

ORIGINAL ARTICLE

Examining perceived barriers to healthcare access for Hispanics in a southern urban community

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ABSTRACT

Background: Disparities in healthcare access among Hispanics in the U.S. continue to rise as a result of contextually based social determinants of health. The purpose of this study was to examine the perceived barriers to primary healthcare access among Hispanics residing in an underserved, urban region of Louisville, Kentucky.

Methods: Guided by critical ethnographic methods, twenty participants were interviewed using a descriptive survey and semi-structured interview guide to assess perceived access barriers. Descriptive and analytic coding, and content analysis techniques were used to identify emerging categories, concepts and themes.

Results: Persistent barriers to healthcare access were related to time and availability, healthcare personnel and patient-provider communication; documentation; limited income and health insurance coverage; and, discrimination and cultural barriers.

Conclusions: Findings inform healthcare systems by identifying the subjective and socially constructed barriers to healthcare access and promoting programs and policies to eliminate access barriers for Hispanics.

Key Words: Hispanic immigrants, Healthcare access, Social determinants of health, Health disparities

1. INTRODUCTION

Representing over 53% of the total foreign-born population in the U.S., Hispanics continue to grow at a higher rate in comparison to other immigrant groups.^[1] Although historically a greater number of Hispanics resided in coastal and border states, in recent years, an increasing number of immigrant groups have migrated inland, to southern, urban regions of the U.S. in search of employment opportunities.^[2] From the 1990's to the 2000's these newly settled, mid-South states like Kentucky experienced a dramatic growth in its Hispanic population, representing over 37% of the total immigrant population.^[3] However, urban communities in this region, such as Louisville, lack sufficient resources and fa-

cilities to support the unique needs of diverse immigrant subgroups.^[4] Despite the establishment of federally funded refugee resettlement programs, and other immigrant focused health and social services in Louisville, Hispanics continue to experience difficulties in accessing timely and appropriate healthcare.^[5] Reasons for these inequities are attributable to the social determinants of health that influence healthcare access and consequently health outcomes for Hispanics.

Despite growing research on social determinants, limited literature explores the mechanisms through which these determinants serve as barriers to healthcare access for Hispanics. Furthermore, the majority of studies in the U.S. that examine barriers rely heavily on cross-sectional, national health

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survey data and quantitative techniques.^[6] Although these studies indicate that accessibility issues do exist, key barriers to access as perceived and experienced by Hispanics are not adequately explored within socio-ecological contexts. Therefore, the purpose of this study was to explore the perceived barriers to primary healthcare access for Hispanics residing in highly concentrated, urban communities of Louisville, Kentucky. This study serves as a qualitative case study that provides baseline foundational data to help develop effective interventions targeted at promoting health seeking behaviors and reducing overall barriers to healthcare access for Hispanics.

Background

Social determinants of health inequities are represented by conditions of daily living that are systematically influenced by inequitable distribution of money, power, and resources.^[7] Research has identified that the lower socioeconomic positions of many Hispanics in the U.S., in relation to their unique historical, sociocultural, economic, and political experiences, make them vulnerable to increased healthcare access inequities.^[8] The National Health Disparities Report^[9] indicates that Hispanics were less likely than non-Hispanic Whites to have health insurance or have a usual primary care provider. These disparities are attributed to complex socio-ecological factors resulting in negative health outcomes and increased health disparities within Hispanic communities.

Acquiring a contextually based understanding of the social determinants of healthcare access among Hispanics warrants a multidimensional approach, and was achieved in this study using the Conceptual Framework for Assessing Access to Health Services (CFAAHS). The CFAAHS^[10] provides an innovative, adaptable, and contextually based method of examining the four dimensions of healthcare access (availability, accessibility, affordability, and acceptability), focusing both on the supply of and demand for healthcare services.

2. METHODS

This study was part of a larger program of research aimed at examining the fit between the delivery of health services for immigrants from a provider's perspective and the utilization of services from a recipient's perspective.^[4] Guided by critical ethnography (CE), qualitative case study methods were employed to collect in-depth interviews using a descriptive survey and semi-structured interview guide. Rooted in critical pedagogy, CE goes beyond conventional ethnography by focusing on uncovering inequities afflicting the oppressed and raising awareness of historical, sociocultural, economic and political influences of power on contemporary social structures.^[11,12] Therefore, CE served as an ideal methodol-

ogy to explore and help illuminate contextually based barriers to healthcare access.

