inclusion criteria

A descriptive cross-sectional study was carried out using a qualitative approach. The target population comprised 20 deported Mexicans who resided for different periods of time as undocumented individuals in the United States. “Undocumented” is understood to mean an (im)migrant person who resides without documents that prove their legal status in a country (Hansen & Krasnik, 2007). Another inclusion criterion was having had an illness or accident in the United States or Mexico that required medical attention. The information was collected in metropolitan Monterrey, in the state Nuevo León, at the facilities of a government shelter and a civic association, both of which work with migrants.⁶ Testimonies were also gathered in the central plaza in the city of Monterrey with deportees who were waiting to be hired.⁷

The fieldwork was conducted from September 2017 to August 2018. A semistructured interview guide was used that aimed to investigate respondents’ health needs, experiences seeking medical attention and perceptions regarding access to health services in the United States and Mexico. The questions regarding the latter country specifically explored experiences of access to healthcare during the initial weeks following return. In the case of the participants who reported previous deportations, they were asked to discuss the most recent event in their responses. Before the interviews began, informants were read a consent letter describing the objective of the study and its ethical guidelines. Consent was obtained from participants verbally and audio recorded. The testimonies were recorded, transcribed and coded using Atlas Ti V5.

⁶ I would like to thank the staff of the state shelter El Refugio del Sistema para el Desarrollo Integral de la Familia (DIF) and the Centro de Capacitación y Comedor al Migrante Nuevo Corazón for authorizing my entry into their facilities and collaborating in the identification of migrants who met the inclusion criteria for this study.

⁷ The central plaza of Monterrey tends to be a space of encounter among contractors and local workers, internal migrants and international migrants alike; informal work agreements are established for manual day labor jobs.

Characterization of the study population

The informants were all men between the ages of 23 and 59 (41 years of age on average) hailing from 15 sites in Mexico, only one having been born in Nuevo León. Of them, 13 had a basic education level, eight reported having completed high school in Mexico or the United States, and one held an associate's degree.⁸ Only six mentioned having had health insurance in the United States through an employer or a family member with legal residency. The years of deportation ranged from 2010 to 2018; the time of residence in the United States ranged from three to 48 years (20.6 on average). These variations, together with the place of residence in the United States, represented a wide range of experiences regarding access to health services. The main states of residency in the United States were Texas, California, Arizona, North Carolina, Alabama, Illinois, Minnesota and Ohio. The informants had worked in occupations including construction, maintenance and services. The main reasons for seeking medical attention were injuries due to accidents on the job or physical aggression in the street, chronic illnesses or infectious diseases (such as tuberculosis, cysticercosis) and dental problems (see Table 1).

Table 1: Sociodemographic profile of study participants

Characteristics	Distribution (absolute numbers)
Age (range)	
23-30	3
31-40	6
41-50	6
51-60	5
Education (highest level completed)	
Primary	5
Secondary	5
Preparatory / High School	9
Associate's degree	1
Time in the United States	
< 10 years	6
≥ 10 years	14
Health insurance in the United States*	
Yes	6
No	14
Year of return (range)	
2010-2014	8
2015-2018	12
Total	20

Source: Created by the authors based on interviews with informants.

* Through an employer or family member.

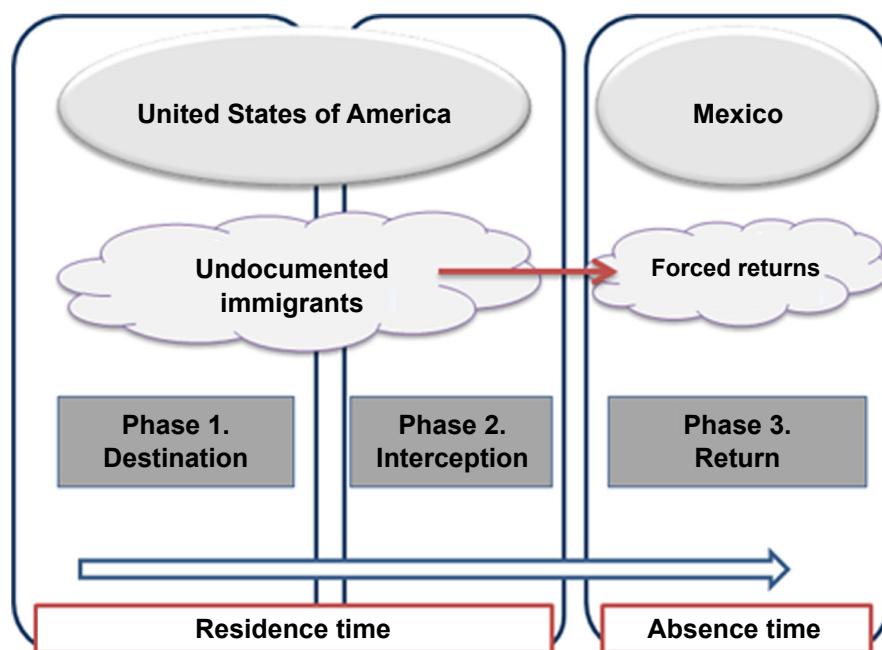
⁸ In Mexico, there is no exact equivalent for this level of studies. This refers to training that is prior to university in which students attend two years of high school.

