Health Policy and Bi- National Elderly Migrants in the U.S. / Mexico Border. The Case of the Ciudad Juarez / El Paso Region

(Angeles López-Nórez, Francisco J. Llera, Candyce Berger)

Introduction

A review of literature about the U.S. - Mexico border presents an array of multidisciplinary, scholarly topics. However there is a paucity of scholarly literature and research among Mexican and American scholars related to the migration of elderly people from Mexico into the U.S. (Judkins, 2007; Zunker and Cummins, 2004; Llera and López-Nórez, 2012; López-Nórez, 2017). In this paper, we present our findings about the impact on the elderly of the process of migration from Ciudad Juarez to El Paso, with specific attention of their access and use of health systems and related institutions. We believe that our research may be the first efforts to understand the needs and challenges faced by individuals who migrate from Mexico to the U.S in their elderly years (defined as 60+ years of age).

Anderson (2003) and Zunker and Cummins (2004) discuss the fast rate of growth of the elderly population in El Paso. Several authors report on the poor quality of life and health conditions of the elderly in this border region (Zunker, Rutt and Meza, 2005; Mier, Ory, Zhan et al, 2008). López-Nórez (2017) found that migration of elderly Mexicans into the U.S. presents unique challenges. One belief is that family reunification is the most important reasons for the migration of retired Mexican elderly populations into El Paso (López-Nórez, 2017). There is concern that migration of Mexican elderly population may increase the financial pressure in the U.S. health system. A few studies

explore the timing of migration on health outcomes, but most of these focuses on mortality but not in the quality of life elder migrants experience as they are ageing in the U.S. (Gubernskaya, 2014; Angel, Angel, Venegas et al, 2010; Gubernskaya, Bean & Van Hook, 2013; Wakabayashi, 2010).

In her recent study, López-Nórez (2017) showed that the migration of elderly people from Mexico into the U.S. is becoming a more common process along the Juarez /El Paso border region. In El Paso County in 2010, there were 82,223 (10.2%) persons 65 and older; 70,000 (10.7%) residing in El Paso city limits; and approximately 10,952 of the housing occupied by the elderly was located outside of the city limits in impoverished, unincorporated communities within the county (U.S. Census, 2013).

López-Nórez (2017) conducted in-depth interviews with a purposive sample of elderly individuals who migrated to El Paso when they reached 30 or more years of age. She found that one of their major pressures was the absence of knowledge and skills that created barriers to accessing need resources, including health care, economic support, and assistance with housing and other social services. For instance, most of the research participants attributed these challenges to a lack of knowledge about the most important agencies that provide support for the elderly people, a little familiarity on how to contact institutions and organizations, communication barriers based on language differences and a lack of confidence to speak with public officials. This lack of knowledge and skills inhibited their ability to obtain the necessary services and resources to improve their quality of life while living in the U.S.

Methodology

We adopted an exploratory research design, using a Grounded Theory approach. We developed a semi-structured interview schedule for specific use in this study in order to conduct in-depth interviews (1.5 hours) with participants to capture deep meaning and nuances from the respondent's lived experiences. The research questions guiding this study included: 1) what motivated the individual to migrate and their experiences with migration; 2) their present living situation including home and community; 3) their perceptions of their health status; 4) where they access health services and why, and 5) the supports and challenges of accessing health care services. We obtained approval for the study from the institutions Institutional Review Board prior to initiation of the project.

We used a quota sample to recruit subjects, selecting: 24 Mexican men and women who migrated in later life (defined as 60 years of age or older) and lived in the U.S. for at least 5 years continuously since migrating. The 24 participants were stratified by gender (12 men and 12 women) and by age (60 – 70 and 71+ years of age. The stratification was based on the health care utilization patterns and cost of health care (Neuman, Cubanski, Huang and Damico, 2015).

Recruitment of participants occurred in several ways. Local agencies in El Paso County agreed to distribute information sheets about the research project and encouraged them to contact the individuals listed at the end of the announcement. We put up signs in local food markets, retail settings and churches in Hispanic neighborhoods. We also gave presentations of the project at local health and social service programs serving the elderly. Finally, snowball sampling became a major

source for recruitment; participants who completed the interview shared the announcement with others in their network and encouraged their participation.

Interested participants established contact with the research team by telephone or email; screening for eligibility occurred at this contact. If eligible, a consent form was discussed and read in the participant's primary language; and if they agreed to participate, we scheduled a time for the interview. To ensure anonymity, no identifying information (e.g., name, address or phone number) was saved from the initial contact; it was destroyed once the participant's interview was completed.

