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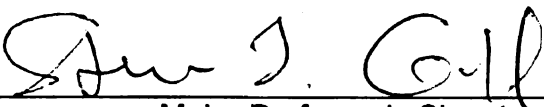
Inequality and Health Care Access: A Mixed-Methods Study
of the Experiences of Mexican Origin Families in California

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INEQUALITY AND HEALTH CARE ACCESS: A MIXED-METHODS STUDY OF
THE EXPERIENCES OF MEXICAN ORIGIN FAMILIES IN CALIFORNIA

By

Pauline Sue Acosta

A DISSERTATION

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ABSTRACT

INEQUALITY AND HEALTH CARE ACCESS: A MIXED METHODS STUDY OF THE EXPERIENCES OF MEXICAN ORIGIN FAMILIES IN CALIFORNIA

By

Pauline Sue Acosta

Going to see a doctor when you feel sick should be uneventful in the United States, the country with the highest health care expenditures per capita in the world (Congressional Budget Office, 2008). Yet, Mexican Americans do not benefit from the way health care is organized in the U.S., as health care access and work are linked. Simply put, Mexican Americans work, work should increase health care access through employer-based health insurance. Yet, working Mexican Americans show a high rate of being uninsured compared with other groups (Bhandai, 2002; Brown & Yu, 2002; Chávez et al., 1997; Fronstin, 2010).

This dissertation begins with a main assumption that the source of illness is social in origin, not just biological, and that the allocation of medical resources depends largely upon economic, political and social resources available to specific groups within society (Chávez et al., 1992; Chávez & Torres, 1994; de la Torre & Estrada, 2001; Doyal with Imogen Pennell, 1979/1994). I use a mixed-methods approach to better understand how the intersection of work and health care shape the experiences of Mexican Americans. I employ Logistic regression analysis on a subset (n=771) of data from a random phone survey conducted to examine health, employment and access issues among Latinos in California. Semi-structured in-depth interviews (n=15) were conducted in English and Spanish with employed Mexican origin respondents to examine health insurance and work histories, and other health care system experiences. Intersectional and political

economy frameworks are used to investigate several questions. These include: 1) How does the organization and delivery of health care in the U.S. shape the access experiences of Mexican Americans? 2) What factors intersect with gender to shape health care access? 3) How do immigration status and citizenship shape access to health care for Mexican origin family members and what strategies are used to access care?

Findings suggest that health care access is a complex web of patterns, and varies along gender, nationality, citizenship and class lines. The working uninsured and undocumented have limited health care such as paying out of pocket via the patch work system. For U.S. residents and citizens, familiarity with the U.S. and Mexico health systems brings a type of “back up” plan which can be accessed if needs are not met in the U.S. Quantitatively, citizenship is an important predictor of health care access for women, while citizenship, work type and marital status are important factors for men. Citizenship and age are found to be important predictors of health care access in Mexico for women and all Mexico born respondents. These findings demonstrate the importance of examining health care access across different social locations.

This study has several policy and research implications. Any health reform legislation that is implemented needs to include a way to increase health insurance access for Mexican origin family members regardless of citizenship. Continuing to link health insurance with work is a barrier to health care for low income family members. Additionally, what I call “transnational health care” is an important avenue of further investigation. This study demonstrates the importance of ensuring affordable and accessible health care services for all.

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DEDICATION

I dedicate this work to María de Los Angeles Gonzalez, my grandmother, godmother and my life-long teacher. She will never know how much she taught me about inequality in society. *Con cariño.*

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As with most endeavors, this dissertation could never have come to fruition without the support of family, professors and friends. To Paul, Genie, Marci and John: Thank you so much for always believing in me, even when I doubted. I couldn't have done this without you. Sergio, Margarita, Sergito and Paulette, thank you for your transnational and transcontinental support.

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CHAPTER 1: INTRODUCTION AND PROBLEM STATEMENT

Healthcare and work in the U.S. intersect. Access to the U.S. healthcare system is made up of a dual patchwork of 1) state funded coverage to the most vulnerable children, the poor and the elderly, and 2) mostly private, for-profit health insurance policies and managed care organizations (MCOs). In some instances the sole intent of these for-profit MCOs can be described as, “to wrest control of services from physicians and hospitals and push providers to make ‘cost efficient’ choices” (Quadagno, 2005: 161). In many cases, this health care system also provides a “safety net” made up of state-provided or low-cost care for the uninsured (Becker, 2004). The current economy, high unemployment, high medical costs and increasing numbers of uninsured families have shown the failures in this politically reactive and historically constructed system, especially since employment-based health insurance (EBHI) is the most common form of health coverage (Fronstin, 2010). This patchwork system leaves many employed and unemployed family members vulnerable to the threats of being uninsured, underinsured, and lacking rudimentary medical care. This study is an attempt to examine how working Mexican origin family members are impacted by and navigate within this health care system.

Some popular portrayals of the failures of our health care system on individuals and families have recently emerged. Death, disability, bankruptcy or a decrease in livelihood has resulted for the chronically ill, the retired, and the working poor who have been denied coverage or treatment or simply cannot afford it¹ (see for example Cohn, 2007; Moore, 2007). Health care accessed by the uninsured is in jeopardy as well. While

¹ The portrayal of the negative consequences of our health insurance system in film is not new. For examples see: Haines, R. (1991) *The Doctor, USA*: Buena Vista Pictures. Cassavetes, N. (2002) *John Q, USA*: New Line Cinema.

the proportion of the poor and communities of color who seek care in safety-net setting is relatively high, services are diminishing due to pressure from the marketplace and cutbacks in public funding (Becker, 2004; Becker & Newsom, 2003). Still, other popular voices have proclaimed the U.S. to have “the best medical system the world has to offer”¹ for those who have consistent access to it.

Popular images of Mexicans have existed in the American consciousness since first contact in the Southwest (Acuña, 1971; Barrera, 1980). And while the image of Mexican Americans has varied somewhat over time (both negative and positive images), none the less, Mexican Americans have been portrayed as “a problem” throughout history (Moore, 1970). The current perception of Latinos and health care is one in which “they” come “here” to the U.S. to use our resources (Chávez, 2008). In the public imagination Latino immigrants, especially the undocumented, are to blame for the current state budget woes and health care expenses through the overuse of health services (Chávez, 2008; Halper, 2009).

There is a strong body of literature which examines the health care experiences of Latino immigrants. Research on Latino immigrants suggests overall that this group may postpone appointments until symptoms worsen, and are similarly fearful of accessing hospital care for fear of being deported, even in emergencies or situations that concern their U.S. citizen children (Chávez, 2008; Heyman et al., 2009; Hondagneu-Sotelo, 1994). Researchers also find that members of this group face other barriers which hinder access to health care including a lack of bilingual and bicultural providers and services, long gaps of time between making an appointment and seeing the provider (Maisonet

¹ http://www.rushlimbaugh.com/home/daily/site_123109/content/01125119.guest.html. Rush Limbaugh Press Conference in Hawaii January 1, 2010. Accessed May 17, 2010.

Giachello, 1994), as well as occupational location (Azevedo, 2001; de la Torre & Estrada, 2001), and socioeconomic factors which prevent payment of high premiums (Azevedo, 2001; de la Torre & Estrada, 2001) or other out of pocket expenses. Immigration status is another factor which may impact health care access, especially regarding public medical insurance (Azevedo, 2001; Chávez, 1986; de la Torre & Estrada, 2001). Taken as a whole, Latinos *under* utilize the health care system. The ambiguous portrait of Latinos created by health researchers and the public perception created in the media complicates this matter even further. Working Mexican Americans in California are a population that has been virtually absent in the dialogue in which work and the organization of health care intersect, most often via employment based health insurance. This dissertation is an attempt to fill in this gap in the literature.

Why working Mexican Americans? I focus on working Mexican origin family members in order to underscore the need for a new way to examine health care access—a way which defines health care access as a social problem and takes race, class and gender and citizenship into account. While my unit of analysis is individual Mexican Americans, conceptually, I address working Mexican America *families* for two reasons. The first reason is that, as Foucault suggests (1980), health care access occurs through families¹. The second reason is that work and health care access are linked via health insurance. More specifically, health care access is linked to employment and occupational location via health insurance (de la Torre & Estrada, 2001; Fronstin, 2010). Sociologists Harrington Meyer and Pavalko (1996) as well as Karas Montex, Angel and Angel (2009)

¹ Foucault posits that the family became the most constant agent of medicalization in eighteenth century Britain, and in the latter part of the century, the family became “the target for a great enterprise of medical acculturation (1980, p.173).”

have examined the link between family, work and access to health insurance for women finding that health insurance access through marriage is an important aspect of health insurance coverage for some women, often more important than her own employment. However, Seccombe and Beeghley (1992) examine gender differences in employer-sponsored medical insurance coverage among full-time workers and their findings suggest that gender is not as significant a predictor of health insurance compared with structural aspects of her job. Jobs that provide medical insurance to female employees are those that also pay higher wages. Similar research on occupational gender segregation across race suggests that Latinas and Asian American women earn less compared with White women due to occupational segregation and because of race/ethnicity, but not both (Cotter et al., 2003). This suggests that gender, race-ethnicity, work and health insurance are important avenues of investigation.

Government estimates suggest that employment-based insurance plans cover about 160 million non-elderly people (61 percent of the non-elderly population), including spouses and dependents (Congressional Budget Office, 2008; Fronstin, 2010). And, as exemplified in Michael Moore's documentary *Sicko* (2007) and Jonathan Cohn's (2007) journalistic investigative analysis *Sick, The Untold Story of America's Health Care Crisis--And The People Who Pay the Price*, when an individual family member loses health coverage, the whole family suffers. The most common way we currently access health care coverage in the U.S., through work, leaves many families vulnerable (Pescosolido 1998), especially Latinos, who are more likely than non-Latinos to be working (Chávez et al., 1997; Kochhar, 2008; Quinn, 2000), and less likely to have health insurance than non-Latinos (Thomas & James, 2009). Undoubtedly, indigent and

unemployed Latino families experience severe difficulties accessing care in California, yet their experiences are beyond the scope of this study.

A note about who is defined as Mexican American. Mexican Americans have been alternatively *racialized* as Mexican and white since the 1800s (Acuña, 1971; Hayes-Bautista & Chapa, 1987). What to call Mexican Americans and indeed other Latinos has varied from the Spanish surname population, Spanish origin to Hispanic, the category created by the Office of Management and Budget (OMB) in the 1970s. David Hayes-Bautista and Jorge Chapa (1987) suggest that the term “Mexican origin Latinos” be used as a way to counter the emphasis on nativity as a racial category. I prefer Latino/Latina, a widely-accepted and used term, Mexican origin or a more precise identity. When possible, specific terms will be used to describe Mexican, Mexican American/Chicano individuals and/or *Mexicanos*, those of Mexican origin, or Mexican heritage families. Mexican origin family members may have various immigration backgrounds (citizen, undocumented, etc.) so I use general terms throughout this dissertation unless I have specific knowledge of immigration or citizenship status. Family composition is not easily defined along immigrant/non-immigrant lines in these “mixed status families.” I will give preference to the labels used by the individual respondent when possible. When referring to the literature, I use terminology as specified in the research article or government document.

EXTENT OF THE PROBLEM

Health care access is often measured according to insurance status, having a usual source of care or having regular office visits (de la Torre & Estrada, 2001; Maisonet Giachello, 1994; Thomas & James, 2009). Health insurance coverage matters as it helps to facilitate access to care, and is a primary factor in explaining racial and ethnic

disparities in whether an individual has a regular source of care (Thomas & James, 2009). The latest information indicates that 45.7 million people in the U.S. are uninsured, approximately 14.7 percent of the population (National Center for Health Statistics, 2008). Thirty-two percent of Hispanics are estimated to be without health insurance coverage nationally, compared with 13 percent of Whites (National Center for Health Statistics, 2008). As seen in Figure 1 (Appendix C), of those with health insurance, 42 percent of Hispanics have employer or individual health insurance compared with 72 percent of Whites, while 26 percent of Hispanics are covered by public insurance compared with 13 percent of Whites (Thomas & James, 2009). While most Americans who have health insurance receive it through their employment or a spouse's employment, rates of overall health coverage vary by citizenship (Figure 2, Appendix C).

Latinos face other health care access challenges as well. For example, Latinos are less likely to report "Having a regular source of care" compared with Whites (77 percent compared with 88.7 percent). Similarly, a higher percentage of Latinos reported "Failing to obtain needed medical care due to cost at some time during the past 12 months" compared with Whites (7.7 percent compared with 6.0 percent) (National Center for Health Statistics, 2008).

Among the Hispanic population, uninsured Hispanics are more likely to report not having a usual source of medical care (62 percent) and no doctor visit in the past year (53%) compared with insured Hispanics (13 percent and 21 percent, respectively)(Thomas & James, 2009).