Strategy of analysis

The information was systematized according to a classification of migration phases proposed by Zimmerman et al. (2011). According to these authors, contemporary migration has taken on more complex aspects that go beyond the dichotomous view of place and of arrival and departure. This argument stresses the relevance of thinking of the migration process in a more dynamic way, specifically through five phases: departure from the place of origin, transit, destination, interception and return. Analyzing migration under this classification offers the potential to identify the factors that inhibit or facilitate access to the right to health in more specific scenarios and circumstances.

This study contains information regarding three phases of migration based on the trajectory related by the informants: destination, interception and return. The first phase involves the analysis of structural and individual factors that influenced exercising the right to health during the time spent in the United States. The second phase focuses on investigating how the right to health was experienced in scenarios of interception or immigration control identified specifically in forced return during situations of detention. The final phase refers to the recent return to the country of origin, which entails both the impact to health during the previous migration phases and perceptions of structural conditions (public programs and health services) designed to assist the Mexican population returning involuntarily (Zimmerman et al., 2011) (See Figure 1).

Figure 1: The right to health among a group of Mexicans in three migration phases and two national contexts



Source: Created by the authors based on information gathered during fieldwork.

Operationally, exercising the right to health is analyzed according to three main axes: seeking medical attention by the migrant; access to health services; and perception of the right to health, which is considered to be exercised if the migrant received care through institutional services. Although some migrants regained their healthcare through social or private entities or individual strategies (home remedies, doctors in shelters, etc.), this is only mentioned as a tangential part of the analysis because it was not framed within the social rights derived from state functions.

The right to health in lived experiences

Phase 1. Undocumented Mexicans in the context of reception

In 2017, 37% of Mexican immigrants in the United States lacked health insurance (Zong & Batalova, 2018). Since the 1980s, access to social services for immigrants in the United States has been restricted based on arguments regarding public spending. In the case of health services, laws such as the Personal Responsibility and Work Opportunity Act (PRWORA),⁹ instituted in 1996, and the Affordable Care Act (ACA), approved in 2010, exclude undocumented people from federal subsidies to pay for health insurance (Valle & Ortiz, 2015). The ACA constitutes the health insurance option for the population that lacks federal health care coverage through their employment or programs such as Medicaid, Medicare or the network of Federally Qualified Health Clinics (FQHCs). Although the ACA incentivizes employers to offer health insurance to workers without investigating their immigration status, this rule applies only to large companies that offer full-time employment, that is, places where undocumented immigrants generally do not work (Aboii, 2014; Portes, Light & Fernández-Kelly, 2009; Wallace, Rodríguez, Padilla, Arredondo & Orozco, 2013).

The requirements for healthcare coverage eligibility for immigrants can be viewed on the Healthcare.gov website. The population authorized to acquire health insurance must have permanent or temporary residency, such as refugees, asylees for humanitarian reasons with work authorization, persons with deferred action status (DACA), nonimmigrants with work or school visas, among others (Healthcare.gov, n.d.). Immigrants in irregular situations are not eligible for the federal health insurance market; however, they are offered the option to purchase coverage through relatives with legal residency in the United States. According to federal law, the undocumented population must have access to emergency services regardless of their ability to pay out-of-pocket under the Emergency Medical Treatment and Active Labor Act (EMTALA).

For their part, some state and local governments, as well as the network of Mexican consulates in the United States, offer extensions of health care programs to all persons regardless of their immigration status. Even so, immigrants must prove their residency in the county where the clinic is located and demonstrate that their income is under a certain threshold to be eligible; alternatively, there are also networks for free medical care represented by philanthropic clinics that stabilize patients in

⁹ Among other employment regulations, this law prohibited access to public services, including health services, for immigrants with less than five years provable residence in the United States.

emergency situations (Portes, Light & Fernández-Kelly, 2009). The government of California, for example, offers coverage for undocumented immigrants through Medi-Cal¹⁰ or county-level initiatives, but the benefits are limited (Covered California, 2019). Likewise, the Mexican foreign service intervenes through its Secretariat of Health, with the implementation of certain programs such as *Ventanillas de Salud* [Health Kiosks], *Semana Binacional de Salud* [Binational Health Week] and *Programa de Repatriación de Connacionales Enfermos Graves* [Repatriation Program for Citizens with Serious Illnesses];¹¹ however, these initiatives only offer preventive and health promotion information as well as referrals to community health units if ambulatory care is required (Dirección General de Relaciones Internacionales [DGRI], 2015).