At the interview, the interviewer reviewed the consent form again, and obtained the participant's signature.

We developed a structured interview guide for use in this project. It addressed into one's perception of the experience of migration in later life; the type, location and challenges of accessing health and social services either in the El Paso, Texas or in Juarez, Mexico; and differences in experiences for women and men. The interview guide also included demographic data (e.g., age, gender, age at migration, marital status, and members living in the household, retirement / work status, and health history). The interviewer took field notes to capture observational data, describing things seen, heard, or experienced during the interviews. The field notes document the researcher's reactions, ideas, questions, and emerging insights and findings (Mount, Boston, & Cohen, 2007).

Initially, we used thematic content analyses, cataloging thematic categories and subcategories that emerged from open coding of the interview data. We paid close

attention in comparing themes across within the interview data and began to identify patterns.

The next phase delved into more detailed analysis of the data using ATLAS-ti software to assist in the analysis. As themes, categories, concepts, or principles of organization emerged, the research team considered the plausibility of new understandings and explored them through the data. We searched through the data to identify discrepancies or interruptions in the patterns, and incorporating these inconsistencies into larger constructs (Marshall & Rossman, 1999).

Findings of the Study

Characteristics of the Elderly Migration Patterns in the Ciudad Juarez / El Paso region

The migration of an elderly population has received little attention in the national or global academic literature. Authors have primarily followed migration patterns of elder people returning from foreign contexts or external national regions to their country of origin (Wang, 2017; Handlos, Olwig, Bygbjerg, Kristiansen, & Norredam, 2015). According to our knowledge, in the U.S./Mexico border region there exists a different migration pattern for the elderly population. Rather than returning to their home country to stay for their last years of their lives, as it happened with the Pakistanies in Sweden or with the Bosnians in Denmark (Naess and Vabo, 2014; Handlos, Olwing, Bygbjerg, Kristiansen and Norredam, 2015). López-Nórez (2017) have found that in the Ciudad Juarez / El Paso border region, there exist Mexican elderly people that immigrate into the U.S. to spend the last part of their lives together with their children and grandchildren.

Most of the research about elder population who migrated into the U.S. addresses individuals who migrated earlier in their lives and aged while in the U.S. (Altangerel and Van Ours, 2017; Becerra and Kiehne, 2016; Hanson and Mc Intosh, 2009). Therefore, we designed this study as a pilot project that may be among the first to target the migration of elderly individuals from Mexico into the U.S.

The United States and Mexico border region is an area that has historically encompassed diverse social, cultural, political and economic interactions among the local inhabitants. One of the most common to this region has been the composition of families where the young generation possesses double nationality and the adult members maintain one nationality. When these younger members with U.S. citizenship mature, they often move to live in the United States. As their parents age, their families in the U.S. encourage them to move to the U.S. to be with family. These elderly parents may hold a different immigration status that avoids the quote standards if they are migrating to live with family who are living in the U.S. and are U.S. citizens. Moreover, this type of immigration is not subject to the typical quotas applied to immigration. According to the Immigration and National Act (INA) of 1965 the parents of U.S. citizens are considered “immediate relatives” and this migration category enjoys of unlimited annual visas (Cepla, 2018; Zong, Batalova and Burrows, 2019). In 2016, 48% of the over one million new green card holders were immediate relatives of U.S. citizens (Cepla, 2018). The percentage of parents that benefit from acquiring legal immigration status through their sons or daughters may vary among the different sub-regions or sectors along the United States / Mexico border region. To illustrate, according to U.S. official immigration data of 2017, foreign-born persons with legal status that are 65

years and older accounts for 11.8% of the total foreign-born population with legal status in Texas, 15.6% in New Mexico, and also 15.6% in Arizona (Migration Policy Institute, 2017).

In the Ciudad Juarez/El Paso border region, López-Nórez (2017) found that the migration of elderly people from Mexico into the U.S. is becoming more common. Data from our study revealed that elderly migrants moving from Ciudad Juarez into El Paso was clustered in two main groups according to the country of origin of their retirement pension or source of income. One group of subjects used to live in Ciudad Juarez, but worked most of the time in the U.S. Their retirement pension and social benefits came from American institutions. A second group lived and worked in Mexico: therefore, their retirement pension and social benefits came from Mexican institutions. The origin of the source of income and the side of the border where they received social benefits created relevant differences in their conditions of life. In Tables 1 to 3, we present some of the demographic information, focusing on social, economic, educational and cultural differences among elderly migrants who have moved to live into the U.S. after they reach 60 years old.