In California, more than one-third of Latinos in the state reported not having health care coverage in the period 2003-2005 (U.S. Department of Health and Human Services Office of Women's Health, 2005). One-fourth of Hispanics in California

reported not having received a routine check-up in the previous 2 years (U.S. Department of Health and Human Services Office of Women's Health, 2005).

Going to see a doctor when you feel sick or need medical attention should be uneventful. Yet, in the United States, the country with the highest health care expenditures per capita in the world (Congressional Budget Office, 2008), seeing a medical provider is not always easy. For those with insurance and other financial difficulties, those who have to juggle work and family obligations, or those who face language and citizenship barriers, health care access can be a matter of life or death. The above findings suggest that Mexican Americans do not benefit from the way health care is organized in the U.S. Simply put, Mexican Americans work, work should increase health care access through employer-based insurance yet working Mexican Americans show a high rate of being uninsured compared with other groups (Bhandai, 2002; Brown & Yu, 2002; Chávez et al., 1997; Fronstin, 2010).

This dissertation begins with several assumptions. A main assumption which defines this research is that the source of illness is social in origin, not just biological, and that the allocation of medical resources depends largely upon factors related to the economic, political and social resources available to specific groups within society (Chávez et al., 1992; Chávez & Torres, 1994; de la Torre & Estrada, 2001; Doyal & Imogen Pennell, 1979/1994), including immigration and the incorporation of immigrants into the U.S. labor market (Chávez et al., 1997). Contrary to the literature, I also assume that Mexican Americans are not as healthy as the researchers suggest. I assume that Mexican origin family members may have health issues and that they would like to be able to access the health care system when necessary. In sum, I assume that working

Mexican Americans are active participants regarding their own health who use resources at their disposal to ensure their own health and the health of their family members.

A mixed-methods approach is used in this research in order to better understand how the organization of health care shapes the experiences of Mexican Americans. Logistic regression analysis is employed on a subset (n=771) of data from the “Health Insurance Coverage Among Working Latinos in California” (Greenwald, 2001) study, a random phone survey of 1000 employed Latinos conducted to better understand questions surrounding health insurance, health care access, health status and employment. Fifteen semi-structured in-depth interviews conducted in English and Spanish with employed Mexican origin respondents in Southern California examine health insurance and work histories, as well as experiences with the health care system and ways of coping with illness. I use a political economy framework and intersectional perspective to investigate several questions regarding Latino health care access. These questions include the following:

First, how does the organization and delivery of health care in the U.S. shape the access and health care experiences of Latinos? What impact do insurance and employment have on health care access?

Second, what factors intersect with gender to shape health care access? Does insurance coverage differ based on age, gender and employment?

And finally, how do immigration status and citizenship shape access to health care for Mexican origin family members and what strategies are used to access care in the U.S. and Mexico?

These questions will be examined more closely in chapter three. I examine the state of the Latino health and health care access literatures, define health care access and review the overlapping literature from various areas in chapter two. These areas include:

1) Medical sociology and health care access, 2) Latino sociology and health care access 3) and “Transnational Health Care Access.” Similarly, the theoretical framework is presented in chapter two as well as definitions used in this dissertation. The methodology used in this dissertation, including the analytic strategies, is discussed in chapter three. I discuss the research findings in chapters four, five and six, including: Chapter four: work & health insurance as trajectory, chapter five: gender, work & health care access, and chapter six: health care strategies & negotiations, respectively. I conclude the dissertation in chapter seven with research and policy suggestions. An epilogue is included at the end of this dissertation in order to place the importance health care findings generated by this research to the current health reform bills passed by the Obama Administration.

CHAPTER 2: LITERATURE REVIEW

Before considering how to conceptualize, measure, and quantify health consequences of discrimination, one caveat immediately is in order: the purpose of studying health effects of discrimination is not to prove that oppression is "bad" because it harms health. Unjustly denying people fair treatment, abrogating human rights, and constraining possibilities for living fully expressed, dignified and loving lives, is by definition, wrong-regardless of effects on health. Rather, the rationale for studying health consequences of discrimination is to enable full accounting of what drives population patterns of health, disease, and well-being so as to produce knowledge useful for guiding policies and actions to reduce social inequalities in health and promote social well-being (Krieger, 1999: 296-297).

This literature review brings together key cross-disciplinary scholarship from sociology, and public health. My study begins with health care access and then asks how our understanding of health care access is expanded by focusing on working Mexican Americans, a population comprised of both immigrants and U.S. born Chicanos.

Within biomedical and public health perspectives, health care access is defined as one component of health status (LaVeist, 2005; Smedley et al., 2003). Other factors that determine health include lifestyle behaviors, genetics and environmental factors. From this perspective, health care access is a necessary component of health, but is not sufficient. Some health researchers have suggested that medical care contributes only a small factor, approximately 10 percent, of the variation of health status (see Satcher & Higginbotham, 2008 for a complete discussion). Other studies indicate that assuring medical care for all would reduce premature deaths by only 10-15 percent, as reported by Geiger (2006). The fact that a small "variation" of health status can be explained by health care access should not be interpreted as health care access being an unimportant topic of study. In fact, health care access inequalities have significant implications for individuals, families, policy makers and society at large (Smedley et al., 2003). Along the lines of Krieger (1999) I believe that researching and advocating for increased health

care access is a vital contribution to the livelihood of Mexican Americans and would have powerful effects on quality of life, including disability, pain and suffering (Geiger, 2006). In *Unequal Treatment, Confronting Racial and Ethnic Disparities in Healthcare* (2003), the Institute of Medicine committee suggests that healthcare disparities along racial-ethnic lines result have complex implications. These include:

- Physicians who are faced with the moral dilemma of balancing high ethical expectations with the mandates of fairness and compassion
- Possible harm to the public's trust in health professions, affecting patients' willingness to seek medical care
- Possibly hindering the efforts of racial and ethnic minorities to advance economically, as healthcare and the workforce are closely linked
- Racial and ethnic inequalities in health care dampen efforts in improving the nation's health, increasing the burden of disease on people of color
- Inadequate care may increase overall health expenditures nationally due to poorly managed or missed diagnoses of chronic conditions
- Possibly tarnishing the image of a society still "wrestling with a legacy of racial discrimination (p. 37),"
- Raising concerns concerning the overall quality of health care in the U.S.

From a sociological perspective, health and illness are the domains of the larger social system. One of the key contributions made by medical sociology is to explore the "general nature of social change and social institutions to recognize, describe, and draw from these changes and institutions implications for health, illness, and healing (Pescosolido and Kronenfeld, 1995: 24)." For example, discussions of health reform in

the U.S. continue to focus on the private provision of health insurance in the work place where employees pick from health plans offered within the work site. Yet this image of health insurance and work do not match (Pescosolido and Kronenfeld, 1995). The social institution of work has been undergoing tremendous transformations. In general, the work place is moving towards higher and higher levels of temporary or short term employment without benefits, so how is the work site still a major locale in which health insurance is accessed? The link between the social institutions of health and work are an important area of study. Health care access is a social process, which suggests that individual experiences are in fact shaped by social institutions such as medicine and work.

In the medical sociology literature, health care access is split into behavioral model work, empirical work which examines structural barriers to health care access, and research in which the factors that contribute to the health care delivery system are examined. Social class or socio-economic status (SES) as it is often conceptualized empirically across the health literature, and is a well-established social determinant of health and health care. Income, poverty level and health insurance are often used to determine SES empirically.

I have organized this chapter as follows: First, I contextualize health care access as it pertains to Latinos and poverty research. Later, I examine medical sociology and health care access, Latino sociology and health care access, as well as immigrant public health. I then summarize the key aspects of this literature. In the second part of the review I examine critical insights to health care access. Finally, I end the chapter with definitions pertinent to this study, and the research questions. I begin with the role of underclass research in health care access.

CONTEXT: LATINOS, POVERTY RESEARCH AND HEALTH CARE ACCESS

Along the lines of Hayes-Bautista (1992), Massey (1993) and Moore and Pinderhughes (1993), I address the notion that the underclass framework is appropriate to examine Latinos in the health disparities research, which emerged almost three decades ago. This context explains the current difficulty in obtaining accurate health data concerning Mexican Americans.

Public Health disparities research initially focused almost exclusively on explaining the role of poverty/the underclass in African American health status. This concept emerged in the 1970s as a way of describing the urban and chronically poor, represented by jobless African American men and welfare recipient African American women whose values were seen as distinct from the main stream in the collective imagination (Massey, 1993; Moore & Pinderhughes, 1993). Funding for empirical research on the underclass began to surge as interest in underclass poverty was at an apex as seen in a large number of foundation grants focusing on underclass research offered, as well as an increase in the number of underclass themes conferences. In the early 1980s, some Latino scholars began to apply African American theoretical models and analytic methods to Latino issues (Massey, 1993; Moore & Pinderhughes, 1993). Applying existing theories and methods to Latino issues seemed a logical path to take, due to funding issues (Massey, 1993). These funding strategies are mirrored in the Latino health field as well. Latino immigrant communities began to gain the attention of social science and health scholars in the mid-1980s. Female headed households, declining marriage rates, out-of-wedlock births, welfare dependency, and high school drop-out rates became especially important predictors of health status for Latinos (see Hayes-

Bautista, 1994). Although U.S. Mexicans are both an old (through conquest) and relatively new (through immigration) population in the U.S., this group has been relatively “invisible” in mainstream health disparities research. Or rather, the assumption that Latinos and African Americans have similar health profiles inadequately explains immigrant health and ultimately leaves out the experiences of Mexican American. The lack of knowledge on Latino poverty (Massey, 1993) and Latino health (Hayes-Bautista, 1992) is a consequence of inserting Latino research into underclass studies. Similarly, while underclass theories focus on the decay of African American family structures as a component of the underclass, evidence portrays Latino families to be intact and supportive of their members (Hayes-Bautista et al., 1994; Moore & Pinderhughes, 1993).

Two indicators—low income and low educational attainment—began to represent classic underclass behavior in the literature, which in turn, it was assumed, would predict poor health status. Yet these assumptions do not hold for Latino families because they do not fit the “dysfunctional family profile (Hayes-Bautista et al., 1994).” Instead of modifying their assumptions of poor Latinos and health when they didn’t see the expected results, health researchers, began to define health indicators inconsistent with their assumptions as a “health paradox.” Three decades later, health researchers have made little headway in their knowledge about Latinos. Instead, health research now centers on explaining health care access (and health status) on cultural issues and acculturation.

This is important to health care access in various ways. First, health research became embedded with frameworks emphasizing the underclass for both African Americans and Latinos. The assumption that underclass theories were appropriate for both African American and Latino health models has contributed to the complexity of

examining Latino health care access. Additionally, Latino health research is embedded with cultural and assimilation frameworks used to predict Latino health and health care access. This will be discussed later in this chapter.

MEDICAL SOCIOLOGY AND HEALTH CARE ACCESS

While sociology developed early on as one of the social sciences to study the health care arena systematically, the current role of the sociological study of health care has arguably diminished (Mechanic, 2004; Pescosolido & Kronenfeld, 1995). In more recent years, the study of health care access has come from psychology, economics, health administration, and what is commonly called “health services research”(Mechanic, 2004; Pescosolido & Kronenfeld, 1995). Although traditionally rooted in stress and mental health, Pescosolido and Kronenfeld (1995) identify four stages in the relationship between sociology and the understanding of how individuals use formal medical care services. An examination into the pattern of health care access research in medical sociology will assist in establishing the gap in health care knowledge regarding Latinos. In stage one which took place from the early 1930s through the middle of the 1950s, the question, “Who is likely to go to the doctor” versus using traditional forms of health care is a central topic of discussion. Stage two, which occurred roughly from the latter part of the 1950s through the latter part of the 1960s, is greatly influenced by Parson’s “sick role” research initially. The third stage, from the late 1960s through the early 1980s, is defined by the development of formal theoretical frameworks and causal models of health utilization behavior. Two dominant models, the health belief model (HBM) and the socio-behavioral model (SBM) are still used in some form today. These models are used to examine perceptions, beliefs and other psychological characteristics that influence whether individuals feel at risk for problems, as well as factors that influence health behavior change and help seeking activities. The SBM takes into account some social factors such as health insurance and income as well as psychological factors.

Stage four, which began in the early 1980s, is defined by difficulties within the subfield of medical sociology, and within the American public's perceptions of the efficacy, inefficiency and unresponsiveness of the health care system. Health utilization models have become more and more specific and less theoretical during this time. It was during this time that medical sociologists began to go outside of sociology departments more and more, and the study of medical care use shifted to other disciplines, while medical sociology research began to focus on other issues (Pescosolido & Kronenfeld, 1995).