The vicissitudes of illness in everyday life

From the perspective of the immigrant population, the right to health is experienced in different ways. In the stories collected, several structural and individual factors appeared that discouraged or incentivized the search for and access to medical attention, among them, time spent in the United States, support from family networks, the type of information migrants possessed regarding the availability of health services for the undocumented and the medical coverage some had through their employers. It should be mentioned that a relevant structural factor is state and local policies aimed at filling some voids in federal legislation by providing health services to the whole population regardless of their immigration status, an aspect that is not developed in this article (Leite & Villaseñor, 2010).

In general, three recurring factors are identified that discouraged the search for medical attention among those interviewed. The first was fear attributed to the risk of being detained after providing personal information to healthcare providers that they may share with Immigration and Customs Enforcement (ICE). This collective sentiment has been widely documented in light of federal initiatives that incentivize collaboration between immigration enforcement agents and local police to identify irregular immigrants, such as the Safe Communities Program or Law SB4 in Texas.¹² Linked to this fear, the cost of medical care halts the search for medical attention due to debt and potential legal problems derived from not liquidating debt (Aboii, 2014; Luque, Soulen, Davila & Cartmell, 2018; Porteny & Campos, 2017).

¹⁰ Until age 19 and including pregnancy coverage.

¹¹ According to Sierra, González-Block, Rosales and Cruz (2016), the main diagnoses that justify the activation of this return mechanism through the Repatriation Program for ill Citizens are chronic renal failure, mental illnesses, paraplegia and cancer. Involved in providing air or land transportation to Mexican territory are U.S. hospitals, Mexican consulates, the Ministry of Foreign Relations and the Ministry of Health.

¹² Under the Trump administration, the policy of detention and deportation has reinforced the threatening rhetoric for the nearly 6 million Mexicans residing in the country without legal documents. Despite the so-called "safe zones" or places where federal police (Immigration and Customs Enforcement and the Office of Customs and Border Patrol) must avoid actions to enforce immigration laws, such as hospitals, accredited health clinics and emergency facilities, there remains a latent fear of deportation among the undocumented. This scenario could translate into greater health risks given the eventual worsening of illnesses that are not treated promptly.

The second factor was underestimating an illness or not recognizing the need to seek medical attention. This perception implied considering the search for medical attention unjustified if the affliction did not prevent the individual from performing their daily tasks. Although some informants recognized the presence of an illness, they also expressed an underestimation of their health: "I can handle the pain, that's the least of it. I've endured worse pain" (Luis, 2018).

Finally, the third factor is interpreted as an attitude of being undeserving of the right to health that some informants attributed to themselves as a result of their irregular immigration situation. This notion was translated into assuming natural rejection by healthcare providers, which thus inhibited the search for medical attention.

During their time in the United States, the informants experienced one or all three of the factors mentioned above. Stories of financial and emotional uncertainty due to the difficulty of paying for medical treatment were common. This was true for Ángel, a 38-year-old deportee originally from Campeche who lived in Texas for six years. His involuntary search for medical attention began after he was left unconscious after being stabbed in the stomach and suffering a blow to the head on the street. He was taken in an ambulance to the nearest hospital, where he was stabilized. The day after his surgery, Ángel was discharged after his address was obtained so that he could be sent a bill. The doctor told him to come back in two weeks to have his stitches removed, and without being prescribed medication, he was taken home in an ambulance. Ángel asked to be dropped off in different area of the city to avoid problems with the group of Mexicans with whom he lived: "They were going to charge me \$150 to take out my stitches. I was earning \$40 a day and I said, I'm not going to be able to afford it. I didn't go to the hospital because I was afraid that I would be charged" (Ángel, 2017). The pressure to pay his debts led him to seek work 20 days after the surgery and remove the stitches from his stomach and head himself.

In other cases, the problem of out-of-pocket spending was added to the perception of being rejected by health services and not feeling entitled to rights. Such a case is exemplified by the testimony of Luis Alberto, a 51-year-old from Guanajuato who lived intermittently in California for a period of 38 years. Luis stated that despite requiring emergency medical attention during that time, he decided not to go to hospitals in the United States because he assumed they would not treat him: "If a dog were to come up beside me, they would treat him and not me because I'm illegal. There is a law there [...] if a doctor realizes that a nurse treated a certain Mexican person, she gets fired, and I wouldn't want that" (Luis Alberto, 2018). Under this understanding of reality, Luis Alberto on one occasion turned to his network of friends to close a wound on his stomach: "I had a best friend who used to be a paramedic back where I'm from, and he's the one who healed me. We did it all homemade; he used a lighter to heat up a needle to sew with and cleaned it with alcohol. We bought a bottle of 96% alcohol, and when it was all over, we drank it" (Luis Alberto, 2018). Such cases increase the risk of a medical emergency by turning to alternatives for rudimentary cures without hygienic protocols.