Table 1. Education and Language Skills

Variable	All N = 24	% with American Retirement Livelihood N=16	% with Mexican Retirement Livelihood N=8	% Retirement Livelihood Total N = 24
Gender				
Male	12	25.00	25.00	50.00
Female	12	41.66	8.34	50.00
Education				
Primary School and below	10	33.34	8.34	41.66
High School completion	7	16.66	12.51	29.16
College and above	7	16.66	12.50	29.16
Language Skills				
Monolingual Person (Spanish)	13	33.34	20.84	54.16
Bilingual Person (English / Spanish)	8	29.16	4.16	33.34

Partially Bilingual (English / Spanish)	3	4.16	8.34	12.57

The total number of subjects participating in this study was 24. The sample shows an even distribution by gender. The group relying in American retirement benefits was larger (66.66 %) than the group relying in Mexican retirement benefits (33.34%); women were more likely to rely of American benefits than men. Overall, the level of education of participants relying on U.S. retirement was more likely than Mexican retirees to only complete primary school of less. However, those on U.S. retirement were only slightly more likely to complete secondary and post-secondary education than those of the Mexican retirement system. Their knowledge of the English language demonstrates that Spanish is the primary language across both retirement systems (54.16%). However, those on the U.S. system are almost three-times more likely to speak or partially speak English than those in the Mexican system. This is not surprising, given that working in the U.S. would increase the necessity to acquire at least some English proficiency.

Table 2 presents the source of income and housing tenure of the sample population. Based on results, it seems that there is a high percentage of participants (37.50 %) who do not have a retirement pension or financial support rather they are still working or may receive family support for their subsistence. These participants are the ones who might face major challenges to deal with health problems since some of them do not have access to health coverage. On the contrary, it is relevant that there are a

small number of participants (8.34 %) that enjoy of simultaneous retirement pensions and social benefits from both Mexico and the U.S. This group of subjects are the ones that enjoy the best health coverage in the region. They can select where to receive medical treatment and prescriptions. In addition, this group may also have strong economic conditions among the research subjects; but further analysis would be required to establish this relationship. As one participant stated *"I worked for about 30 years in Mexico as a boot maker and as school janitor; after I retired there, I moved to El Paso and I have been working in the United States since I obtained my residency 6 years ago… I am retired and I have medical services from the IMSS, in Mexico. They give me my monthly check up and they give me medication there too….here, in the United States I have medical insurance too…"*

Regarding housing, the large majority of participants (79.16%) live in a private home and there is only a small percentage (20.84 %) living in public housing. Research subjects living in public housing are those who mostly developed their working trajectories within the U.S. This pattern was present among the five research subjects that were interviewed within public housing projects. Housing location suggest that people that work the majority of time in the U.S., while living in Juarez during their working life. When they retired, it required them to obtain housing in the U.S. in order to access human and health services.

Table 2. Main Source of Income and Housing Tenure

Variable	All N = 24	%American Retirement Livelihood N=16	%Mexican Retirement Livelihood N=8	%Total Retirement Livelihood N = 24
Gender				
Male	12	25.00	25.00	50.00
Female	12	41.66	8.34	50.00
Source of Income				
Formally worked and retired in one Country	13	25.00	29.16	54.16
Formally worked and retired on both Countries	2	0	8.34	8.34
Husband / Spouse Pension	6	16.66	8.34	25.00
None of the above (still working, family support, other)	3	8.34	4.16	12.50
Housing Tenure				
Living in Public Housing	5	20.84	0	20.84
Living in Private Housing	19	45.83	33.33	79.16

Table 3 provides participant´s information about their period or date of migration from Mexico into El Paso, Texas. According to our data only 25% of the sample population has 5 years living in El Paso. We noticed that 16.66% of those subjects worked and lived their entire productive live in the Mexican side and when we observed the patterns of home companion we find out that none of such participants live alone in the U.S. These Subjects that used to live most of their life in Mexico either live with spouse/husband (20.84%) or with family members (12.50%). These findings confirm what Venegas (2010) and Wasem (2004) have stated that elderly migrants tend to migrate to the U.S. to live with family members in contrast to those who migrate searching for working opportunities.