One distinctly sociological model is the network episode model. The Network-Episode Model (Pescosolido and Boyer, 1999; Pescosolido, Boyer, et al., 1999) draws on the strengths of previous models. In essence, the model focuses on the social aspect of health and illness, targeting social networks and social support systems in the lives of individuals—social aspects individuals use to negotiate how to respond to illness (Pescosolido and Boyer, 1999). Unlike the other models which focus on conceptualizing help seeking as a series of decisions or unilateral steps, in this model, “individuals are seen as pragmatic users of common-sense knowledge and cultural routines as well as seeking out and responding to others when psychiatric or unusual behaviors [or symptoms] occur (Pescosolido and Boyer, 1999). This model, however, does not suggest that people do not rationally weigh their options when coping with illness, but indeed suggests that since people maintain social interaction at varying degrees, illness is experienced within this context. Social interactions can encourage or hinder treatment. Although sexual orientation is not explicitly listed in social content/episode base for the individual, we can assume that sexual orientation influences one's social location and, according to NEM, would also influence one's social support system, illness career and

treatment. This may explain the differences in health care utilization between lesbian women and other women, as well as the discrepancies in health status across different groups. It is also interesting to note that race/ethnicity is not mentioned under social content/ episode base for the individual either, yet, as the authors point out in their example of Mariel Cubans and Haitian refugees arriving in South Florida in the early 1980s, race/ethnicity indeed plays a role in shaping our experiences and social location (Pescosolido and Boyer, 1999, 410).

This dynamic model is composed of four inter-related segments (as seen in fig 1): Social Content /Episode Base for the Individual; Social Support System; The Illness Career and the Treatment System (Pescosolido and Boyer, 1999; Pescosolido, Boyer, et al., 1999) and focuses on how the individual's social location influences her social network, her illness career and her interaction with clinical services. According to the authors, the NEM model conceptualizes the medical system as a changing set of providers and organizations with which individuals may have contact with when they are ill. There are four basic assumptions behind this model: First, that all societies hold a vast reserve of people who can be and are consulted during an illness episode. Second, that "bounded rationality", not strict economic rationality, drives the process with individuals "satisfying" rather than "maximizing". Third, the help-seeking process is a dynamic one, with individuals combining a series of decisions over some stretch of time into "patterns" and "pathways"; and fourth, people make decisions for treatment and acquire attitudes about medical care through contact with others. It is through this information exchange and influence process that individuals attach meaning to their situation and determine appropriate help-seeking patterns. The underlying mechanism at work in this model is interaction in social networks. For these authors, questions to be

answered include: Is there a discrete set of patterns of use of lay, folk, medical and mental health providers for mental health problems? Specifically, is there more than one way that individuals enter the health care system? What influences choice of one combination of provider over another? They also ask if having more social networks with higher levels of support in low-income areas predict a lower resort to patterns that include formal care?

In what could currently be called stage five, it appears that sociology is returning to an examination of health care access with an emphasis on sociological factors such as race, gender, immigration and work as well as the various health reform issues (for examples see Akresh & Frank, 2008; Harrington Meyer & Pavalko, 1996; Karas Montez et al., 2009; Pescosolido, 1998). Similarly, more recent discussions in this literature explore the historical context that contributes to our current system, for example, the historical development of insurance in the U.S., and managed care (Mechanic, 2004; Quadagno, 2005).

Marital status and family patterns of health care use have also been considered by sociologists who study health care. Although this area is scant, empirical research suggests that family members tend to resemble one another in their rates of health care services (Schor et al., 1987), and that marital status and employment are important indicators of health insurance coverage for women (Harrington Meyer & Pavalko, 1996). For Mexican origin and African American women, employment and marriage, however, play a more complex role. In their research on health insurance, employment and marital status, Karas Montez and colleagues (2009) find that marriage increases the chance of having health insurance among white women, while employment increases the chance of health insurance for African American women. Yet, the pattern among Mexican origin

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women in the study is more complex. Mexican-origin women were found to have higher odds of health coverage if employed, yet neither employment nor marriage nor does their combination assure insurance coverage for this group.

LATINO SOCIOLOGY AND HEALTH CARE ACCESS

The question of why Puerto Ricans and Mexican Americans have low health care utilization rates has been under investigation since the 1950s when researchers such as Margaret Clark (1959) and Lyle Saunders (1954) proposed the importance of ethnic factors and group personality traits as explanations of (inferior) health attitudes and behaviors. Additional cultural explanations to explain delayed care that came out of research in the 1960s and 1970s include the use of *curanderos* and other types of folk medicine as well as the negative aspects of extended family (or *familism*) on health care access and other related behaviors (Andersen et al., 1981). While structural explanations of low health care access such as blatant discrimination, lack of health insurance and occupational stability rose in the late 1970s (Andersen et al., 1981), cultural explanations have always been embedded in the literature. Given the timeframe, this early research focused on U.S. Latino groups such as Mexican Americans and Puerto Ricans, mostly in California, Texas and New York. Portes and Rumbaut (1996) suggest that context of reception and immigrants perceptions of discrimination influence health seeking behaviors.

Immigrant Public Health

Coinciding with the rise of immigrants from Latin American countries arriving and settling in the United States, Latino immigrants have become the focal point of health care access and utilization research, with a particular emphasis on language as a barrier to health care. About the same time, health care status became a more important focal point for researchers than health care access per se. The question often addressed in the literature is, “What explains the good health of (immigrant) Latinos?” Cultural

competency of medical providers has become increasingly a point of interest in increasing Latinos health care, with an increasing interest in language and cultural attributes. In this approach, health care access is examined along individual and behavioral models. Mortality statistics for adult Latinos are generally favorable when compared with Whites and African Americans. Low birth weight and infant mortality rates for Latina immigrant women are also favorable when compared with those of Whites and for African Americans, even though poor birth outcomes have generally been thought to be tied to lower socioeconomic status, nutrition and other poverty related factors (Lara et al., 2005). Other health outcomes for U.S. Latinos are much more complex, varying by national origins. These unexpected but consistent mortality and perinatal statistics have been described as an “epidemiologic paradox” or “Mexican American paradox” by researchers (Abraído-Lanza et al., 1999; Rumbaut & Weeks, 1996; Scribner & Dwyer, 1989) and explaining this “paradox” has been on the forefront of recent research on Latino health disparities since the 1980s. Factors used to explain these differences include not only traditional indicators such as socioeconomic status, educational level and age, but also language of fluency, immigration status, generation in the U.S., or what is commonly referred to as acculturation (Lara et al., 2005).

Several explanations have been hypothesized to explain these favorable mortality statistics among adult Latinos. These include: The Salmon Bias, The Healthy Migrant, Mexican Culture as Protective, and Acculturation. The Salmon Bias hypothesis suggests that Mexican Americans, who are close to dying, return to their birthplace. In doing so, they become “statistically immortal” which contributes to a lower mortality rate in the U.S. A second explanation, the healthy migrant hypothesis, suggests that Mexican immigrants in the U.S., who emigrated from Mexico, were generally healthier to begin

with. A third hypothesis suggests that somehow Mexican American culture offers protection against some disease (Cuéllar & Roberts, 1997; de la Torre & Estrada, 2001; Scribner & Dwyer, 1989). And a fourth explanation is the acculturation hypothesis, which examines the relationship between U.S. orientation, Mexican cultural orientation and morbidity and mortality (Landale et al., 1999).

Knowing if someone is a "high bicultural" or a "low bicultural" and how this is related to depression, as Cuellar and Roberts (1997) do in their seminal article, assumes culture/ethnicity to be static, measurable, unilinear concepts. To explain some of the good health outcomes experienced by immigrants as resulting from "cultural orientation" or "cultural protector factors" (Landale, 2000; Landale et al., 1999; Vega & Amaro, 1994) is extremely different than explaining them as resulting from structural forces that allow for the creation of social networks, for example (Zhou, 1999), or better, to problematize and redefine the concepts as some scholars do (Flores, 1997).

It is important to note that the current assimilation paradigms that are used in health research are comparable to the early research that emphasized a dichotomous assimilation process into the White middle-class. The term "acculturation" has become accepted in the Latino health literature, used to "measure" how integrated the non-Anglo group (in this case, Latinos) has become in Anglo dominant society. The underlying assumption is that "they" must become like "us" by shedding their cultural traditions and embracing the new, more progressive traditions of the dominant group. An underlying assumption in the literature is that health status may be related to degree of "Latinoness." These assumptions generate many more questions than they answer, including what exactly is the meaning of "Latino" if national origin diversity is acknowledged? In fact, measuring how "traditional" or "Anglo oriented" one is, ignores race-ethnicity as

historically situated and socially constructed, and is tied to nativist thinking that has defined non-Anglos as "other" (Acuna, 2003; Segura & de la Torre, 1999).

Many different perspectives exist on this topic of race, assimilation and health; yet two important points need to be emphasized: First, history and social context of each group are important. It is not acceptable to assume similar (if any) assimilation processes across racial/immigrant groups because social/political/economic factors affect how they have been received in society (context of reception, political status, etc.), and the circumstances under which they left their homes countries, whether "voluntarily" or involuntarily. Secondly, in this research, my point in examining this concept is to stress how race-ethnicity is conceptualized differently within the biomedical and intersectional perspectives. Health researchers are currently measuring Latino assimilation into the mainstream, which results in reifying the notion of "Latino." It also continues to be the dominant concept of how "others" are incorporated in the U.S. This model also begs the question, "Can assimilation predict health status?"

It is evident that a continued emphasis on this statistic obscures other recent findings of Latino health, including suicide and mental health issues among Mexican immigrants, their relatives and Mexican Americans (Borges et al., 2009), mental health service use (Alegía et al., 2007), frailty among the elderly (Ottenbacher et al., 2009), the importance of paternal race-ethnicity on birth outcomes (Ma, 2008), and the role of country of origin on asthma prevalence (Subramanian et al., 2009). From a sociological perspective, studying mental and physical health of racial-ethnic minorities addresses classical aspects of theory, such as "anomie" and "alienation," which sought to explain the relationship between the experiences of individual embedded in larger social structures (Vega & Rumbaut, 1991), and continued in the work of Gordon (1964) and

Park (1950) that emphasize the consequences of minority status and cultural distinctiveness (Vega & Rumbaut, 1991).

Health care access is bleak for Spanish speaking Latinos compared with English speaking Latinos. In their national, population based study of Spanish and English speaking Latinos and health, Dubard and Gizlice (2008) document that access to care was far worse for Spanish speaking Latinos than for English speaking Latinos: 55 percent of Spanish speakers lacked health insurance vs. 23 percent of English speaking Latinos; 58 percent did not have a personal doctor compared with 29 percent of English speakers; 45 percent were less likely to have had a check up in the past year vs. 36 percent of English speakers; and 27 percent of Spanish speakers were unable to see a doctor for needed care in the past year because of cost vs. 19 percent of English speaking Latinos in their study.

Similarly, Pippins (2007) and her colleagues found evidence that insured Mexican, Puerto Rican, Cuban, and other Latinos in the study with low English language proficiency have more negative experiences in accessing care than their insured English speaking counterparts, including longer wait times and greater difficulty obtaining information or advice by phone from medical offices. What is unclear in this line of investigation is what role language serves in health care access. Do Spanish speakers have a harder time accessing care because of language barriers, implying that bicultural medical care would solve these issues? Could language preference be a proxy for birthplace or citizenship, indicating that Spanish speakers in fact prefer a different type of health care? Perhaps Spanish speaking patients are treated differently in medical settings compared with English speaking patients with comparable health insurance. Regardless, the “dominant perceptions of people of color build on and elaborate stereotypes that become the rationale for the differential treatment of groups and individuals” (Zambrana

& Thornton Dill, 2006, 195). These issues need to be addressed critically during all aspects of the research process to better facilitate health care access studies. In regions where Spanish speaking health facilities exist (like Southern California), language barriers may not be a large barrier to care.

While classical models that describe minority adaptation in U.S. society emphasized upward as being contingent on accepting White middle-class cultural and social standards through assimilation, current research on immigrant adaptation emphasizes various processes of incorporation and adaptation into U.S. society (Hirschman et al., 1999).

New thinking about the effects of acculturation on health status suggest that immigrants moving from less developed countries to more industrialized countries will exhibit health advantages initially, and then over time, these health advantages will decline due to changes in health behaviors. This “Oliver Twist Theory” presumes that immigrants who moved from countries with high rates of infectious disease, low sanitation and low access to clean water, will show better health status once in their host country, in which they benefit almost immediately from “environmental and public health measures that prevent the epidemic spread of infectious disease, and from advances in biomedicine that provide a cure for many conditions. . .”(Finch et al., 2009, 478).