On the other hand, factors were also identified that encouraged the search for medical attention. To a large extent, these determinants were related to the stories of informants that emigrated as children or adolescents and remained in the

United States continuously until being deported.¹³ The first factor was knowledge of or familiarity with the healthcare infrastructure. Some interviewees described the existence of clinics and hospitals and government programs geared toward low-income populations: “There is a cost, but you don’t have to pay it, they don’t charge you, there are assistance programs they send you to” (Jesús, 2018). Due to the interaction they had with social workers in U.S. hospitals, they had information regarding the institutional mechanisms for referrals to philanthropic clinics,¹⁴ the option of payment plans and even the possibility of being exempt from fees. This is what was recounted by Jorge, a 42-year-old from Veracruz: “An acquaintance took me to a large state clinic [in Illinois]. They did tests on me and didn’t charge me anything because they processed me like a poor person” (Jorge, 2017). A second factor already noted in the literature was the presence of personal networks of support in the United States (Maya-Jariego, Cachia, Holgado & Ramos, 2014). In the context of this study, these networks were represented by family members, other Mexican immigrants who had been in the country for longer, and employers. The support consisted of recommending health service providers, serving as interpreters to facilitate communication with medical staff, and offering loans to pay for medical attention. A third factor was the awareness of the right to health. Although this perception was atypical among participants, it is relevant to note due to the contrast with the majority. Among the few informants who referred to the obligation of healthcare providers to provide treatment was José, who lived in Texas for 33 years and stated: “Any hospital has to treat you, and then afterwards, there is a social worker to look into your case and see if you can apply for some program” (José, 2018).

It should be noted that with the exception of one informant, all were unaware of the healthcare programs offered by the Mexican consulates in the United States. In most cases, registering with the consulate was the only reason for contact with these diplomatic offices; however, they did not receive information about the health programs Mexico offers its emigrants in the United States.

Phase 2. The fragility of health during interception

Most of the participants in this study were held in detention centers for different lengths of time before being deported.¹⁵ According to data from the Federal Bureau of Prisons (FBP), in April of 2019, 12.1% (21,672) of those in detention in the United States were of Mexican origin (FBP, n.d.). This migration phase of “interception” has a high cost in terms of collateral damage to the health of migrants. Within the prisons, the health risks and need for treatment among this population increase exponentially due to exacerbated violence, the use of addictive substances that circulate in these spaces and wait times for receiving medical attention.

The right to health in penitentiaries is guided by international norms. The United Nations stipulates the minimum rules for offering medical services, which includes access to doctor’s visits, dental services, transportation to hospitals, mandatory and

¹³ Some had health insurance in the United States through their employers or family members.

¹⁴ In Texas, the Taub Hospital located in Harris County was mentioned.

¹⁵ From two months to five years.

immediate checkups of all inmates during intake, as well as isolation in case of infectious disease (Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos [ACNUDH], 1977). Meanwhile, U.S. laws stipulate under the Eighth Constitutional Amendment that is the responsibility of the federal prisons system to provide health services to inmates (Bosworth, 2002). According to the FBP, inmates receive essential medical and dental services and are given medical referrals to specialized health units to treat chronic illnesses, and a clean and healthy environment is promoted. Regarding mental health, psychologists and psychiatrists must be available to provide treatment and individual or group counseling as well as suicide prevention strategies (FBP, n.d.).

Despite these regulations and the existing facilities, in practice, diverse problems have been documented within prisons. Part of this situation is explained by the gradual privatization of these spaces and attempts to reduce costs. While private prisons are required to comply with basic standards of care, they also enjoy certain autonomy in areas regarding the management of staff and implement policies regarding temporary contracts and low salaries. Specialized medical care is scarce and ambulatory services tend to be deficient because prisons are not appealing workplaces for the most qualified doctors and nurses (Bosworth, 2002).

Testimonies of detention limbo

Informants' detention in the United States were primarily due to felonies (drug or weapons possessions), unauthorized reentry into the country or connection with a crime. The intake process at detention centers involved a routine medical checkup as an epidemiological protocol. This process is carried out even if inmates do not demonstrate signs of illness. The interviews coincided in describing this checkup as prolonged and meticulous: "All of us who arrive at the prison are put on a daily list. They give you a physical, they check you from head to toe, your eyes, nose, mouth, gums, they ask you for your whole history, if you have episodes, illnesses, to see if you're fine or if you're crazy; they asked me, 'do you want to kill yourself?'" (José, 2018). This protocol is carried out without exception during intake regardless if the detainee underwent another recent medical review at another detention center. In these spaces, the problem of access to healthcare was identified in subsequent requests for medical attention.