Table 3. Migration Period and Home Companion

Variable	**All** **N = 24**	**American Retirement Livelihood** **N=16**	**Mexican Retirement Livelihood** **N=8**	**%Total Retirement Livelihood** **N = 24 (%)**
Gender				
Male	12	25.00	25.00	50.00
Female	12	41.66	8.34	50.00
Migration to El Paso				
More than10 years ago	8	29.16	4.16	33.33
6 to 10 years ago	10	29.16	12.50	41.67

5 years ago	6	8.34	16.66	25.00
Living with				
Living with their family members	4	4.16	12.50	16.66
Living Alone	9	37.50	0	37.50
Living with Spouse/Husband	11	25.00	20.84	45.84

According to the data, the sample of participants lived in the U.S. for many years post-migrating; 58.32% lived in the U.S. six or more years, with almost 30% residing for more than ten years. One explanation may be associated with their years of employment in the U.S. When they retired, they may have established a network of friends, and/or obtained residency in order to access their U.S. retirement benefits. As one of the participants commented: *"…My husband worked his entire life in the U.S.A and we made many friends in El Paso… we used to come to parties and make many friends in El Paso… I got used to the life in the U.S.… when my husband pass away it was not difficult for me to move to live in El Paso"*. This might also explain why those living in the U.S. after migrating were also more likely to be living or with their spouses (62.5%). For those living in Mexico, whether or not working in the U.S., their recent migration could create challenges to adjusting to U.S. life. One participant describe it as follows *"…I live right next to my daughter… it is because her property is so big and she*

gave us a piece of it... we have a trailer home... I barely have friends in here... I do not like to go out very often… it is because my husband does not like to go out... Why do I need to have friends if I barely go out ".

Medical Service Provision and Elderly Migrants

We have discussed that the majority of the sample population in this study has worked and retired either in the U.S. (33.34 %) or in Mexico (20.84 %) and only a small percentage of them worked and retired from both Mexico and the U.S. (8.34 %). In addition, 12.50% of the participants are still working and subsisting through their salaries. This information is relevant to understand the characteristics or the type of health coverage enjoyed by the sample population on both sides of the U.S. / Mexico border. Our findings, presented in Table 4, show that 58.32% of our research subjects have health insurance in the U.S. These results also suggest that the larger the period of migration the most common is to search for health insurance in the U.S. As was expressed by Subject 2: "…*my daughter told me to go to that Clinic because sometimes I used to bring some medication from Juarez and she told me to go to a Clinic here so they could do a checkup and they could give me medication, and she is the one that took me to the Clinic... When I receive medical attention, everybody speaks Spanish there*..."

Our data also display that 16.65% of the sample population have access to Health Insurance on both sides of the border. This situation allows them to have more alternatives to choose where they prefer to receive medical services, medical treatments or provision of medicines. This situation was illustrated by Subject 1 who

stated: "*….here, in the United States I have medical insurance too… Blue Cross Blue Shield… I have seen a doctor here so I could have an open file and medical history here… if there is an emergency I could use my medical services here… I go to Juarez on Saturdays when I am not working… to see my daughters and so then I just take advantage and go to the doctor*…".

Table 4. Health Insurance Coverage

Variable	**All N = 24**	**% Migrating El Paso >10 years ago N=8**	**% Migrating El Paso 6-10 years ago N=10**	**% Migrating El Paso < 6 years ago N=6**
Gender				
Male	12	16.66	16.66	16.66
Female	12	16.66	25.00	8.34
Health Insurance Coverage				
Insured in U.S.A	14	20.84	29.16	8.34
Insured in Mexico	4	4.16	4.16	8.34
Insured in both Mexico and the U.S.A	4	4.16	4.16	8.34
Uninsured in both Mexico and the U.S.A	2	4.16	4.16	0

The opportunity of a certain number of subjects (16.65%) to choose in what side of the border they would like to receive medical services is also relevant for their self-confidence and quality of life since they feel secure to face any emergency while they visit or conduct activities on both sides of the border. A good sign identified by this study is that the percentage of elder migrants that lack of some type of health insurance in the U.S. or in Mexico is low (8.34%). Even when these subjects recognized that they formally lack of health insurance they are not totally unprotected on both Ciudad Juarez and El Paso.

On both sides of the border they have alternatives to receive some type of medical services. In the U.S. this population might find access to health services or primary care attention and in Mexico such population will enjoy of full medical coverage by law. These was confirmed by a round table session with U.S. and Mexico academic specialists and decision makers as the U.S. Decision maker #1 stated "*in our Medical Institution, when people become legal we give them five years and then they lose their medical discounts… they lose benefits because they now have access to other options like Medicare or Medicaid after five years… sometimes this people depends on others to go for medical visits in Mexico and this people do not want to cross the border* " and also complemented by the Mexican Decision Maker #1 who stated: "*In Mexico, health services are free for elderly… when the problem or disease is complex we send them to Mexico because here is very expensive… and in Mexico they can get services for free … medical services are by law offered for free* ".