Alegria and her colleagues (2007) address rates of depression, anxiety, and substance use disorders, and include gender, nationality, English proficiency, length of residence in the U.S., age at migration and generational status in their analysis. They attribute higher rates of psychiatric disorders among (English speaking) Puerto Ricans and other U.S. born Latinos compared with immigrant Latinos to: Exposure to chronic demoralization, the stress of heading a household with little social support, and for those

who are not economically successful in the U.S., a greater perception of discrimination (Alegria, Mulvaney-Day, Torres, Polo, Cao and Canino, 2007) when comparing themselves to their more successful counterparts.

Qualitative studies document the complexities of studying a non-heterogeneous group such as Latinos, by examining health care access disparities along the Texas-US Border, hypertension among “Black Hispanics” and “White Hispanics” (Borrell, 2009), and the association between the use of language (Spanish or English), self-reported health status and health behaviors among U.S. Hispanics in the adult population (DuBard & Gizlice, 2008), or by focusing on “the healthy migrant” hypothesis by examining self-reported health of immigrants from Mexico and other countries to the U.S. (Akresh & Frank, 2008) and Canada (Urquia et al., 2009).

Given these partial and sometimes contradictory explanations between conventional public health expectations and the status of some Latinos indicators, many scholars have argued for a more nuanced, Latino focused research perspective (Bastida et al., 2008; Hayes-Bautista, 2002; Heyman et al., 2009; Zambrana & Thornton Dill, 2006) which includes contextualizing the lives of Latinos and placing their experiences within the complex forces which contribute to inequalities. Individual and cultural value models often assume that culture shapes action by supplying the values to direct action (Swidler, 1986). Unfortunately, this emphasis on cultural values in the area of health services research without an accompanying analysis that reveals the link between social inequality and health may be doing more harm than good to the populations that health researchers investigate (Hirsch, 2003). Focusing only on cultural values and beliefs as determinants of health, instead of on the structural aspects of health, contributes to the idea that health problems can be solved if only every immigrant group’s tastes and preferences could be

met (Hirsch 2003). Although this type of simplistic cultural values focus can be well-meaning, focusing on the traditional notion of culture is dangerous since it often fails to take structural issues into account (Chávez, 1986; Hirsch, 2003; Krieger, 1999). For example, contrary to the lingering notion that traditional Mexican culture influences the health beliefs of Latinos seeking medical care, evidence documents the underuse of health services by Mexican Americans to be caused by lack of health insurance and other socioeconomic factors (Hubbell et al., 1991), and fear of deportation in non-citizen Mexican Americans (Chávez et al., 1985; Chávez et al., 1997; Heyman et al., 2009).

In an early study of the cultural components of pain among Jewish, Italian, Irish and “Old American” patients at a New York VA hospital, Zborowski (1967) explicates how attitudes and behaviors regarding pain responses differ among immigrant parents and their U.S. born children, how work is linked to pain responses, and how family influenced ideas about pain may conflict with those from the larger social environment. In other words, he examines how the pain experience is socially constructed along cultural lines, that is, according to specific norms.

Similar to Zborowski, Swidler (1986: 278) views culture broadly and argues that in fact “strategies of action are cultural products. . . ways of organizing experience and evaluating reality, modes of regulating conduct, and ways of forming social bonds, which provide resources for constructing strategies of action” and suggests that this use of culture appears to shape action for “settled cultures” and “unsettled cultures”(pg. 278). These cultural meanings or culture as “tool kit” are ultimately determined by structural and historical opportunities which contribute to the success of cultural strategies (Swidler 1986: 277). In fact, in a recent article in the *Journal of Health and Social Behavior*, Olafsdorrit and Pescosolido (2009) consider how “whole culture systems” impact mental

health help-seeking behavior. This is a beneficial first step in the examination of the values, expectations and beliefs of adults in the U.S. towards mental health providers, yet absent of information that may contribute to understanding the strategies Mexican origin families use to access health care in the U.S. or Mexico if need be. Ethnic resources, along with class resources, are beneficial to the economic survival of the racial-ethnic group (Gold, 2000), including affording and accessing health care.

Additionally, using working Mexican origin families as a case study, I suggest that “transnational health care access” may increase access to health care for some families. Transnational access may occur in a context in which various factors operate. For example, due to changes in the organization of work and immigration reform, many Mexican origin families are not able to gain health insurance through employers or through Medi-Cal (Medicaid in California) or state programs for children. According to health researchers: (1) unauthorized immigrants may avoid accessing the formal health care system out of fear of retribution and (2) U.S. immigrants may be going to their country of origin for health care, as evidenced by de la Torre and Estrada (2001) and Heyman, et al. (2009) and others. Accessing health care outside of the U.S. is not limited to Mexican Americans. Medical tourism, the practice of patients in the U.S. seeking lower cost health care procedures abroad (U.S. Senate Special Committee on Aging, 2006) was the subject of a recent U.S. Senate Special Committee.

As researchers, we have to pay special attention to health care access within families, as Mexican American family members may be unauthorized, legal residents or U.S. citizens, and may have different types of coverage, for different time periods, based on age, type of work, citizenship and time in the U.S. This question is difficult to

investigate, since the question “Have you ever had medical care outside of the United States” has not been asked on national surveys to my knowledge.

Latinos, health insurance and work

Currently, a large body of work focuses on health insurance and Latinos. The literature suggests factors that influence health insurance coverage for Latinos include: occupational location (economic sector and business size), eligibility issues (fulltime vs. part time status) ; salary (de la Torre & Estrada, 2001), language (DuBard & Gizlice, 2008) gender, and immigrant status. Only 43 percent of Latinos get their health insurance through their employer or through the employer of a spouse or family member, compared with the national average of 64 percent (Quinn, 2000). In an early random phone survey of (citizen, documented and undocumented) Latinos and Whites in Orange County, CA, researchers found that Latinos were more likely to be working than Whites surveyed, yet were also more likely to lack health insurance, and to score lower on all access to healthcare indicators (no regular source of care, no physician visit in the previous year, difficult access, medical care created financial difficulty, language difficulties) compared with Whites (Hubbell et al., 1991) in the study.

Latinas and Latinos are more likely than other racial-ethnic groups to be working (Chávez et al., 1997), and to be working in jobs which do not have health insurance (Bhandai, 2002; Brown & Yu, 2002). Non U.S. born Latinos are more likely to be working in dangerous occupations than U.S. born Latinos. In 2002, 62 percent of foreign born workers who were fatally injured were Latino, with 42 percent of these workers being from Mexico (AFL-CIO, 2005). According to *Safety is Seguridad*, a report published in 2003 by the National Research Council, Latino men have the greatest

overall relative risk of fatal occupational injury (22 percent higher than all other male workers) (as cited in AFL-CIO, 2005).

In the vast majority of uninsured Latino families, there is at least one person who works, and in more than half of Latino families, a person works full time for the full year, a rate comparable to White families (56 percent vs. 55 percent) and greater than African American families (44 percent) (Quinn, 2000). Work plays a large role in how we access health care in the U.S, yet working Latinos are less likely to have health insurance and health care access than non-Latinos. The question remains, what role does work play for Mexican origin families in how health care is accessed? Focusing solely on health insurance as a proxy for health care access leaves unexamined how working families without health insurance access care. Similarly, assuming health insurance access leads to health care access neglects other problems that may occur due to having health insurance.

In her research on migrating and non-migrating farm workers in California, Azevedo (2001) argues that barriers are inherent in public and private health insurance programs and severely limit access to medical services for farm workers, and, I would add, other marginally employed workers as well. Azevedo (2001) found that the most significant factors which impact both potential and realized health care access include: type of medical coverage, stability of work, and the possibility that a person can seek medical services in Mexico. Azevedo (2001) finds that private health insurance coverage may not facilitate realized health care access as the result of high premiums or employer constraints. Similarly, public medical insurance may not cover the whole family, only certain family members, especially given the possibility of mixed immigration status within families (Azevedo 2001).

“[A]ny proposed financing of a health care plan depends on an image of ‘work’ that matches neither current situations nor likely trajectories”(Pescosolido & Kronenfeld, 1998, 9). Chavez argues that we must understand the role Latinos in the secondary sector of the US labor market in order to understand the economic factors that influence undocumented immigrants’ use of health care. “The secondary and informal sectors of the labor market thus tend to define the opportunity structure that immigrants confront. They also define the immigrants’ ability to meet financial requirements for receipt of health care “(Chávez, 1986).

SUMMARY OF EMPIRICAL RESEARCH

Thus far in this chapter I have highlighted the important bodies of literature which address health care access in medical sociology and public health, which inform this study. The sociological literature on health care access has provided information regarding the organization of health care delivery, as well as other factors, such as marital status, family and health insurance. The public health research, on the other hand, focuses on the empirical aspects of health care access, including health insurance, the cultural aspects of Latino immigrants, and immigration status. It is important to note that by emphasizing cultural and assimilation explanations of health care access and inequality rather than examining the role of the health care delivery system on health care access, public health researchers across disciplines may result in masking the true barriers to care, mainly the construction of the system itself. Baer (1982) says that “it is unfortunate that medical anthropologists and sociologists concentrate their attention on the search for ‘cultural resistances’ to medical innovation rather than on the political economy of health (p. 16).”

GAPS IN THE LITERATURE

Health care access research on Latinos is becoming more and more focused on immigrant and migrant health, and less inclusive of U.S. born Chicanos. One reason may be that Latinos are thought of as a homogenous group (Hayes-Bautista & Chapa, 1987; Hayes-Bautista, 1992). The public health research is more empirical than theoretical. Seldom does this literature include theoretical integration or ways to improve health care access, and often emphasizes cultural explanations over structural explanations. Cultural beliefs are important, yet examining how culture impacts health care access does not explain lack of access (Chávez & Torres, 1994). In fact, some scholars suggest that “the effect of language on screening practices should not be interpreted as a cultural factor, but as an access factor” (Lara et al., 2005, 377). Similarly, the focus on the underclass has really limited knowledge of the determinants of Latino health. Instead of assuming that Latinos are synonymous with African Americans, or even that Latinos are one group, it is important to take the perspective of Mexican Americans if going to generate new knowledge.

It is important to study immigrant health, but Chicano health is missing in this health care access debate. Latino immigrants are vulnerable to health care access problems, but all of the public health literature suggests that immigrants are simultaneously vulnerable and protective by culture. If this is true, then researchers need to focus on Chicano health, who may not have these protections. Similarly, this research tends to homogenous non whites as “people of color” hiding the effects of immigration, nationality, gender and class.

This research focuses more on determinants than on critiquing the system. What is necessary is a critical and theoretical perspective into the social determinants that impact health care access, as well as an examination of the experiences of Mexican Americans as they negotiate the health care system. Critics examine the rise and fall of managed care and the role of managed care in health care access. The question of “what is an acceptable level of care” is rarely debated in the health literature. Focusing on “safety net” masks the examination of how human suffering is heightened by such a system (Becker, 2004). It is important to put a human face on the social problem, and to reach out to policy makers, the general public in order to foster advocacy, change perceptions and influence policy (Becker 2004).

“TRANSNATIONAL HEALTH CARE ACCESS”

An associated area of investigation is the strategies Latino families engage in when they do not have any or sufficient access to health insurance—what I have coined “transnational health care access.” Applying the concept developed by immigration scholars to describe the various social ties and other cross-border processes such as maintaining political and economic participation in sending and receiving countries (Bash et al., 1997; Levitt, 2001), is the idea that Mexican Origin individuals live in the U.S. yet access health care, through necessity or through choice, in Mexico. According to health researchers: (1) unauthorized immigrants may avoid accessing the formal health care system out of fear of retribution and (2) that U.S. immigrants may be going to their country of origin for health care, as evidenced by de la Torre and Estrada (2001) and Heyman, et al. (2009) and others.

Although inadequate or a complete lack of health insurance coverage is detrimental to families, ethnographic research suggests that many Latino families find ways to gain necessary care through emergency rooms, paying out of pocket for medical expenses, delaying care or gaining access through the Mexican medical system (Hondagneu-Sotelo, 1994).

Leo Chavez and his colleagues (1985) have shown that Latino immigrants in San Diego may go to Tijuana (a border city) for care, or to their home Mexican city. Pierette Hondagneu-Sotelo (1994) demonstrates that immigrant families in her “Oakview” study pay out of pocket for healthcare expenses. Azevedo’s (2001) research with migrating and non-migrating Latino farm workers in California suggests that some (documented and

undocumented) farm workers in fact have IMSS (Instituto Mexicano del Seguro Social⁴) health coverage for themselves and their families and therefore use Mexican social security hospitals for care. Bastida (2008) and her colleagues examined the use of health care services in Mexico by Texas border residents, and found that in Texas this process is often seen as a safety net by the healthiest uninsured Mexican Americans, who are able to pay for services in cash, and are not restricted by immigration issues. Six hundred-thousand of the approximately 4.2 million Latinos in Los Angeles visit Mexico for their health care (Hispanic PR Wire, March 15, 2006⁵). Individuals may also receive pharmaceuticals in neighboring Mexican states, which lowers out of pocket expenses (de la Torre and Estrada 2001). Accessing health care outside of the U.S. is not limited to Mexican Americans. Medical tourism, the practice of patients in the U.S. seeking lower cost health care procedures abroad (U.S. Senate Special Committee on Aging, 2006) was the subject of a recent U.S. Senate special committee.