The setting for this study was determined using geospatial analysis to identify the regions of Louisville with the largest concentration of Hispanic subgroups that were geographically isolated by income, educational attainment, language abilities, and access to primary healthcare facilities. Purposeful sampling methods were used to recruit 20 participants in 3 community centers and health services located in these identified regions of Louisville: a community center providing social services to immigrants, an infectious disease clinic serving individuals who are HIV-positive, and a primary healthcare clinic serving migrant workers in the local equine industry. Inclusion criteria were self-identification as a Hispanic and/or Latino; born outside of the U.S. mainland, and older than 18 years of age.

Participants consisted of 10 males and 10 females with an average age of 41 years (ranging from 21 to 57 years). Participant countries of origin included, Guatemala (n = 6), Mexico (n = 5), Cuba (n = 5), Puerto Rico (n = 2), Ecuador (n = 1), and Honduras (n = 1). Only 11 participants identified their ethnicity as Hispanic or Latino. The remaining participants stated that they did not know their ethnic background. Interestingly, over 80% of participants (n = 16) identified their race as Hispanic or Latino; 15% (n = 3) stated that they were *blanco* or white; and, one participant stated that she was *mestizo* (mixed Spanish and Latin American heritage). Eighty-five percent of participants stated that they did not speak any English (n = 3) or spoke very little English (n = 14).

IRB approval (12.0530) was obtained from a university prior to recruitment and data collection. The principal investigator conducted in-depth interviews with participants using a descriptive survey form and a semi-structured interview guide. The interview guide had 20 core questions examining cross-cultural perceptions of health and healthcare, barriers and facilitators to accessing care, and sociocultural, political and economic contextual factors that influence access. Interviews lasted approximately 60 minutes and were audio taped and transcribed to assure accuracy in analysis. Four interviews were conducted in English and the remaining were conducted in Spanish and lasted over a 5-month period.

Data collection and analysis occurred concurrently and in several phases. Management and initial coding of qualitative data were facilitated using NVivo data management software.^[13] Descriptive coding and content analysis techniques, including NVivo word-based coding techniques were used to analyze the definitions and relationships between concepts allowing the investigator to make inferences about the in-

dividual or group being studied.^[14] Analytic coding using line-by-line analysis allowed for categorization of in-depth, emergent themes under the four overarching constructs of the CFAAHS (see Table 1). Querying the text helped contextualize participant perspectives about their environment, community, relationships with healthcare providers, healthcare system, and political views among other areas. Overall study validity and rigor was supported through methodological congruence, and trustworthiness of data was maintained through prolonged engagement in the field, triangulation, and purposeful sampling techniques.^[12, 14]

3. RESULTS

The largest variations in healthcare access among participants were associated with country of origin, immigration

status and socioeconomic factors (see Table 2). Although 19 participants said they had a healthcare provided in the U.S., only 11 had a regular primary healthcare provider. Eight participants accessed health services at the infectious disease clinic, which does not provide general primary healthcare services. Of the 6 participants who were undocumented none had health insurance and five were HIV-positive. Participants from Mexico and Guatemala were less likely to have health insurance (n = 11) than Cubans and Puerto Ricans (n = 2). Twelve participants reported experiencing discrimination in the healthcare setting. In-depth themes derived from participant interviews are further discussed under the major constructs of availability, accessibility, affordability and acceptability (see Table 1).