Inside these spaces, the risk of getting sick and the right to health are experienced differently. In some prisons, there is greater exposure to contagions, as well as a prevalence of critical situations due to deficient facilities for attending to chronic/degenerative diseases: "Once 14 died in a month. They had heart problems, high blood pressure and diabetes. They did not give us enough medication" (Antonio, 2018). Likewise, various factors exist that, when combined, lead to differences in access to health services and undermine the human rights of the inmates, such as preferential treatment of U.S. citizens by staff, the food, type of health services required, severity of illness, rotation between detention centers, and security dynamics of each center (González-Paz, 2017).

Wait times and frequent rotation of immigrants between detention centers seriously restricted access to health services. The procedure for obtaining a doctor's visit

consists of requesting a turn and waiting for weeks or even months. The informants attribute rotation to three interrelated causes: 1) saturation of the physical capacity of the centers; 2) not having family members to request that they remain in certain places or counties; and 3) preferential treatment of U.S. citizens as reflected in shorter wait times for receiving medical care. Dental care was described as the least accessible type of service in terms of wait times. This was stated by Daniel, a 37-year-old from Baja California, who requested a dentist appointment due to intense pain in a molar:

It was almost impossible for us to receive medical attention while detained because it's according to a very long list. I got tired of asking them [for treatment]; I was in the detention center for ten months, and when I thought they were about to treat me, they moved me to another prison, and I had to apply again (Daniel, 2018).

Based on the experiences of some informants, the approximate wait times for dental care was 13 or 14 months.

On the other hand, access to medications was partially conditioned by the purchasing power of inmates. Prison authorities discount the cost of medication to inmates that have savings accounts at the prison. Luis stated: "Now they don't want to give out medicine for free like before. If you have money in the books, they take it from there" (Luis, 2018). Considering this practice, informants mentioned that they preferred to spend their money on other goods before having a doctor's visit to avoid being charged for medications. It should be mentioned that if they did not have savings, inmates would receive the medication anyway, as long as there was not a lack of supply.

Problems were also mentioned regarding mental health. Receiving psychological or psychiatric care involved the same procedure as a general medical visit; however, in some centers, this care was not offered in person but, rather, through telemedicine. Some informants mentioned ill effects of the tranquilizers provided to inmates: "The pills were making me crazy, they make you lazy, so all you want to do is lie in bed" (José, 2018). Another recurring issue in the testimonies was uncontrolled use of medication that some inmates obtained after a psychiatric consultation. The technique recounted is faking symptoms of depression or schizophrenia to then sell the active substance to those who are addicted to it.

Phase 3. The tacit right to health of recent returnees

The return phase also entails challenges regarding exercising the right to health for the deported population. After facing barriers to access to health services in the United States, Mexicans who return to their country of origin experience a similar exclusion from healthcare institutions. It has been documented that approximately 65% of deportees lack public health insurance in Mexico (Velasco & Coubès, 2013).

A series of structural problems linked to the existing physical capacity, the availability of human resources and bureaucratic procedures influence limited access to health services for the nonmigrant, immigrant and returnee populations alike. In the case of deported individuals, their absence from Mexico, lack of family networks and lack of official documents are added to the factors mentioned above. Over time,

their documents issued in Mexico may expire or become lost or stolen, or if they do have them, they may not be carrying them when they are deported from the United States.

In recent years, the period that saw the most voluntary and forced return of Mexicans from the United States was 2004 to 2006, with more than a million annually. While this number has declined in subsequent years, arrivals by returnees continue to average approximately 400,000 per year (Jacobo & Cárdenas, 2018). The federal government's response to the needs of this population was initially focused on receiving and fostering the social and labor reintegration of the deported population through the Human Repatriation Program¹⁶ (Rosales, Bojorquez, Leyva & Infante, 2017), and it later expanded its approach to voluntary return through the *Somos Mexicanos* strategy (Jacobo & Cárdenas, 2018). The implementation of these government initiatives is backed by the General Population Act, which regulates assistance and social protections for the repatriated population.¹⁷

In terms of access to healthcare, the population experiencing forced return basically relies on the network of services of the Ministry of Health (SSA) and the National System for Integral Family Development (DIF). Given that this population's entry into Mexico signifies being outside of the labor market for an indefinite period, their unemployed status automatically places them within the so-called *unprotected population*¹⁸ (Flamand & Moreno, 2014). Prior to 2004, the unprotected population lacked government subsidies for medical care, which thus signified catastrophic out-of-pocket expenses for some families. For this reason, *Seguro Popular* (SP) [public health insurance] was created to provide financial protection for this population. All Mexicans without social security, including deportees, have the right to join this program for three years and may renew it as many times as they like, regardless of whether they are employed. However, some deportees can join for only 90 days upon entering Mexico, which is the limit for those who do not present complete documentation.¹⁹ Based on a socioeconomic analysis, deportees are generally exempt from payment due to precarious life circumstances; this means that they receive free medical care at SSA units by presenting their policy information, with the exception of treatment for illnesses not covered by the insurance.²⁰

On the other hand, the Mexican Institute of Social Security (IMSS) is another option for medical care for the deported population, although it depends on the sector of employment. This opportunity is limited for those in certain occupations linked to construction, maintenance, or day labor (typically performed by deportees), as these jobs rarely provide social security.