⁴ It is important to note that the IMSS offers Mexican-origin workers and their families who work outside of Mexico health insurance at Mexican Social Security hospitals. This health insurance can be purchased at Mexican Consul offices in Los Angeles, Houston and Chicago on an annual basis.

⁵ URL accessed on April 21, 2006: <http://www.hispanicprwire.com/news.php?l=in&id=5777&cha=9>

THEORETICAL FRAMEWORK

Political Economy of Health

Research on the political economy of health care in the social sciences has been sporadic since the nineteenth century. Most recently because of the failures of functionalism and the failure of many studies to place an analysis of health problems and the organization of medical care in a larger societal context (Baer, 1982). “Only the emphasis on profit in the prevailing conceptions of health and illness can explain why certain crucial problems in medicine have been continuously neglected (Dreitzel as quoted in Baer 1982, 2 and 13).”

Political economy of health care is concerned with the impact that the capitalist mode of production has on the production, distribution, and consumption of health services, and how these processes reflect the class relations of the larger societies within which medical institutions are embedded (Baer, 1982). A contradictory relationship exists between capitalism’s continued drive for profits and the health needs of the masses of people in society (Baer, 1982; Doyal & with Imogen Pennell, 1979/1994; Rylko-Bauer & Farmer, 2002).

Gay Becker (2004) argues that the structure of our health care system raises questions about ways in which the social order is maintained through structural inequalities along racial-ethnic and class lines.

The inadequacy of safety net health care and the continued lack of universal health insurance in the United States can be seen as the reproduction of the moral order, in which deeply rooted cultural views of the dominant majority are upheld through long-standing structural inequalities that undermine the health of poor people and ethnic minorities. These inequalities are masked by reframing health care in terms of managed care and by designating the loose conglomerations of charity-oriented health care services as a health care safety net. This system contributes to higher mortality and morbidity rates among ethnic minorities and

reflects the perpetuations of long standing structural inequalities that are being shrouded in a new guise (Becker 2004: 261).

The health care safety net, made up of public hospitals, emergency rooms, community clinics and health centers as well as county health departments is being strained to its limits by a combination of cuts in public funding and an increase in the ranks of the poor and the uninsured (Becker, 2004; Rylko-Bauer & Farmer, 2002).

Based on the previous two sections of this chapter, it is evident that an important issue which needs to be further examined is: How does the organization and delivery of health care in the U.S. shape the access and health care experiences of Latinos? And how does the organization and delivery of health care in the U.S. apply to working Mexican origin family members?

Political economy of health is a critical endeavor which attempts to understand health-related issues within the context of the class and imperialist relations inherent in the capitalist world-system. Medical care requires a holism to study and can be divided into two areas: the political economy of illness and the political economy of health care. These two areas are not mutually exclusive, but are intricately linked (Baer, 1982).

Programs such as MediCal and Medicare are designed to subsidize the private sector and to eliminate the high cost of health care for both capital and labor. The public sector provides health care for the patient population that is unprofitable or less profitable for the private sector (Baer, 1982).

Debates regarding the health care delivery system and problems in health care access or quality of care rarely occur in the context of challenging the for-profit structure of health care (Mechanic, 2004; Quadagno, 2005; Rylko-Bauer & Farmer, 2002). Many theorists argue that allowing market forces to dictate the shape of health care delivery

ensures that health inequalities such as an increase in the numbers of uninsured and other racial, ethnic and class disparities in access to care will continue to widen (Becker, 2004; Becker & Newsom, 2003).

Quality of care problems, rising costs, devaluation of doctor-patient relationships, and persistent inequalities of access and health outcomes have been voiced since the 1970s and 1980s. While this has been an issue, our health care system has also been transformed into a market-based system, resulting from the Health Maintenance Organization (HMO) ACT of 1973.

HMOs began as local, non-profit corporate entities. Overtime, the number of managed care organizations (MCO) increased and became for-profit through the involvement of the business sector. MCOs were conceived as a way to help control the increasing costs of health benefits, introducing explicit rationing, and managing both physicians and patients through cost-containment techniques. The assumption behind these managed care organizations suggest that if unnecessary use of services can be limited, and delivery of care becomes more efficient, patients are better off and money is saved. By 1990s, this had become the dominant form of health care delivery. Who knows if money has really been saved, but none of this has addressed the “primary access problem” of the uninsured not having access to real health care except the emergency room.

The inequalities we see in health care access mirror the inequalities seen in other social institutions—labor, housing, education, and the justice system. Surely the pervasiveness of racism, sexism, poverty, violence and exploitation manifest themselves

in the health status of populations as well as in the disparities in health care delivery (Becker, 2004). One major inequality is the unequal distribution of health insurance.

Quadagno (2005) explains that the U.S. does not have a national health insurance program because historically, special interest groups have persistently lobbied against it—physicians via the American Medical Association (AMA), corporations, trade unionists, social reformers and insurance companies have all worked together and against each other to negate government intervention. This system of special interest lobbying and government appeasement has resulted in our existing patchwork system. In response to each call for a national health care system, piece-meal state and private insurance programs have been established. At the same time, unions lobbied on behalf of their own members for safe working conditions and health insurance since the early 1900s. The aim of American Association for Labor Legislation (AALL) was to improve workers' health by 1) banning poisonous materials in the workplace, 2) establishing workplace compensation for injuries and 3) through the establishment of compulsory health insurance. They created a bill, which was subsequently defeated, that would provide workers with free medical services, hospital care, sick pay and modest death benefits. This defeat was important because it set the tone for all debates to follow—it contributed to a limited welfare state, distinctive health care system and culture of special interest power that continues to resist universal coverage to date. And it linked health insurance to the corporation⁶.

Hospitals prepayment plans were established after the depression, first to its own employees, then to other groups like teachers and firefighters. This prepayment plan

⁶ It was the end of labor's involvement in a national health system, but just one of many political debates for a national health care system, which goes on to date.

allowed for free hospital care if hospital prepayment plan members got sick. The prepaid hospital plan was approved by the American Hospital Association, but did not have the support of the AMA. This prepaid hospital plan was the precursor to Blue Cross/Blue shield, and it allowed community hospitals to stay open during the difficult economic climate of the depression.

By the 1930s, several trade unions began negotiating with Blue Cross for their own group hospital plans. Unions used to give their members old age pensions and health funds, but this practice decreased with the depression. Blue Cross was acceptable and preferable to commercial insurance companies because they were community rated and offered full-benefits with no deductibles or co-payments. Physicians were opposed, but by the end of the depression, this opposition declines as they were struggling to pay their employees and bills, like many others.

In 1946 the United Mine Workers went on strike to get the mine owners to fund health and welfare funds, as these workers had the highest rates of tuberculosis, pneumonia and black lung disease. Two million miners had died between 1910 and 1945. The strike began to impact the economy, railroad workers were laid off, Ford began to shut down operations, and New Jersey declared a state of emergency. Fifty-nine days later, the mine owners agree to contribute ten cents for every ton of coal to set up a health and welfare fund. This fund would provide free medical care for miners and their families, hospital care with choice of physician, cash benefits for disabled miners, and survivor benefits for their widows. The fund would be controlled by a trusteeship and a union representative. This agreement set a precedent. Between 1940 and 1966, the

number of people “insured against the costs of medical care” (Quadagno, 2005: 49) increased from 6 million to more than 75 million, mostly through trade unions.

Use of private health insurance increased in the face of World War II. Due to the industrial expansion created by the loss of 15 million civilian workers to the armed forces, unemployment decreased, labor markets tightened and gave rise to higher wages and work speedups. Workers were discontent—they were getting higher wages, but those wages were eroded by higher prices. Waves of strikes attempted to threaten production. Several labor decisions in the 1940s reinforced the relationship between increase of private health insurance and corporations. One of the decisions was that employer contributions to employee benefit plans would not be taxed as wages, in the wake of the Revenue Act, which applied an 80-90 percent tax to any corporate profits that were higher during the war than before the war, to prevent wartime profiteering. However, employer contributions to group pensions and health insurance plans were not included in the calculation of profits, because they were considered to be a tax-deductible business expense. These decisions incentivized corporations to deposit profits in fringe benefit trust funds. Depositing profits in fringe benefit trust funds allowed corporations to evade taxes on these profits, and increased the role of corporate employers as health insurers.

By the 1960s, health care spending was already out of control. For the next 40 years, government took measures to cap costs through the development of Medicare financing policies and later, cost containment. In the 1970s corporations began negotiating directly with physicians and hospitals in the face of sky rocketing employee medical bills in order to manage the costs (and improve their profits). This soon gave

rise to health maintenance organizations in the 1970s and 1980s, leading up to the current health care crisis.

I include this brief history of health care delivery in the U.S. in order to remind the reader that health care access is far from straightforward. In fact, Baer calls the health care system (p. 129) a “set of relationships within and between all health care modalities in light of political economic forces (Baer, 1986). Political economy of health is a critical endeavor which attempts to understand health-related issues within the context of the class and imperialist relations inherent in the capitalist world-system. Inequalities are not the concern of the markets. Ultimately, health care should not be considered a commodity, like food or clothes (Rylko-Bauer & Farmer, 2002).

An Intersectional Approach to Health Care Access

What is the relationship between health and social structures such as race-ethnicity, class, gender and nation? Can we gain insight into the causes and consequences of health care access inequalities by examining these relationships and the lived experiences of those affected by these inequalities? These questions are at the core of intersectional health research. Critical and intersectional perspectives of health offer a body of knowledge which situates women and men in multiple systems of domination, through which health and illness are experienced. These approaches to health and inequality examine power structures relationally, examine group level inequalities, and focus on how structures of inequality are intricately linked and mutually reinforce each other (Weber, 2001). Similarly, examining health care access according to social location gives a more complete view than conventional perspectives of health, since

health and illness are defined within social contexts, and are experienced according to social location (Lorber, 1997)

At the core of this debate in the biomedical domain are issues related to accurate conceptualization of health predictors such as race-ethnicity (Krieger 1993 & Scrimshaw 1996). The feminist and intersectional health literature maintain that an important lens into health and social inequalities is through power inequalities within and across groups that result from systematic relations of domination and subordination such as race, class and gender. These patterns of inequality are structured through social institutions (Hill Collins 1996, Williams & Ricket 2000) such as health, medicine and work, and experienced differently based on social location.

If we proceed under the assumption that both biomedical and feminist perspectives of health incorporate race, class and gender analysis into their research to different extents, how then, do these perspectives differ? Within the dominant biomedical research, predictors such as race, class or gender are used to examine the distribution of health status among racial-ethnic groups. They are assumed to be natural categories, with the basic questions under investigation centering on physiological links to disease, as well as possible exposures which may contribute to disease among various populations (Krieger et al 1993).

An emerging perspective into health inequalities involves investigating the effects of racism on health, or the effects of racial oppression on health status. Instead of examining racial differences in disease (biologically), as is the traditional concern of public health research, sociological and epidemiological studies on racism and health often examine whether health outcomes are comparable among members of different

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racial-ethnic groups at the same socioeconomic level (Krieger et al 1993). Similar studies on racism and health focus on the physical and mental health consequences that result from racial segregation in housing patterns or the labor force (Krieger et al 1993) or other health outcomes that result from racial oppression (Broman 1996, Herman 1996).

Empirical research on racial-ethnic health disparities often rely on biologic and underclass models as partial explanations of health inequalities. Empirical work in this area includes underlying assumptions regarding the operationalization of race-ethnicity for African Americans and Latinos including: Racial-ethnic groups are homogeneous, therefore, 2) biological factors associated with race-ethnicity are important to investigate and 3) social group inequalities can be eradicated at the individual and population levels (Weber and Parra-Medina 2003).