Table 1. Availability, accessibility, affordability and acceptability barriers

	Themes	Subthemes (References, Sources)*
Availability Barriers	Time and Availability	<ul style="list-style-type: none"> • Long waiting times (12,11); Treated like a number (12, 6); Limited time and contact with doctor (11, 6); Limited availability of appointments (8, 4); Limited clinic operating hours (1, 1)
	Healthcare Personnel Characteristics	<ul style="list-style-type: none"> • Interpreter availability and training (16, 9); Lack of cultural competence (11, 10); Lack of Bilingual Healthcare Personnel (8, 6)
	Patient-Provider Communication	<ul style="list-style-type: none"> • Lack of communication (25, 14); Lost in Translation (11, 9); Language Barrier-LEP of Participant (6, 9)
	Navigating the Healthcare System	<ul style="list-style-type: none"> • Medical history paperwork (5, 3); Lack of advertising public resources (5, 4)
Accessibility Barriers	Documentation	<ul style="list-style-type: none"> • Lack of Health Insurance (21, 12); Lack of legal immigration documents (15, 10)
	Emergency Room	<ul style="list-style-type: none"> • Negative Emergency room experiences (13, 8)
	Type of Healthcare Facility	<ul style="list-style-type: none"> • Specialty Health Services (5, 4); Public health clinics (2, 2)
Affordability Barriers	Financial Barriers	<ul style="list-style-type: none"> • Expensive healthcare costs (33, 15); No health insurance coverage (27, 13); Limited income or financial resources (18, 9); Dependents (7, 5)
	Knowledge and Awareness	<ul style="list-style-type: none"> • Unaware of affordable options (4, 4)
	Resources	<ul style="list-style-type: none"> • Lack of Government support or intervention (3, 3)
Acceptability Barriers	Discrimination	<ul style="list-style-type: none"> • Discrimination based on race and ethnicity (17, 12); Discrimination based on language (14, 11); Discrimination based on HIV status (8, 5)
	Cultural Barriers	<ul style="list-style-type: none"> • Stigma associated with HIV (11, 6); Self-medication (7, 5); Lack of treatment effectiveness discourages access (6, 5); Traditional medicine (4, 4)
	Health-seeking Behaviors	<ul style="list-style-type: none"> • Delaying accessing care (12, 8); Prioritization (8, 7); Lack of awareness or education (6, 5); Lack of prevention (4, 4)
	Mental Health	<ul style="list-style-type: none"> • Emotional distress discourages access (13, 6); Discrimination causes discomfort (9, 8)
	Healthcare Business	<ul style="list-style-type: none"> • No desire to help from healthcare provider (14, 8); Patient vs. Customer (11, 5); Inhumane treatment (8, 6); Lack of social support (3, 3)

Note. * References refer to data or items that are coded under a specific theme. Sources refer to each source of data (i.e. individual interview) (QSR International, 2012)

3.1 Availability barriers

Major themes under perceived availability barriers to healthcare access were related to *time and availability* of providers, characteristics of *healthcare personnel* and *patient-provider communication*. Participants faced significant challenges entering the healthcare system and developing trusting patient-provider relationships as a result of limited clinic operating times, availability of appointments, and long waiting times. A male participant from Cuba expressed his frustrations:

“When I had pancreatitis I was upset because I called my

doctor many times and they told me that he was not available. They said he was busy. So practically it felt like, ‘I don’t care if you are sick...’ in my country you get to see the doctor directly. They make the time for you when you are sick and you don’t even have to pay. And here, it costs so much money and you have to work around their (the doctor’s) schedule.”

Participants expressed additional difficulties communicating with healthcare providers due to limited availability of interpreters and bilingual healthcare personnel. Limited communication and perceived lack of linguistic and cultural com-

petence from providers led to feelings of mistrust in the healthcare system. To overcome language barriers, participants often used family members, including their young children to communicate with providers. One mother from Mexico expressed her fear of miscommunication with her provider on crucial health information:

“When you are talking about medical terms you should be

very careful. The doctor might be telling me something in English and there should be a trained interpreter telling me what I should do with my baby. The explanation should be crystal clear by the doctor and the interpreter. They need to make sure that I understand because I am the mother and I am going to carry out the treatment for my baby. One little mistake can be fatal.”

Table 2. Country of origin, documentation status and income in relation to factors of healthcare access

Country of Origin	Immigration Status	Weekly salary range	Years in US mainland	HCP in Country of origin	HCP in US	Health insurance	Major Health concerns	Most important person when sick	Discrimination in Healthcare setting
Guatemala (n = 6)	Undocumented	\$250-\$374	18	No	Yes	None	HIV	HCP	Yes
		≥ \$375	12	No	Yes	None	HIV	Family	No
		\$125-\$249	0.6	Yes	Yes	None	HIV	HCP	No
	Documented	≥ \$375	20	Yes	Yes	Employer	Muscle pain	Family	Yes
		\$125-\$249	18	Yes	Yes	None	Ovarian cysts and fibroids	Family	Yes
		\$250-\$374	12	No	Yes	None	Vaginal bleeding	Family	No
Mexico (n = 5)	Undocumented	≥ \$375	10	Yes	Yes	None	HIV	Family	No
		\$250-\$374	4	Yes	Yes	None	HIV	HCP	Yes
		\$0-\$124	6	No	No	None	Anemia; Flu	Family	Yes
	Documented	\$250-\$374	14	Yes	Yes	None	Gastrointestinal	Family	No
		\$250-\$374	16	Yes	Yes	Employer	Gastrointestinal	Family	Yes
Cuba (n = 5)	Documented	≥ \$375	10	No	Yes	Employer	HIV	Family	Yes
		\$0-\$124	13	Yes	Yes	None	HIV	HCP	Yes
		\$125-\$249	2	Yes	Yes	None	Varicoceles	Family	No
		\$250-\$374	11	Yes	Yes	Employer	Breast cancer; High cholesterol	HCP	No
		\$250-\$374	11	Yes	Yes	Employer	Cardiac; Hypertension	HCP	No
Puerto Rico (n = 2)	Documented	≥ \$375	26	No	Yes	Employer	HIV	Employer	Yes
		≥ \$375	15	No	Yes	Employer	Diabetes	Family	Yes
Ecuador	Documented	\$125-\$249	14	Yes	Yes	None	Bronchitis; Asthma	HCP	Yes
Honduras	Documented	\$125-\$249	14	Yes	Yes	Employer	Thyroid problems	Family	Yes