¹⁶ This program was implemented at some points of reception of the National Institute of Migration.

¹⁷ While Mexico has had a Migration Law since 2011, it does not mention the returned population.

¹⁸ This refers to the target population of the Ministry of Health, composed of unemployed and self-employed individuals in the informal economy who thus lack social security.

¹⁹ The documentation consists of birth certificate, Unique Population Registry Code (CURP by its acronym in Spanish) and proof of address.

²⁰ In 2019, *Seguro Popular* covers 294 services including diagnoses, procedures, medications and inputs described in the Universal Health Services Catalog (CAUSES by its acronym in Spanish).

A blurred trajectory winding road home: Experiences of health during recent forced return

A distinctive feature of forced return is entry into Mexico through the repatriation units of the National Institute of Migration (INM). The informants in this study entered through the Tijuana/San Isidro, Ciudad Juárez/El Paso and Nuevo Laredo/Laredo border crossing points. At these check-points, the INM issues a letter of repatriation and offers some social services. These services are optional, and not all deportees decide to take advantage of them, perhaps underestimating their usefulness, including the *Seguro Popular* medical coverage.

Upon leaving, the participants in this study were hospitalized in different parts of the country or went directly to Nuevo León due to family networks or information about employment opportunities:

They told me there was a lot of work here, and there is. In some places they pay well, but in the factories, they pay very little. There is no way to get a job where you don't have a boss such as painting, masonry, carpentry, because the bosses here are very bossy (José Luis, 2017).

Once in Nuevo León, the majority joined the workforce during the first two weeks of their return in low-skilled occupations, working as construction assistants, car mechanics, carpenters, shoe shiners or car washers. The minority obtained employment with social security benefits, working as taco vendors, waiters or security guards.

In this phase of migration, the right to health was once again exercised in different ways. The length of time away and presence of personal networks in Mexico played an important role. Meanwhile, both factors influenced the possession or lack of identification documents that facilitated migrants' reintegration into Mexican society. In this sense, a group of eight informants had spent a large part of their life in the United States, and their closest blood relatives remained in that country, while the rest had been absent from Mexico for less time due to previous deportations. The latter group was more familiar with shelters, soup kitchens and contractors they met during short stays in border states before emigrating again.

Aarón, age 36, was part of the former group. He was born in Zacatecas and spent 24 years in North Carolina, where he got married, had children and worked in restaurants. His need for medical care began a short time before entering Mexico, when he was beaten by border patrol agents after refusing to give them money. Aarón arrived in Nuevo León with a broken jaw and unable to speak well and began an odyssey, visiting several medical facilities until finally receiving treatment:

I arrived here, and they sent me to an IMSS [Institute of Social Security] hospital; from there, they sent me with a pass to the Hospital Universitario. They told me that to be treated I had to pay for a visit. I couldn't speak because of how swollen I was, and they never gave me a single pill. Then they sent me to the Hospital Metropolitano, where they asked me for a paper from a doctor here at the shelter. I came back with the paper, and without checking me or taking a single X-ray, they told me they were going to operate. How could I let myself be operated on? From there, they said they couldn't treat me. Where

they helped me was at Las Monjitas.²¹ The dentist there checked me, set my jaw and gave me medication (Manuel, 2017).

Upon arriving in Mexico, the only identification document Aarón had was his repatriation letter; however, it was stolen on the way to Nuevo León. During his stay at the government shelter, he received assistance in obtaining his CURP [Unique Population Registry Code] and birth certificate.

Meanwhile, Genaro illustrates the situation of the second group of deportees. Originally from Puebla, he was 36 at the time of the interview. He had emigrated several times to California, where he lived intermittently for five years until being deported for the last time in 2018. During his previous returns, he stayed in border cities, residing in shelters and working. Like other deportees, Genaro had a social security number²² that he reactivated upon his return to Mexico when he joined formal employment. Despite being an IMSS beneficiary, when he required medical attention, he preferred not to use the service because he considered it inefficient and instead went to another healthcare provider for a stomach infection: "I went to the Red Cross. They checked me. They gave me a prescription, and the person I'm working with bought me the medication. At the IMSS, they are bureaucrats; you have to be dying in order for them to treat you" (Genaro, 2018).