Conventional biomedical research into the examination of racial difference in disease often results in dichotomizing race into White/black or Latino/white categories. The underlying assumption here is that the category “White” is the norm, the standard thereby constructing the racialized categories as “other.” This approach, however, leaves the category of “White” unexamined and it becomes a non-category. As Frankenberg suggests, “the stability of whiteness as location of privilege, as culturally normative space, and as standpoint, is secured and reproduced (1993, 242). This dichotomization also leaves untouched another assumption, that the experiences of Latinos are similar since they are not White or not Black. The Latino/White dichotomy fails to capture the richness of diverse Latino heritage. Native American, African, Spanish and other European influences have contributed to the diverse populations of Latin American countries, as have the slave trade between West Africa and the Caribbean to work in

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sugar cane plantations. Brazil, Columbia, Cuba, the Dominican Republic, Ecuador, Panama, Puerto Rico and Venezuela have significant Black African populations as a result of the slave trade, while other countries such as Uruguay, Chile, and Argentina have virtually no Blacks due to racial genocide (Comas-Diaz, 1996).

In contrast, feminist and intersectional perspectives in the health literature examine how health is experienced and constructed within a “matrix of domination” or how each of us lives within a system that frames our relationships to each other, constructs our access to the opportunity structure, and that vests us with varying levels of power and privilege (Anderson and Collins 2001, Collins 1996). In other words, the oppressed are not able to see what they are oppressors as well, within the traditional dichotomous us/not us classifications of race, class and gender. Instead, intersectional scholars take the theoretical stance that we have all been affected by race, class and gender categories of analysis that have structured our treatment and this allows us to be open to the possibilities for using these same constructs that have structured our treatment, as categories of connection in order for us to be able to build empathy (Collins 1996). It is my contention that a structural inequalities perspective is an important lens through which health care access inequality should be examined.

Early critical scholarship in public health emphasizes the importance of better conceptualization of racism, classism and sexism and their effects on health, and the need for new approaches to the study of health disparities. The causes and severity of health inequalities are difficult to understand since multiple and conflicting definitions of race-ethnicity can be used. This it becomes difficult to compare across studies and to compare across populations under investigation. Scrimshaw and McMiller (1996) examine the

scientific value of using race-ethnicity as a social construct in the health literature. The argument for continuing this measurement is that without having accurate rates of disease for racial-ethnic groups, the appropriateness of medical policies may be at risk and individuals may be harmed (Krieger 1999, Laveist 1996). “Though not obvious, how a person is named influences how that person’s disease is named (Scrimshaw and McMiller 1996 5).” How to measure these concepts is an ongoing debate.

An important area of interest involves investigating the effects of racism on health, or the effects of racial oppression on health status. Instead of examining racial differences in disease biologically, the traditional concern of public health research, sociological and social epidemiological studies on racism and health often examine whether health outcomes are comparable among members of different racial-ethnic groups at the same socioeconomic level (Krieger 1993). Similar studies on racism and health focus on the physical and mental health consequences from racial segregation in housing patterns. This line of investigation suggests that policies which address racial discrimination may not necessarily address the issue completely, since these policies focus only on intentional discrimination, and need to focus on unintentional discrimination (1994) as well. Mental health scholars suggest that racial-ethnic stress may be the result of discrimination, immigration, or other cultural influences and is an important predictor of mental health.

Within intersectional approaches, race-ethnicity and racism are beginning to be understood within the context of social inequalities embedded in societal institutions (Williams 2000). Historically, race, class and gender inequality are embedded in society’s institutions.

In their seminal article examining the causes and differences of low birth weight and infant mortality among Latinas and African American women, Krieger (1993) and her colleagues review the historical aspects of the effects of inequality on health, and argue that structural inequalities need to be conceptualized and measured in order to systematically study these barriers to health (Krieger & Fee, 1994; Krieger et al., 1993). Krieger & Fee (1994) are also quick to point out that the data on social class, which are needed to show the effects of racism on health, are rarely collected, and that women's health research outside of the maternal health arena is solely lacking.

Segura and de la Torre (1999) examine how biomedical research relies on the stereotypes of Chicana/Mexicana motherhood and "interjects itself acculturation frameworks, obscuring the complexity of gender as a social construct among Chicanas/Mexicanas in favor of a static moment in a populations history and culture (pg. 156)." They argue that using acculturation as a predictive factor "may mask a critical renegotiation of gender position for recent immigrant women" (Segura and de la Torre, 1999: 155-156) and suggest feminist-based models be used in order to emphasize "the dynamism within their cultural adaptation and identity formation. . . . What is 'traditional' is adaptation and innovation, both of which flow from Mexicana/Chicana agency" (Segura and de la Torre, 1999: 163).

Schrimshaw, Zambrana and Dunkel-Schetter (1997) examine the notion that Latinos under utilize health care in their hospital-based ethnography of obstetrical physicians and their pregnant Latina (mostly Mexican) immigrant patients in Los Angeles. They find that most of the patients did indeed access prenatal care in other hospitals or in Mexico. However, since the care was obtained outside of the hospital, no

record of care is included in the patient file, leading to the physician misperception of no prenatal care.

Along these lines, Zambrana and Thornton Dill (2006) argue that what they call the “poor as healthy paradox” for Latinas “is an artifact of aggregated data and further reflects a large body of literature that focuses on healthy, young, reproductive-age Mexican-origin women. Needed instead are rigorous studies of structural and political factors such as quality of care and its relationship to diagnosed and misdiagnosed health conditions among Latinas of different ages and subgroups. The uncritical approach taken by many investigators promulgates the myth of health among Latinas, which is challenged by recent data on chronic conditions by subgroup (Zambrana and Thornton Dill, 2006: 204-5).

David Hayes-Bautista (1992) suggests that the Latino research agenda should encompass standards which begin with Latino health status in mind, due to the rapidly expanding population and positive social characteristics, not from the usual “dominant culture world-view as exemplified in the common practice of employing Whites as a reference group and assessing the health of minorities in relation to Whites” (Weber & Parra-Medina 2003: 196).

Many of the following scholars are heeding his call. Scholarship on Latino health care access which puts structural inequality at the core includes: The healthcare access experience for unauthorized immigrants at the Texas border (Herman, 1996), the structural factors which determine health care access for documented and undocumented Latinos and Whites in Orange County, CA (Chávez et al., 1997; Hubbell et al., 1991), factors that influence choice of health care system for Mexicans residing at the Mexican

Border with California (Guendelman, 1991); political economy perspectives of Latino Health care access in San Diego, CA (Chávez et al., 1985), the mental health issues of African Latinas (Comas-Días, 1996); whiteness in health disparities research (Daniels & Schultz, 2006), and structural inequalities related to health care access for Latinas and African Americans (Geiger, 2006)

DEFINITIONS

Health care access:

Broadly speaking, access to health care can be examined in terms of *potential access* and *realized access* (Azevedo, 2001). In other words, is medical attention possible if needed? Has a medical provider been seen? Health care access is important because it influences health status and quality of life and influences preventive health services. In fact, access to the health care system and health status are not mutually exclusive but are intricately linked (Baer, 1982; Becker, 2004; LaVeist, 2005). Additionally, the terms *medical utilization* and *help seeking* are often used interchangeably.

Empirically, health care access is often conceptualized as health insurance or *health coverage*, but for this dissertation, a further distinction is made to include all aspects of everyday health care access, including having a regular source of care and access to care in Mexico on top of other strategies respondents engage in. This distinction is based on ongoing informal conversations with Latinos of other backgrounds, my study respondents, my own family experiences, and emergent themes in the literature. An additional term used in health care access research is “health care delivery system “ which critical theorists use to examine the transformation of our health care system, or more specifically, market-based care (as exemplified in Mechanic, 2004; Rylko-Bauer & Farmer, 2002).

“Health care trajectory”

Health care trajectory can best be defined as the course of health care access available over one’s lifetime and includes circumstances under which health care coverage is and is not available. This path changes over time and place, and is dependent on many variables including age, work status, marital status and gender and immigration, as well as social and political policies regarding health insurance and health care delivery. Use

of this concept is preferable to the idea of investigating health care access at one point in time.

Social location

Social location refers to the social place of a group or an individual within the hierarchies of race-ethnicity, class, gender, and other social hierarchies (Weber, 1998; Weber, 2001) such as nationality.

Privilege

Those who benefit from the existing social arrangements are said to be in positions of social privilege.

Class Background

Conceptualizing class background is an important aspect of health care access. While I did not ask income data from the respondents in the study, I got class background indirectly from the respondent in some cases, took notes of some qualitative indicators of class background, and, in one case, asked the respondent his class background based on the conceptualization below:

Table 2.1 Class Background Definition

	Working Poor	Working Class/Middle Class	Middle /Upper Class
Residence/ Neighborhood <ul style="list-style-type: none"> Own or rent house/apartment doesn't matter as much location of residence 	Live close to "inner city" or in an "urban" or working class neighborhood.	Live in "urban" or working class neighborhood.	Live in suburban neighborhood.
Income & Occupation	<ul style="list-style-type: none"> -Qualify for public health coverage based on income /Would qualify for public coverage if legal resident. -Low wage full time, part time or other type of work. 	<ul style="list-style-type: none"> - Employment may or may not have benefits, but have to work -Constantly having to struggle financially while living modestly. -Make too much money to qualify for public health coverage -Stable factory, administrative or other work, often in a business setting. 	<ul style="list-style-type: none"> -Higher Income/Savings/ Retirement plans/ Other financial resources -Administrative, professional or similar occupation
Health Coverage	<ul style="list-style-type: none"> -More likely to be uninsured or partially insured -Strategies are drastic—like putting off health care when sick. Little power to effect (health coverage) change. No consistent health care. 	<ul style="list-style-type: none"> -May have to strategize health care issues such as Rx co-payments, etc. but have (some) resources to make health coverage and health care decisions. -More likely to have health insurance than the working poor 	<ul style="list-style-type: none"> -Access to more "privileges" than others /don't have to strategize that much. More likely to have health insurance than other groups, and able to
Citizenship status	Undocumented/ recent immigrants (5-10 years, or less)	U.S. citizens/ long term immigrants	U.S. citizens

SUMMARY

This dissertation has three goals: 1) to investigate how the organization and delivery of health care in the U.S. shapes the access and health care experiences of Latinos, 2) to investigate how gender shapes access to health care for Mexican origin family members? Along insurance, age, and employment lines, and 3) to investigate how immigration status and citizenship shape access to health care for Mexican origin families?

While the literature review suggests that health care access for Latinos is more complicated than the “overuse of services” image constructed in the mainstream consciousness, this review suggests that health care access research needs to encompass tools from various perspectives in order to ensure health care access for all. In the next chapter, the methodology of this dissertation will be explored, accompanied by a review of the methods used.

CHAPTER 3: METHODOLOGY

THOUGHTS ON RESEARCH AS SOCIAL JUSTICE

Following the lines of Feagin and Vera (2001), given my own social location as a middle class, Mexican American woman living in Southern California, previous work on Latino health, and activist motivations to ensure health care access to all vulnerable populations, I note that this work is a subjective endeavor aimed at studying and rebuilding society through a universal health care system. The act of “choosing what should be studied” is a “crucial and indispensable decision in sociological practice. Injustice should be examined not just in its maldistribution of goods and services but also in the social relations responsible for that distribution. These social relations,

among which oppressive power relations are a key part, are responsible for the way in which social goods are distributed. They also determine whether individuals, families, and other groups are integrated into or excluded from society’s important decision-making processes. And they shape the development of identities and the sense of belonging and dignity (Feagin and Vera 2001: 12).

I first became aware of the importance of elucidating the social injustices that occur for Latino families as they try to access health care many years ago when I was an undergraduate student at UCLA. In researching a paper on doctor-patient interaction for a medical sociology course, I read an article about a young Spanish-speaking woman in Chicago who went to the emergency room with an excruciating headache. Her young son served as her interpreter in the absence of bilingual medical personnel. She explained in detail the severity and intensity of her headache, but the doctor, understanding only “headache” gave her an over-the-counter pain remedy and sent her home. She later died at home. We will never know if the situation would have turned out differently in a bilingual/bicultural setting, or if she had had a regular medical

provider who knew her medical history—but Latino families, and all families, deserve at least the chance to access medical care safely and with dignity.⁷ Our current health care system is composed of social policies which distinguish between those who are “deserving” and those who are “undeserving” in terms of productiveness and ability to finance medical care (Becker, 2004: 260). I think an additional aspect that is considered in the national debate of who is “deserving” of care is citizenship. “Actions of the state may cloak racialized policies that are aimed primarily at ethnic minorities and can be seen as forms of discrimination(Becker, 2004: 259)” in health care access. The recently approved health care reform bill may improve health care access for some of the millions of uninsured, but undoubtedly, many Latinos will continue facing barriers to health care access if the structure of our health care system remains unchanged.

⁷ I was already volunteering as a clinic assistant and Spanish interpreter at the Venice Family Clinic the quarter I took this course, but it was during this time that I became dedicated to working and volunteering with vulnerable populations including those at risk for HIV infection, injection drug using women at a needle-exchange site, post-partum women in clinical settings and interpreter at other family clinics in the state. These experiences set the stage for my interest in Latino health care access (cite role of life narratives?)