In Table 5 we present the universal medical Institutions that provide medical attention to participants of this study on both sides of the border. Results show that

91.64% of the entire sample population is covered by health insurance either in an American health institution (66.66%) or in a Mexican health institution (24.98%). The factor that the majority of participants expressed that they have health insurance or health coverage in the U.S. might be partially truthful. It is real that they have access to health provision within some local health institutions in El Paso, although, this factor does not guarantee that participants enjoy of a health insurance which provides of full coverage to their health needs.

Table 5. Medical Service Provision

Variable	**All** **N = 24**	**% Migrating El Paso >10 years ago** **N=8**	**% Migrating El Paso 6-10 years ago** **N=10**	**% Migrating El Paso < 6 years ago** **N=6**
Gender				
Male	12	16.66	16.66	16.66
Female	12	16.66	25.00	8.34
Medical Service Provision				
American Health Institutions (Insurance Coverage)	16	25.00	29.16	12.50
American Health Institutions (No Insurance Coverage)	2	4.16	4.16	0
Mexican Public Health	5	4.16	8.34	8.34

Institutions				
Mexican Private Health Institutions	1	0	0	4.16

On the contrary, we found out that 8.34% of the sample population has access to medical institutions which provide basic medical services but not comprehensive coverage in case of the necessity of specialize medical attention or hospitalization. In other words, an important number of participants enjoy of underserved medical attention in El Paso, Texas. Overall, the three largest providers of medical services to our sample population on both Ciudad Juarez and El Paso are the Mexican Institute for Social Security (IMSS) 16.66%, Private Doctors 12.50%, and the University Medical Hospital 8.34%.

A factor of considerable attention in this research was to learn about the health status of the sample population. Official Mexican data pointed out that one third of the people of 60 years and older requires some type of care or health support (NOTIMEX, 2012). Diabetes mellitus and cardiovascular diseases are among the three major causes for death among the Mexican elder. This study found out that chronicle diseases are the most frequent health problems experienced by participants. Data in Table 6 demonstrates that 66.66% of the total sample population has health problems related to diabetes and /or hypertension.

Table 6. Health Conditions of Elderly Migrants

Variable	All N = 24	Migrating El Paso >10 years ago N=8	Migrating El Paso 6-10 years ago N=10	Migrating El Paso < 6 years ago N=6
Gender				
Male	12	16.66	16.66	16.66
Female	12	16.66	25.00	8.34
Diseases				
Diabetes & High Blood Pressure	16	25.00	29.16	12.50
Arms, Legs, Back and Hip Injuries	2	8.34	0	0
Heart & Circulatory System Diseases	3	0	8.34	4.16
Other Diseases	1	0	4.16	0
None	2	0	0	8.34

This health pattern observed within the sample population confirmed the predominant health problems experienced within the Mexican society. Independently from the period of migration, more than 60% of participants suffer of diabetes. The second most relevant health affectation among participants was related to heart and

circulatory diseases (12.50%). The prevalence of such type of diseases among participants makes more relevant to have access to full medical coverage.

Chronicle diseases and heart diseases demand permanent medication, medical reviews and costly treatments which in the long term become serious financial burdens to deal with both for patients and for their families. Findings form our research display that the four major health problems experienced by our sample population during the last six months were hypertension, 21%; cataract surgery, 8.4%; knee surgery, 8.4%; and diabetes, 4.2%.

As we have already pointed out 66.66% of the total sample population has health problems related to diabetes and /or hypertension, and another 12.50% of these participants, present health problems related to heart and circulatory diseases. Based on such health patterns in Table 7 we present results about the frequency of medical visits and distance to medical services from our sample population. Our data results suggest that almost 50% of the total sample population attends to medical visits at least once every three months. Such frequency on visiting medical institutions for periodical reviews, concedes importance to the proximity of the medical place where subjects receive medical attention.