Note. HCP: healthcare provider

3.2 Accessibility barriers

Most participants identified *documentation* pertaining to health insurance and immigration status as a significant barrier to access. The ability to obtain health insurance was contingent upon job status, type of employment and immigration status. Being undocumented affected the ability to access federally funded programs such as Medicaid. An undocumented male participant from Guatemala stated:

“The first thing that they ask you at the front desk is, ‘What is your Social Security number?’ This makes it more complicated. There is no explanation. Explaining your migratory status is difficult. A lot of times I just say I left it at home and I don’t have it with me. If they ask for social security paperwork then I never go back to that place again.”

3.3 Affordability barriers

Participants described expensive healthcare costs, limited income, unemployment and lack of health insurance coverage as compounding financial barriers to accessing healthcare services. One participant from Ecuador who works as a part-time janitor stated:

“Sometimes here in the U.S. I’m afraid of going to the hospital because I don’t know the amount of money I have to pay. The sicker you are, the less you can work. And to get money you have to work to pay your bills. So it’s difficult here in the U.S. You are thinking about your health all the time.”

3.4 Acceptability barriers

Significant themes under acceptability barriers included *discrimination, cultural barriers, health-seeking behaviors*, and

healthcare business. Participants indicated that discrimination based on race, ethnicity, language, and immigration, health insurance and HIV status discouraged health-seeking behaviors. One participant from Puerto Rico stated:

“I know they treat me differently when they ask me where I’m from. They talk to me slow. I’m like, ‘Hello, I speak English! Just because I’m Hispanic it doesn’t mean I don’t know your language.’ Most of the time they treat me a little slower.”

Negative cultural stigma associated with Western medicine discouraged the use of preventative measures (i.e. screening) and adherence to treatment regimens, resulting in the use of traditional healing methods and self-medication. Participants indicated that using traditional, naturalistic and homeopathic remedies were common practice in their culture. A male participant from Guatemala expresses how this impedes utilization of timely and appropriate healthcare:

“In our culture, there are a lot of myths. People in general don’t get checkups and don’t go to the doctor. What they do is take more home remedies. One myth, for example is that if you go to see a doctor, supposedly you go in walking and you come out on a stretcher. That’s what people think.”

Accessing healthcare was not a priority for several participants, who placed greater emphasis on family and work. Immigration status and the fear of deportation were significant contributors to delayed health-seeking behaviors. Participants were concerned that healthcare providers would report undocumented status to Immigration and Customs Enforcement:

“I knew of a case of a lady who had appendicitis and that lady didn’t want to go to the doctor. She was scared that they were going to send her back to her country. She said ‘No! They are going to get my information and pass it along to immigration.’”

Participants expressed negative cultural stigma towards HIV and its association with homosexuality, leading to experiences of discrimination within their own communities. This was heightened by lack of awareness on prevention. Seven of the eight participants who were HIV-positive learned of their status after immigrating to the U.S. A Cuban male who is HIV-positive stated:

“I think that in my Latin race, many people don’t know they are infected with HIV and they don’t get a test done. And when they finally do get a test they are in the final stages of the condition.”

Accepting the business aspect of healthcare in the U.S. was particularly difficult for participants in this study because of the vastly different healthcare systems they were accustomed

to in their countries of origin. In several cases, participants perceived that healthcare providers lacked the desire to help patients, or in extreme cases treated patients inhumanely. Perceived lack of compassion and respect from providers resulted in feelings of insignificance and isolation. A male participant from Cuba stated:

“I started to realize that it’s a business. If the money wasn’t so calling to them, the professionals would be more conscientious. A Cuban doctor earns thirty to forty dollars a month and they treat you with a lot of pleasure. It doesn’t matter if you’re brown, white, dirty, or if you come stinky, they treat you with the same kindness and respect.”