In Nuevo León, the search for medical attention led some informants to the challenge of joining *Seguro Popular*. None of the interviewees joined this insurance program at the repatriation units of the INM. As previously mentioned, the public healthcare providers that serve the uninsured population consist of the network of treatment centers of the DIF and the SSA. Deportees with healthcare needs were sent to these centers by shelters or personal contacts; however, the administrative barriers and precarious facilities of the health services limited the availability of timely medical attention. In this context, Manuel, a 30-year-old from Coahuila, returned to Mexico after 25 years in the United States. In the initial weeks following his return, he dislocated a kneecap while jumping over a wall. Manuel required an X-ray to get an accurate diagnosis, but the DIF lacked X-ray equipment, and the SSA staff requested his *Seguro Popular* policy in order to treat him:

Now that I was even more screwed, I went to a health center. First, they told me I needed Seguro Popular, and then from there, they sent me to the *Pabellón* [municipal government office] to get an alien birth certificate, but they told me it wasn't recorded. They gave me a [telephone] number, and I have been calling, but nobody answers (Manuel, 2017).

Other informants without Seguro Popular who requested medical attention at the SSA were treated on an exceptional basis, with the condition that they must present their policy at subsequent appointments.²³

²¹ *Las Monjitas* is the name commonly used by deportees to refer to a religious center that offers various social services to persons in situations of vulnerability, such as free cafeterias and doctor's visits. The official name of this organization is Comunidad Apostólica de María Siempre Virgen (CAMSVI).

²² This number is assigned to workers on a permanent basis; however, it is deactivated once an individual ceases to contribute to the IMSS.

²³ The requirement for receiving this coverage is based primarily on a financial justification. The Ministry of Health has budget deficits with each appointment, input or medication it provides to users who are unable to pay.

Joining Seguro Popular was also a challenge for some informants. The process varied based on the documents that each one had to obtain to satisfy and challenge the bureaucracy. One of the most extreme experiences was that of Daniel, who continued to be unable to join, despite having attempted to do so on several occasions:

They sent me to get Seguro Popular. The thing is, they asked me for a ton of papers, as if to say, we're not going to help you. They asked for my birth certificate (which I have), I have the CURP that I got here, they asked me for my INE credential, and I told them I haven't been given one yet; they told me if you don't bring another form of identification, we need your diplomas, and they sent them from the U.S., but they told me that they're not valid here. They told me to go attend elementary and high school again. My sister-in-law in Zacatecas sent me a copy of my elementary school certificate, and they didn't accept it because the photo doesn't look like me, but your features change! And anyway, my name was right there on it (Daniel, 2018).

In no case was this process described as simple; however, the deportees that had been absent from Mexico for the least amount of time obtained their policy faster, given that they possessed nearly all the valid documents or knew the best way to obtain them.

In the return phase, underestimating illness delayed the search for medical attention, as in the United States. Priority was given to addressing basic needs such as finding employment or paying rent over health; even the informants residing at the shelter saved part of their income in anticipation of the rent they would have to pay once their stay was over.²⁴ Going to a health center instead of work meant a monetary loss, and at the same time, worsening of their health. Daniel, age 37, from Baja California, described having lost approximately 30 kilos over the course of two years following his return to Mexico. This symptom, along with a cough and headache, led him to visit doctors at private clinics affiliated with pharmacies:

They tell me it could be depression, that I don't eat well; they say I should buy vitamins, but they don't test my blood. Now I've got a job here in Guadalupe [Nuevo León municipality], and I have to leave at 6 a.m. and I don't have time to go to the health center so that they can weigh and monitor me (Daniel, 2018).

In the medium or long term, these types of cases lead to chronic illnesses that can be disabling.

The lack of Mexican identification documents was attributed to not only the period of absence from the country of origin but also street violence in which personal belongings were stolen, as well as another unusual factor related to a measure of personal protection. For Ángel, for example, it was important to hide his identity, and carrying his birth certificate represented a latent risk: "I'm from Reynosa. Sometimes I get the train and go to another state, and I don't want people to know that I'm from there because it's dangerous, so I always rip my [birth] certificate, then they think poorly of me because that city is burnt-up" (Ángel, 2017). Although this fact was mentioned by only one informant, it is notable because it reflects the context of

²⁴ The maximum stay allowed in the DIF shelter is three months.

violence and fear in which they live—fear was also present in the country of origin; however, unlike in the United States, it is not attributed to the risk of being deported but, rather, the situation of vulnerability that many faced in a practically unknown environment. Thus, for Aarón, who was deported in 2017 after having been away from Mexico for 25 years:

You arrive, and it's like highway robbery for those who were illegal. Here, the police stop you and ask you, where are you from, how do we know you're from here? We're going to do a routine check. Then you're afraid to go out in the street; they take your money and bring you to jail with no rhyme or reason. I speak from experience. There is a lot of injustice (Aarón, 2017).

These testimonies illustrate not only the difficulty of health services in Mexico but also the risks to physical and mental health deportees face in public spaces.

Final reflections

The analysis of the social right to health from the perspective of migrants reveals relevant aspects for understanding how the discourse of this right increasingly disappears in lived experiences. Likewise, a disaggregated analysis in three phases of migration made it possible to identify contextual specifics that affected the experiences of health that were recounted. Given the retrospective nature of the information, memory bias is an implicit methodological limitation in this study.