Table 7. Frequency of Medical Visits and Distance to Medical Services

Variable	All N = 24	% Migrating El Paso >10 years ago N=8	% Migrating El Paso 6-10 years ago N=10	% Migrating El Paso < 6 years ago N=6
Gender				
Male	12	16.66	16.66	16.66
Female	12	16.66	25.00	8.34
Frequency of Medical Visits				
Monthly	4	0	12.50	4.16
Quarterly	8	16.66	12.50	4.16
Bi-annual	6	12.5	8.34	4.16
Annual	3	0	8.34	4.16
Occasional	3	4.16	0	8.34
Average Distance				
5 miles or less	12.50	20.84	4.16	
6 to 10 miles	4.16	4.16	0	
11 to 20 miles	4.16	4.16	8.34	

21 miles or more	12.50	12.50	12.50

Data results on Table 7 show that 37.50% of the total participants receive medical care in medical institutions located within an average distance of 5 miles or less. In this decision, external reasons were more decisive than personal reasons. Our results show that more than 30% of the sample population with medical insurance in the U.S. was assigned to the medical place where they receive medical services and only 12.50% of the subjects choose the place to receive medical care taking in consideration the aspect of proximity. This short proximity contributes to guarantee fast medical attention in case of an emergency and to facilitate the movements and transportation of participants to attend medical periodical reviews. This might also explain why almost 90% of the participants drive their own cars to attend medical appointments and even if they take the public transportation system they do not need to spend too much time to attend medical appointments.

There are also another considerable group of participants who need to travel longer distances to receive medical attention. Data results on Table 7, show that 37.50% of the research participants need to travel 21 miles or more to receive medical attention. This is the group that faces more disadvantages to access to medical service provision. The larger number of these research participants belongs to the group that used to live and worked in Mexico, and therefore, receive their retirement pension and social benefits from Mexican institutions. Figure 1 shows how within our sample population those

receiving social benefits and medical coverage in Mexico are settled in further geographic distances to the Mexican boundary than those which receive their medical service provision within the U.S.

The geographic dispersion and location remoteness of our research participants with Mexican Health Coverage might be explained by considering, according to our data findings, that they migrate into the U.S. to be closer to their family or to live with their relatives. Based on such criteria proximity to the Mexican boundary line was not a factor for choosing the residential place to live. As subject 3 expressed: "*I go to Juarez once a month for medicine and to see the doctor every three months*" and Subject 1 confirmed: "*to receive medical attention in Juarez I travel, on average, about 32 to 40 miles for and back…"*