4. DISCUSSION

Persistent barriers to healthcare access were related to time and availability, healthcare personnel & patient-provider communication; documentation; limited income and health insurance coverage; and, discrimination and cultural barriers. Consistent with literature, limited availability of appointments and longer waiting times resulted in delayed access to healthcare.^[15-17] Studies also identified lack of interpreter services and cultural competency among healthcare providers as significant barriers to access for Hispanics.^[18,19] However, even when seeking health services in federally funded organizations, which are mandated under Title VI to provide interpreter services, participants emphasized the limited availability of appropriate interpreter services.

Despite existing evidence indicating that undocumented immigrants have lower educational and income levels, and were highly likely to be uninsured and underutilize healthcare services due to fears of deportation,^[6,16] this study illuminated a critical area- unidentified communicable diseases among the undocumented. The Centers for Disease Control (CDC)^[20] reported that HIV/AIDS disproportionately affects Hispanics, representing 21% of new HIV infections in the U.S. in 2010. The majority of study participants with HIV were diagnosed with the condition after immigrating to the U.S. They were often times in advanced stages of the disease as a result of negative cultural stigma and lack of awareness, prevention and resources in their home countries. Although studies have examined the determinants of delayed HIV presentation in states with established undocumented Hispanic populations,^[21] few have examined the growing issue of HIV among undocumented immigrants in newly-settled regions.

Supported by previous empirical findings,^[18,19] participants from this study who were from Mexico, Guatemala, Ecuador or Honduras faced more barriers to healthcare access as a result of limited income, lack of health insurance, and undocumented status when compared to those from Cuba and

Puerto Rico. These variations in Hispanic sub-groups are inextricably linked to political and economic relations between the U.S. government and respective nations. However, despite their non-immigrant status, Cuban and Puerto Rican participants also faced barriers to accessing healthcare services and insurance, which indicates the need to further explore specific cultural and social influences on health-seeking behaviors. Moreover, current healthcare reform efforts, it is essential to explore changes on rates of uninsurance among Hispanics in newly-settled regions. For example, recent data indicates that as a result of the ACA uninsurance rates in Kentucky have plummeted in several counties from roughly 17% to 20% down to 5%.^[22] The impact of this law on undocumented immigrants is yet to be explored.^[23]

Significant acceptability barriers identified by participants included discrimination, cultural barriers, and the idea that healthcare in the U.S. was more of a business than a basic human right. As indicated in previous studies, perceived discrimination based on race, ethnicity, language and health insurance within healthcare and community settings resulted in underutilization of health services.^[24] However, perceived discrimination based HIV-positive status from primary healthcare providers was an emergent theme that is not adequately supported through empirical findings. The intersectional influences of discrimination based on undocumented and HIV-positive statuses on healthcare utilization require further exploration from sociological and epidemiological standpoints.

Limitations

Findings from this study may not be generalizable to other populations and settings, as purposeful sampling methods were used to target a specific Hispanic population within

a distinct geographic setting in Louisville. A sample size of 20 participants may be deemed as a limitation of this study. However, qualitative methodologies determine sample size adequacy through the use of data saturation, valuing the quality of the sample over the quantity.^[14] Although efforts were taken to provide a diverse representation of Hispanic subgroups in Louisville, this study was not inclusive of all Spanish-speaking countries. Incorporating the perspectives of other Hispanic subgroups could have provided depth in understanding barriers to healthcare access, especially in relation to varying cultural and socioeconomic backgrounds.

5. CONCLUSIONS

Exploring contextually based, perceived barriers to healthcare access illuminates several implications and recommendations for healthcare systems. Findings inform health service providers, recipients and policymakers by identifying the subjective and socially constructed barriers to healthcare access and promoting development of programs and policies to reduce health disparities and improve access to healthcare for Hispanics. Developing interventions through community programs and policy advocacy to eliminate healthcare access inequities among Hispanics in newly settled, underserved communities must be taken as the next logical step to this research program. The effectiveness of these interventions in improving healthcare access can be efficiently examined through community-based participatory research approaches. Community-engaged research initiatives aimed at understanding perspectives on healthcare is an empowering mechanisms that illuminates the voice of marginalized immigrant groups in research. Continual research focused on examining effective methods to establish equitable healthcare access and reduce health disparities is crucial to improving community health.

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