METHODOLOGY

Given the partial perspective that has developed of Mexican origin health care access based on the current research, my purpose is to gain a more comprehensive understanding of how the social institution of health and medicine intersects with gender, work and citizenship, to shape the health care access experiences of working Mexican origin family members in California. I have chosen to use a political economy framework and standpoint theory, as they are methodologies which are compatible with my research questions. As previously mentioned, using a “political economy of Latino health” perspective on Mexican American health as exemplified by Chávez (1994) allows me to explore the political and economic factors that contribute to the development of our unequal health care system. This perspective also allows for the examination of the “real” cause of health care access problems—the inherently oppressive social relationships of capitalism (Baer, 1982; Baer, 1986; Doyal & with Imogen Pennell, 1979/1994). Similarly, this research starts with the lives of Latinos. As standpoint theorists suggest (see Harding 1991, for example), knowledge must be socially situated, that it must start from the lives of women and “others” and not just be inclusive of lived experiences.

“Pragmatic Research”

I use both qualitative and quantitative research methodologies in order to examine the health care experiences of the study population. A mixed-methods approach is critical in order to better understand how the organization and delivery of health care in the U.S. shape the access and health care experiences of Latinos. Onwuegbuzie and Leech (2005: 383) suggest that “pragmatic researchers” or those who used both

qualitative and quantitative research methods, are better able than single method researchers “to *zoom in* to microscopic detail or to *zoom out* to indefinite scope, ultimately combining the macro and micro levels of a research issue.” The qualitative questions asked in this research were constructed in order to examine the everyday struggles and processes of workers as they negotiate accessing health care within their work and environments (the micro level), communities and families, while the data analyzed from the dataset are intended to develop a larger (macro) picture of working Latinos in California across male/female, birth country and citizenship lines, which will allow for a more nuanced analysis.

This research differs from other dissertations in three ways. First, I collected the qualitative data before defending the proposal. In essence, the qualitative data functions as the exploratory step in this research. As Brannen suggests, (2005), each phase of mixed-methods research has a particular aim and addresses different research questions and concerns. I analyzed the secondary data after collecting and transcribing the qualitative interviews, which contributed to the quantitative measures I use and did not use. Second, this dissertation was originally imagined as an all-qualitative project in which I would examine the health care experiences of working families of Mexican origin in California and Michigan along various social locations. I believe the current methodology, however, makes this an even stronger dissertation. And third, ironically, the reasons I had to alter these plans and embrace what I will describe below are related to the health issues of my own (Mexican origin) family. When I first began the IRB process I consciously chose *not* to limit my categories of interest and to focus on legal immigrants, undocumented immigrants, Mexican American women, the insured, and the

uninsured (knowing full well that limiting the analysis to one or two of these categories would make my life easier). I was frustrated with the partial perspectives I encountered in the health literature—what was asked and what was not asked—and I knew that I wanted my contribution to the literature to show that health care access is more complex than is usually demonstrated in the Latino health literature. I insisted that it was only in locating the health care experiences of “Mexican Americans” (and not just immigrants or just Chicanos or just Chicanas) into a political and social context that a more accurate and complex picture would emerge. The original plan was to analyze the experiences of 15 families (dual parent or two family members), giving me a sample of at least 30 married individuals, or more if other family members were available. I made plans to start my field research in California early that spring and summer (2004) in order to arrive in Michigan to teach the second summer session. I anticipated needing at least two to three summers to complete the California data collection, as I usually taught part of the summer, leaving the rest of the summer to schedule and conduct interviews without interruptions. I assumed I could make Michigan contacts during the academic school year. As it turns out, my father experienced a severe medical crisis during my stay at home in California in 2004--time I had earmarked for data collection. My immediate family members mobilized and my mom, sister and I took turns with the care work. With a family member’s help, someone who works at a Mexican American social service agency, I was able to contact and interview about nine members of different families. The following summer I faced my own urgent medical scenario—a cancer scare. Even though I ultimately received a diagnosis of another chronic condition and not cancer, the laparotomy and subsequent recovery period were more taxing than I had anticipated. By

this point I knew the original plan would have to be altered. And then two summers later I moved back home in anticipation of my mother's heart operation. Always a very healthy woman, we were able to plan the whole thing. Yet, complications set in, so what should have been a two month recovery period lasted almost a year, yet another delay.

After the initial interviews during the first "research period" I was able to listen to and transcribe the data. Five subsequent interviews were conducted at various other times when I was in California. One additional interview was conducted over the telephone. I used my own and family contacts for the other six respondents.

These issues have impacted my work in several ways. First, given graduation time constraints, I was forced to decide what was important about the research—the fact that it would be qualitative, or the perspectives I was to use would allow me to portray a more accurate portrait of health care access and Mexican Americans. Along the lines of Brannen (2005), a conceptual shift took place on my part as a result of these issues. This shift went from a focus only on meaning and experience of accessing health care (all qualitative) to a focus on context, meaning and the interplay with the health care system (mixed-methods). Indeed, Onwuegbuzie & Leech (2005) identify five broad purposes to mixed-methods research including: 1) triangulation (seeking convergence and corroboration of results from different methods studying the same phenomenon), 2) complementarity (seeking elaboration, enhancement, illustration and clarification of the results from one method with results from the other method), 3) development (using the results from one method to help inform the other method), 4) initiation (discovering paradoxes and contradictions that lead to a re-framing of the research question, and 5)

expansion (seeking to expand the breadth and range of inquiry by using different methods for different inquiry components).

Second, through personal history, I have come to realize the importance of what Azevedo (2001) calls *potential* and *realized* health care access first hand, and the social, economic and political resources that go along with access. By resources I mean not only health insurance, but also the economic resources which allow one to pay for health and medical-related products and services such as ambulances, prescription medicines, and medical equipment for diabetes care, respiratory therapy or special items that aide in the recovery process, such as orthotic devices, compression stockings or special diets. Third, these experiences put me in touch with ideas that I do not think I would have had otherwise. C. Wright Mills (1959) reminds us that, as sociologists, life experience becomes part of our intellectual work, and we must learn to continually examine and learn from it. I was a participant observer (Atkinson & Hammersley, 1994) in each of these medical “life experiences” that I describe previously, in large medical facilities in Orange County, CA in which many languages (predominant among these are Spanish and Vietnamese) are spoken among medical providers and patients, and in a comprehensive cancer center in Lansing, MI in which only English is spoken⁸. These experiences greatly impact all aspects of the research. And fourth, as I will show below, due to the changes that I made in recruitment, my respondents are in “stable” living situations.

⁸ Although I use this term loosely here, I was indeed negotiating health care access for myself and for family members in each of the scenarios I describe, while simultaneously observing the context around me. At times I would “disclose” my status as a PhD student who happens to be doing her research on Latino access to health care, while other times I was able to engage in everyday conversations with medical personnel or with patient family members or friends while waiting in waiting rooms, often times hearing their “stories” in the process. Of course I *did not* go into any of these situations thinking that it would be the perfect time to generate data for my dissertation, but I was able to examine the “goings on” around me during the non-life-or-death situations. While I do not feel it would be appropriate to call this an ethnographic endeavor, I do think that my unplanned participant observation contributed to the overall project, in even the slightest manner.

What I mean is that, although I was able to interview a mix of undocumented, documented and US citizens, most of my respondents are home owners and have lived in California for eight (double check this) years or more. None are what would be called “migrants workers” or are currently working as farm workers or living in temporary arrangements.

What I ultimately constructed is the following. I interviews 15 family members. I examine the research questions in several ways: through questions on (1) family history; (2) work history and “illness procedures”; (3) health insurance history; (4) family “illness procedures” or the processes people engage in when sick, i.e., taking time off from work or asking a neighbor where to go for care; (5) access to regular care; (6) language/cultural barriers and “satisfaction” with care.

RESEARCH SITE

Study participants for the qualitative interviews were recruited primarily from Los Angeles and Orange Counties. The diverse ethnic population of Southern California includes a large Mexican/Latino population. Los Angeles County has the largest Latino population in the U.S., followed by Harris County, TX; Miami-Dade County Fl; Cook County, IL; and Maricopa County, AZ (U.S. Census Bureau 2006).

Mexicans have had a presence in California since Mexico became independent from Spain in 1821 (Camarillo, 1984). However, the current demographic growth of this population has occurred in combination with global economic transformations (Ochoa & Ochoa, 2005). As of 2006, Latinos comprise 47.1 percent of the population in Los Angeles County. The Mexican origin population accounts for more than 75 percent of Latinos in the county (US Census Bureau, 2006). In Orange County, Latinos accounts for 33 percent of the population; 87 percent of Latinos in Orange County are of Mexican Origin. Santa Ana, CA is 78.5 percent Latino, with 75.5 percent of the city population being of Mexican origin. While Latinos have continually been portrayed as foreigners due to U.S. expansionist policies; labor recruitment during good economic times; and scapegoating and deportation of laborers and their families during economic downturns (Ochoa & Ochoa, 2005; Valle & Torres, 2000), in 2003, 63.2 percent of Latinos living in Los Angeles were born in the U.S., while 41.2 percent of the foreign born were naturalized citizens. In Orange County, 70 percent of Latinos were born in the U.S., while 44 percent of those foreign born were naturalized citizens (U.S. Census Bureau, 2000).

Historically, Los Angeles became incorporated into the U.S. economy through the California gold rush, the building of the transcontinental railroad, agricultural industries, and through the use of recruited Mexican labor. Mexicans continued to arrive in Los Angeles at the beginning of the 20th century as a result of the economic, political and social upheaval created by the Mexican Revolution (1910-1920), and the expansion of various industries including agriculture, transportation, petroleum, motion pictures and tourism (Camarillo 1984). The Mexican arrivals came from diverse backgrounds including rural workers, professional people, urban craftsman and ousted office holders fleeing the political instability. Other Mexican arrivals included white collar workers and merchants (Camarillo, 1984). The Mexican population in Los Angeles was estimated at 5000 in 1900; 29,000 in 1910 and 50,000 in 1920 (Ochoa & Ochoa, 2005). By the late 1920s, Mexican workers accounted for 80 percent of the farm workers in Southern California, and a large portion of Mexican workers in California were employed in blue collar jobs in construction, canning and packing, and the garment and service industries—industries dependent on labor of the Mexican worker (Camarillo, 1984). The economic depression of the 1920s and 1930s resulted in blaming Mexican workers for the grave economic conditions and high unemployment, and contributed to massive deportations of nearly one million Mexican laborers (or more) and their families, many of whom were U.S. citizens (Acuña, 1971; Ochoa & Ochoa, 2005).

World War II again presented another labor need in the U.S., resulting in the establishment of the Bracero Program in 1942. The program, constructed by both US and Mexican officials, was established in order to ensure a stream of temporary agricultural labor in the US, while simultaneously providing health and safety protections for the

workers. The program waxed and waned for the next 20 years, depending on labor needs of U.S. businesses, and was officially dismantled in 1964. Although the program was established to reduce exploitation of Mexican laborers, exploitation continued throughout the program. Similarly, Mexican laborers were once again systematically repatriated in the 1950s during Operation Wetback (Acuña, 1971).

There has been a significant transformation in the composition of the Latino population since the 1960s (Ochoa & Ochoa, 2005). Due to changes in Mexican policies and Mexican economic crises in the 1980s and 1990s, Mexican immigrants have arrived in the U.S. more and more from non-traditional sending areas, and a larger number have been urban college graduates, women, and the indigenous (Zapotecs and Mixtecos) from the state of Oaxaca (Ochoa & Ochoa, 2005).

The 1970s and 1980s brought about great changes in the manufacturing industries in Los Angeles. The loss of well-paying, often unionized jobs in steel, auto, and tire factories, which used to employ thousands, has been replaced with the growth of lower paid, less secure jobs in the garment, plastics and electronics manufacturing industries, smaller, hi tech, craft oriented manufacturers employing 150-250 employees.

Manufacturing industries (that mostly employ US born and immigrant Latinas) in Los Angeles include apparel, furniture, leather manufacturing, printing, transportation, metal, chemical and petroleum-related industries (Ochoa & Ochoa 2005). Sassen argues that “global cities” have experienced a surge in the demand for highly paid professional positions, as well as a great demand for low-paid service and domestic care workers, increasingly targeted toward migrant and newly arrived immigrant women (Sassen, 2009). Many of these economic shifts have been blamed on the immigrant workers

themselves. In reaction to these economic challenges and perceived consequences of immigration, several (legal and illegal) state proposals have been voted into effect in order to limit immigrant incorporation into society, such as 187, which attempted to exclude the undocumented from receiving health and human services, 209, which eliminated affirmative action, and 227, which sought to eradicate bilingual education in the state (Ochoa & Ochoa 2005). In reaction to these threatening policies, and anti-immigrant climate, immigrants have chosen to become business owners. In California, of 428,000 Hispanic owned businesses, 276,000 are owned by Mexicans. Latinos have become an ever increasing and important presence in California and in Los Angeles County, as their presence is increasingly tied with these global, political and economic forces (Valle & Torres, 2000).