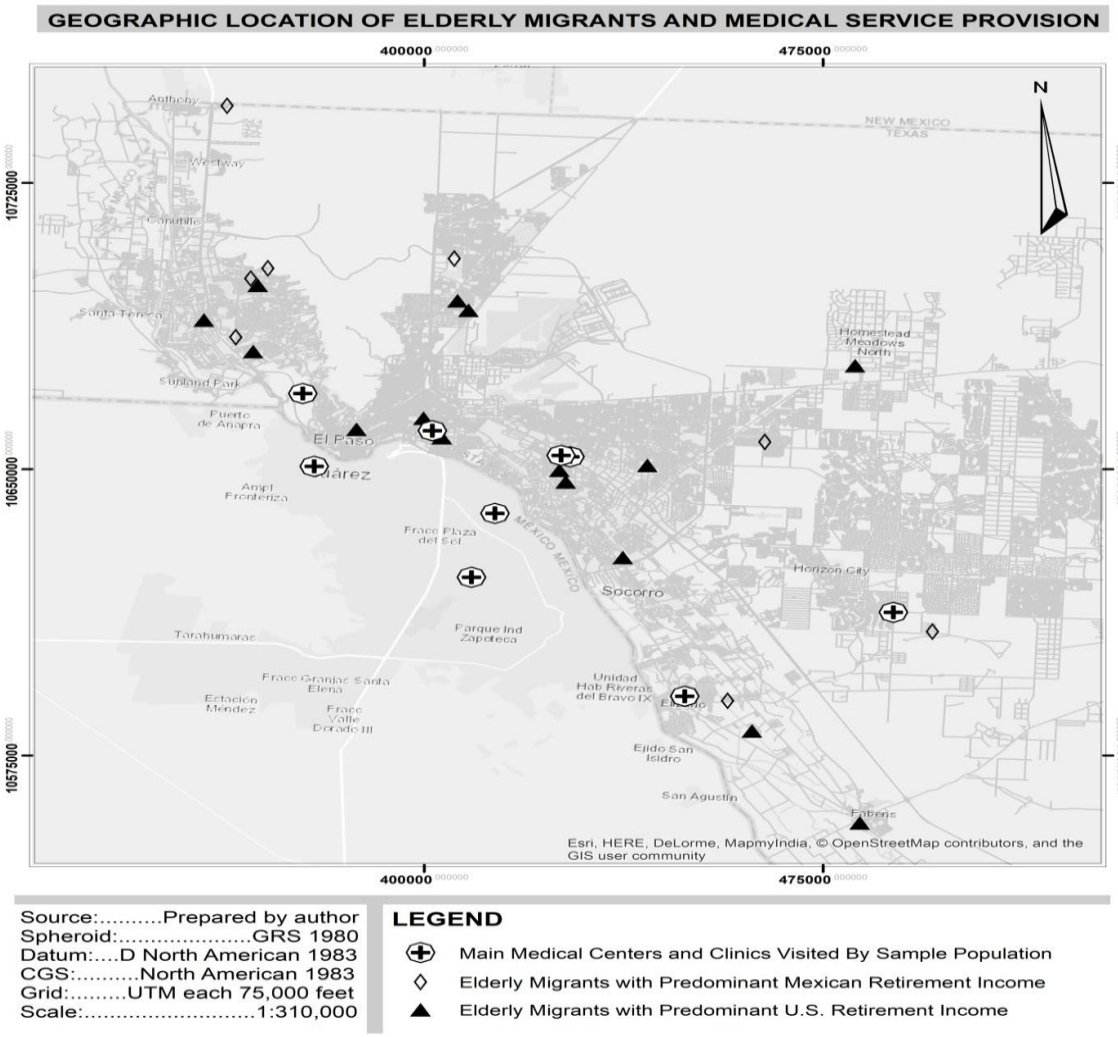

Figure 1. Geographic Location of Elderly Migrants and Medical Service Provision

The preference of some of our research subjects to seek for medical attention in Mexico rather than in the U.S. has also relationship with cultural aspects. In our study, almost 30% of the research subjects considered the "formalities of the System" as one of the most relevant limitation to access to medical services in the U.S. As the U.S. Decision Maker #1 mentioned "*Elder people still have strong attachment to Juarez… they go to Juarez to see specialists and we send them their medical studies* ". This observation is

complemented by the Mexican Decision Maker #2 "*when I used to do my medical practice some of my elder patients used to go to my medical office just to talk and they told me once I have already seen you I feel better*". In our sample population, the most common medical visits in Mexico were done searching for General Medicine, 25%; Odontology, 12.50%; Cardiology, 4.20%; Ophthalmology, 4.20%; Gynecology, 4.20%; and other, 12.50%.

Finally, some our subjects are also crossing the border to acquire medicines in Mexico rather than in the U.S. because many of those medicines are cheaper or accessible for free to them in Mexican public hospitals. Our data results display the following purchase pattern to acquire medicine in Mexico.12.6% of our research subjects obtained medicines from the Mexican Institute for Social Security (IMSS) while 8.4% obtained their medicines from private Mexican pharmacies. In the U.S. side, 25% of our research subjects obtained their medicines in Walmart and 16.7% in Walgreens.

Conclusion

Findings from this research project display several opportunities for future research. First, the themes and patterns identified with this small sample can be tested with a larger population using more rigorous research approaches, such as standardized surveys. This will increase confidence in the findings of this project. Second, this study is unique due to the geographical context. Migration does not limit the individual's ability to travel back to their home country with relative ease, given the border proximity. Further research could examine migrating elderly who move to U.S. cities that are at a greater distance from their native country or reside in Latin American

countries that are further from the border. This geographic distance could produce different issues and challenges that were not identified in this study. Third, the research team is interested in explore migration of elderly individuals in other border communities along the U.S. - Mexico border region.

References

Altangerel, K. & Van Ours, J. (2017). U.S. Immigration Reform and the Migration Dynamics of Mexican Males. *De Economist*, 165:463-485.

Anderson, J. (2003). The U.S.-Mexico border: a half century of change. *The Social Science Journal*, 40, 535-554.

Angel, R.J., Angel, J.L., Venegas, C.D. and Bonazzo, C. (2010). Shorter stay, longer life: Age at migration and mortality among the older Mexican-origin population. *Journal of Aging Health, 22*:914-931. DOI: 10.1177/0898264310376540.

Becerra, D. & Kiehne, E. (2016). Assesing the Relationship between Remittance Receipt and Migration Intentions among Mexican Adolescents Living along the U.S. – Mexico Border. *NORTEAMERICA*, 11(2), 7-30.

Cepla, Z. (Feb. 14, 2018). Fact Sheet: Family-Based Immigration. In National Immigration Forum. Retrieve from: https://immigrationforum.org

Gubernskaya, Z. (2014). Age at migration and self-rated health trajectories after age 50: Understanding the older immigrant health paradox. *Journal of Gerontology, 36*(4), 464-473. DOI:10.1093/geront/gbu049,

Gubernskaya, Z., Bean, F.D., and Van Hook, J. (2013). (Un) healthy immigrant citizens: Naturalization and activity limitations in older age. *Journal of Health and Social Behavior, 54*:427-443. DOI: 10.1177/0022146513504760.