In general terms, this article documents the scant connection that exists between exercising the right to health among migrants and the laws that support it. The notion of compensatory justice as a pillar of social law is blurred in practice in view of the limited expected benefit of residual policies geared toward vulnerable populations, which include the immigrant and deported population. As a result, the emergence of policies and international agreements that protect their social right to health is out of touch with the real and daily needs for medical attention.

The creation of migration status as a category of legal connection to the state and the access “pass” to the benefits of welfare regimes implies a concession conditioned upon the right to health. Behind the discursive recognition of this right, an economic interest is imposed that distorts the objective of reducing social inequalities. Based on the evidence, migrants with fewer resources and little medical coverage are far from being subjects of preferential protection. In the United States, the federal policy of limiting public spending restricts to the minimum the possible health coverage of undocumented immigrants,²⁵ while in Mexico, this coverage for deported persons has modest outcomes due to the rigidity of a bureaucratic apparatus that is activated only through certain paperwork.

Migration status was a cross-cutting factor in the two contexts analyzed. This legal category is defined in different ways in the destination and site of return; however, it had a similar influence on exercising the right to health. On one hand, in the United

²⁵ This policy ends up being more costly, not only in financial terms but also in terms of the detriment to quality of life and increase in mortality rates among these populations. It has been documented that frequent hospitalization linked to medical emergencies is more costly than the preventive or ambulatory care denied by the U.S. federal government to the undocumented immigrant (Khullar & Chokshi, 2019).

States, undocumented status refers to the lack of documents that prove legal residence in the host country. This condition explicitly limits the right to health at the legal level, and its duration is indefinite or permanent as long as there is no immigration policy that allows for the regularization of immigrants such as the 1986 amnesty. On the other hand, in Mexico, undocumented status is defined as the lack of identification documents. Although at the legal level no person is excluded from the right to health, in practice, a lack of papers is a temporary obstacle to obtaining medical coverage. While this problem is fixed when deportees are able to identify as Mexican, the gravity of the matter is highlighted when this population is required to pay for medical attention that would be free with the SP policy.

Likewise, differences were identified in exercising the right to health based on the factor of time. According to Portes and Rumbaut (2010), this structural determinant fosters the establishment of social networks and offsets the complications derived from immigration. In the context of this study, time also contributed to exercising the right to health among some informants with prolonged stays in the destination phase. Under this same logic, in the return phase, time of absence from the place of origin caused a weakening of personal networks that at some point represented a source of support. Length of stay in the United States in some cases consisted of more than half the life of the informants (continuous residence), and for others, it represented the sum of several short stays (intermittent residence), which in certain cases implied the maintenance of personal networks in Mexico during temporary returns.

In the destination phase, migration policy and federal health policy toward unauthorized immigrants in the United States had effects on the behavior and attitudes of the informants. The anti-immigrant discourse that prevails in that country, legal restrictions on medical care and denial of government subsidies had repercussions in terms of the informants' decisions regarding exercising their right to health. In this analysis, it was found that nearly all of those interviewed went to hospitals or clinics only when their ailment was putting their life at risk.

The interception phase as part of the deportation process involved several risk factors for the physical and mental health of the informants. The right to health in the context of detention centers is practically reduced to care protocols aimed at epidemiological control. Stays in these spaces created states of vulnerability for detainees due to their exposure to contagions, aggression, drugs, and prolonged wait times for receiving medical attention.

Finally, in the return phase, Mexico is making slow progress both legislatively and operationally with regard to the recognition of differentiated care for returned citizens, especially those experiencing forced return. Deported Mexicans continue to bear the status of undocumented migrants, which is imprinted on their life trajectory outside of the country of origin. This status is highlighted when, upon return, the challenge all Mexicans face in exercising their right to health is multiplied due to the stigma of past migration. An additional circumstance that influenced this phase of the most recent return was the status of deportees combined with that of internal migrants because nearly all were from states other than Nuevo León; for some, returning to their place of birth implied being near family but without job opportunities or exposed to social contexts of violence.

In the three migration phases, the absence of comprehensive medical care was a constant, above all care geared toward addressing the emotional damage caused by fear, loneliness and stress. Time of residence or absence, support from personal

networks, type of information about health services, and attitudes toward illness were all factors that influenced exercising the right to health among the participants in this study.

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Yetzi Rosales

Mexican. Doctor in Social Sciences with a specialty in Regional Studies from El Colegio de la Frontera Norte. Professor-Conacyt in El Colef, at Monterrey since 2015. Research lines: Mexico-United States migration, health policies and systems and undocumented migration. Recent publication: Rosales, Y., Bojórquez, I., Leyva, R. & Infante, I. (2017). Oferta de servicios de salud a migrantes repatriados por Tijuana, Baja California: Cooperación y capacidad de respuesta interinstitucional. *Frontera Norte*, 29(57), 107-130.