Handlos, N.; Olwin, K.; Bygbjerg,Ch.; Kristiansen, M. & Norredam, M. (2015). Return Migration among Elderly, Chronically Ill Bosnian Refugees: Does Health Matter? *International Journal of environmental Research and Public Health*, 12: 12643 - 12661.

Hanson,G. & Mc Intosh, C. (2009). The Demography of Mexican Migration to the United States. *American Economic Review: Papers and Proceedings*, 99 (2), 22-27.

Judkins, G. (2007). Persistence of the U.S. - Mexico Border: Expansion of Medical – Tourism amid Trade Liberalization. *Journal of Latin American Geography*, 6(2), 11-32.

Llera and López-Nórez. (2012). *Colaboración Transfronteriza en Ciudades Gemelas*. *Lecciones y Retos en Ciudad Juárez-El Paso y Frankfurt (Oder)-Slubice*. México: Universidad Autónoma de Ciudad Juárez/El Colegio de Chihuahua.

López-Nórez, A. (2017). Gerontología Ambiental: Experiencia espacial de envejecer en la región Ciudad Juárez / El Paso. Ciudad Juárez, Chihuahua. Center for Development and Quality of Life, Alianza para el Desarrollo y la Calidad de Vida, Colegio Ciencias Políticas y Administración Pública: El Paso, Texas, U.S.A.

Marshall, Catherine and Gretchen B. Rossman (1999). Designing qualitative research. 3rd. ed. London: Sage Publications.

Mier, N., Ory, M., Zahn, D., Conkling, M., Sharkey, J. & Burdine, J. (2008). Health-related quality of life among Mexican Americans living in colonias at the Texas - Mexico border. *Social Science and Medicine* 66, 1760-1771.

Migration Policy Institute (2017). State Immigration Data Profiles. Demographics. Retrieve from: tps://www.migrationpolicy.org

Mount, B.M., Boston, P.H., & Cohen, S.R. (2007). Healing connections: on moving from suffering to a sense of well-being. *Journal of Pain and Symptom Management,* 33 (4), 372-388.

Neuman,T., Cubansky, J., Huang, J.,& Damico, A. (2015). The rising cost of living longer: Analysis of Medicare spending by age for beneficiaries in traditional Medicare. Menlo Park. CA: The Henry J. Kaiser Family Foundation.

NOTIMEX. (AugU.S.t 24th, 2012). En aumento población de adultos mayores en México. REPORTE.

U.S. Census Bureau. (2013). American FACT FINDER. Community Survey El Paso County. Retrieved from: http://factfindr2.census.gov

Wakabayashi, C. (2010) Effects of immigration and age on health of older people in the United States. Journal of Applied Gerontology, 29, 697-719. DOI: 10.1177/073346480935602.

Wang, M. Rieger. M.O., & Hens, T. (2016). How time preferences differ: Evidence from 53 countries. *Journal of Economic Psychology*, 115-135.

Wasem, R. E. (2004). U.S. immigration policy on permanent admissions. Washington, DC: Congressional Research Service.

Zong, J.; Batalova,J. &Burrows, M. (March 14, 2019). Frequently Requested Statistics on Immigrants ad Immigration in the United States. (SPOTLIGHT). Retrieved from: tps://www.migrationpolicy.org

Zunker, C., Rutt, C. & Meza, G. (2005). Perceived Health Needs of Elderly Mexicans living on the U.S.-Mexico Border. Journal of Transcultural Nurse, 16(1), 50-56.

Zunker, C. & Cummins, J. (2004). Elderly health disparities on the U.S.-Mexico border. Journal of Cross-Cultural Gerontology, 19, 13-25.

Mexican Decision Maker 1: Adriana Martinez Landaverde, Mexican Consul

Mexican Decision Maker 2: Lorena Garcia, State Secretary of Health/Program of Elderly People

Mexican Decision Maker 3: Nubia Denis Rodríguez, Office for Family Development/Program of Elderly People (DIF)

U.S. Decision Maker 1: Ismael Rodríguez, University Medical Center

U.S. Decision Maker 2: Yvette Lugo, Rio Grande Area Agency on Aging (AAA)

U.S. Academic Expert 1: Shafik Dharamsi, UTEP College of Health Science

U.S. Academic Expert 2: Guillermina Solis, UTEP College of Health Science

U.S. Academic Expert 3; Candyce Berger, UTEP College of Health Science