Health Insurance Coverage Among Working Latinos In CA Dataset

I specifically chose a dataset from California in order to elucidate patterns that may not be seen in national studies (Hubbell et al., 1991). Similarly, this dataset focuses on Latinos and was the only one I found that asks the question, “Have you ever had medical care outside of the United States?” This is an important distinction, as previously mentioned in chapter two. It is important to go beyond the traditional health research approach, which would be to employ a national survey that “oversamples” Latinos, but is not really representative. Instead, a smaller study which engaged in “appropriate sampling” of Latinos is used (Weber & Parra-Medina, 2003: 199). The Health Insurance Coverage Among Working Latinos in California (Greenwald, 2001) study, a random phone survey of 1000 employed Latinos of various ethnic backgrounds

in the state of California, which was funded by the California Healthcare Foundation. The study was conducted to better understand why California Latinos often lack health insurance, and includes questions regarding health status, health insurance coverage, health care access, and satisfaction with care. The uninsured were asked questions pertaining to why they have been uninsured, if they have ever tried to get coverage, and if they were eligible for employer coverage. Demographic questions include age, sex, household size, English speaking ability, immigration status, place of birth, and various socioeconomic status indicators. Additional questions related to work experiences and employer characteristics were also surveyed.

Random digit dialing was used in 2001 by English and Spanish interviewers to first screen households for Latinos adults, then screen for employed Latinos. Up to eight attempts were made for each residential telephone number (an initial call, and seven follow-up phone calls) identified during the data collection process. Random digit dialing increases the probability of accessing those with unlisted phone numbers. The data also contained a weight variable, that compensates for the underrepresentation of those working Latinos without phones (Greenwald, 2001).

The quantitative data focus in this study is on male and female Mexican American/Chicano respondents (n=771) born in the United States or in Mexico, working and living in California.

DATA ANALYSIS PLAN

Logistic regression is used in this study to evaluate the association between the predictors and the dependent variable, health care access. Logistic regression is an appropriate form of analysis when response (dependent) variables are qualitative or have scale consisting of a set of categories, and/or when using qualitative predictors (Agresti & Finlay, 1997). This analysis is used to better understand the following relationships among Mexican origin respondents, women and men (filtered), and U.S. born and Mexico born respondents (filtered): 1) Is there a relationship between the independent variables and health insurance? 2) Is there a relationship between the independent variables and health care access with a specific clinic or health care provider? 3) Which factors, if any, are associated with accessing healthcare outside of the U.S? While this question only applies to a small number of survey respondents, it is an important avenue of inquiry for future research.

As is the case with statistical methods, these relationships are examined as hypotheses. Since the analysis falls along three categories and there are three hypotheses, a total of nine hypotheses are examined. [These are more specifically delineated in analytic strategies.] These hypotheses include: 1) There is no relationship between the independent variables and health insurance, 2) There is no relationship between the independent variables and health care access with a specific clinic or health care provider, and 3) no factors are associated with accessing healthcare outside of the U.S.

To better examine health care access patterns for Mexican origin women and men, citizens and non-citizens for the dependent variables, I sorted and applied appropriate filters to the dataset when necessary. For the racial-ethnic category “Mexican

origin,” I created a subset from the original Latino study, of those who identified as Mexican/Chicano. The subsequent “Mexican origin sample” became the main source of data for the analysis. The gender and country of birth categories were established by either using a “split file,” which allows for comparison of the output along each category code, or by “selecting cases” within the appropriate variable. Similarly, the “layer” function was used during cross tabulations when necessary. SPSS version 15.0 for Windows was used. This section is informed by Acton (2009), Agresti & Finley (1997), and Burns & Burns (2008).

MEASURES

Dependent Variables. The dependent variable for this study is *access to health care*.

The dependent variable is operationalized in three ways: 1) having some type of health insurance, 2) having a consistent source of care and 3) going to another country if necessary to obtain health care.

1) Do you have ANY kind of health care coverage including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medi-Cal?

2) When you are sick is there one particular place or health provider you go to? And

3) Have you ever gone to another country for health care? Health care access is often conceptualized in the literature as health insurance coverage or *potential access*

(Azevedo, 2001), but there are several reasons to include actually seeing a provider when sick, or *realized access* (Azevedo, 2001). Data show that men are more likely to have

health coverage than women, yet are less likely to see a medical provider, and women are less likely than men to have health coverage, yet are more likely to see a medical

provider (American Association of Health Plans, 2003). As a whole, Latinos are less

likely than other racial-ethnic groups to have health insurance, yet are finding other ways of accessing care. Some scholarship suggests that Latinos pay out of pocket for medical

care or go out of the country for care and pharmaceuticals (Bastida et al., 2008; Chávez et al., 1985; de la Torre & Estrada, 2001; Hondagneu-Sotelo, 1994). It is possible that the

notion that Latinos under utilize health care is a myth and health researchers may need to change their assumptions concerning health care utilization concepts, and that a more

accurate picture of Mexican origin health will result if researchers change their

assumptions. Los Angeles hospital-based obstetricians believed most of their pregnant

immigrant patients did not receive prenatal care, yet, during an ethnographic study done in the hospital, women's health scholars documented that a majority of their Latina immigrant patients did in fact receive prenatal care. But since the prenatal care was often conducted at other hospitals or in Mexico, there was no record documenting this in the patient file. Consequently, Spanish-speaking patients were not asked about prenatal care based on the assumption that none was sought out, thus contributing to the stereotype (Scrimshaw & McMiller, 1996) of no prenatal care.

Independent Variables

The independent variables for this study include marital status, age, work arrangement, and citizenship.

Marital Status. Research suggests that married women are more likely to have health insurance than unmarried women (Burt Ruzek, 1997; Karas Montez et al., 2009).

Although married women are often in charge of their family's health and well-being, women are particularly vulnerable to having low health insurance access due to occupational segregation. Single women are also at a disadvantage. Karas Montez, Angel and Angel (2009) most recently examined how employment and marriage relate to health insurance coverage for Mexican-origin women compared with White and African American women. They found that employment (full time, part time or unemployed) and marriage (married, divorced or never married) have different implications on health insurance access for the different groups of women. In particular, Mexican origin women were less likely to have private health insurance compared with White women for every role combination, and less likely than African American women for almost every role

combination (except unemployed, never married). Employment seems to be more important for Mexican origin women than marriage, although employment does not assure health insurance coverage for Mexican origin women in their findings (Karas Montez et al., 2009). In this study, marital status is asked, “What is your marital status (married; not married but living together; never married; widowed; divorced; separated)?” and is recoded into 0=never married; widowed; divorced or separated and 1= married; not married but living together.

Age. Age is another factor that has emerged as important in determining health care access. Several trends related to age have emerged in the literature and seen in the raw national data —children and seniors are more likely to have health insurance access compared with other age groups, and older individuals are more likely to have health insurance than younger individuals (for example see, National Center for Health Statistics, 2008). Age is measured as a continuous variable in this study.

Work Type. Employment is an important aspect of accessing health care in the U.S, yet the link to health care access has yet to be clarified among Latinos. As previously discussed, among Latinos, research suggests that work does not increase health care access like it does for other racial-ethnic groups. Could this be related to the work arrangements Latinos might engage in? “Work stability” is one factor that contributes to health care access (Azevedo 2001). While employment was one criterion for participation in this study, 30 percent of Chicanos/U.S. Mexicans said they were uninsured. Another aspect of work must be at play. What role does “work type” or work arrangements play for Mexican origin respondents along gender and nationality lines?

Work type is defined as, “Do you work year round, or do you have another work arrangement? 1= year round, 2= other arrangement.”

Citizenship. Since Latino health is often approached along comparative lines, (Whites and Latinos, or sometimes, Whites, Latinos and African Americans), empirical research often does not distinguish between Mexican born immigrants/migrants and U.S. born Chicanos/Chicanas. This is due not only to ideological reasons--Latinos are often thought of as a homogenous group—but also for practical and methodological reasons—sample sizes need to be large enough to display significant predictive power, and Latinos are often under-represented in national datasets. Here, I examine Mexican origin respondents along citizenship status (U.S. citizen or not a U.S. citizen), “Are you currently a citizen? 1= yes, 2= no” and along birth country lines, through a filter for birth country.

The dataset does not include a questions regarding legal residency. The category of *Chicano/Mexican ancestry* is explored through selecting subsets of cases and creating new datasets from the original (Acton et al., 2009). The additional axes of gender and country of birth were selected or “layered” as appropriate in order to perform the analysis within these categories. SPSS version 15.0 was used.

Table 3.1. List of Dependent and Independent Variables

Dependent Variable:	Health Care Access
Operationalized as:	Health Insurance Particular Place for Care Medical Care Outside of the U.S.
Independent Variables:	Years Lived in the United States 1-10 11-20 21-30 31+ Work Type Year Round Other Marital Status Married/Living as Married Not Married Birth Location US Mexico Citizenship Status US Mexico

DEMOGRAPHICS

Characteristics Of Mexican Origin Sub-Set

As previously mentioned, the population which comprise this data set consists of Latinos of various ethnic backgrounds (n=1000). Analysis for this study will focus only on the self-identified Mexican origin sample. As seen in Table 3.2, the Mexican origin sample (n=771) maintains the representativeness of the original study. While the study population as a whole appears to have slightly more education, and the Mexican origin sample appear to be more likely to be U.S. born, the Mexican origin sample retains its consistency with the original study. The strength of this data can be seen in its random selection process, large Mexican origin sample and focus on California Latinos.

Demographic Characteristics Of Respondents

The demographic measures of gender, age, education level, household size, employment type, household income, citizenship, birthplace, parental status, and marital status are examined in Table 3.2 for the original study population and the Mexican origin sample. Tables 3.3 and 3.4 show comparable descriptive information for women and men, and for U.S. born and Mexican born respondents, respectively.

Demographic similarities can be seen in Table 3.4 between the original all Latino study population and the Mexican origin subpopulation on which this dissertation is based. Notwithstanding the differences in country of birth, women made up a slightly larger percentage in the original study, and the original study Latinos show slightly higher educational attainment, both groups are comparable, suggesting that little

predictive power has been lost in selecting the Mexican origin sample from the original study.

As seen in Table 3.3, slight differences between male and female demographics are revealed upon initial examination, such as Mexican origin women are slightly older (36.9 years) than Mexican origin men (34.2 years), and men are slightly more likely to be working year round (86.6 percent) compared with women (83.1 percent). More stark differences between the two groups can be seen in citizenship rates, birth location and marital status. Women are found to be citizens (71.6 percent) at greater numbers compared with men (52.1 percent), and women are more likely to be born in the United States (51 percent) compared with men (34.5 percent). While women are slightly more likely to be parents or legal guardian of a child under age 18 (58.6 percent) than men (55.4 percent), men are found to be married (62.5 percent) at a higher rate than women (53.2 percent). Women are also more likely to have higher annual household incomes than men (25 percent having household incomes greater than \$50,000 vs. 20 percent for men), perhaps because women also have higher educational attainment levels than men, with 33 percent of women having post-secondary educations compared with 31.2 percent of men.

Table 3.3 compares the demographic characteristics of the U.S. born respondents and Mexico born respondents. Mexico born respondents are slightly older (35.4 years vs. 34.7 years), and have slightly larger household sizes than U.S. born respondents (4.2 persons vs. 3.9 persons). U.S. born respondents have more years of education (51.2 percent of the Mexico born have less than a high school education compared with 34.0 percent of those born in the U.S.), have higher household incomes (67 percent of Mexico

born have household less than \$30,000 compared with 66.3 percent of U.S. born), and are slightly less likely to have year round work types (86.3 percent of U.S. born vs. 84.0 percent of Mexico born). The Mexico born are more likely to be parents of a child under 18 (61.0 percent vs. 56.7 percent) and to be married or living as married (62.7 percent vs. 59.1 percent) compared with the U.S. born. Mexico born respondents have lived in the US for 11 years or more (72.7 percent), and less than one-third have become U.S. citizens (31.2 percent).

Table 3.2. Demographic Characteristics of Study population and Mexican origin sample

Demographic Characteristics	Mexican origin sample (n=771)	Study population (n=1000)
Gender (%)		
Female	36.1	37.5
Male	63.9	62.5
Age (18-78)	34.2 years	34.7 years
Education (%)		
<High school grad	33.7	32.5
High school grad	30.1	27.2
Some tech school/Some college	20.2	21.5
Tech school grad	2.5	2.3
College grad	8.7	10.8
Post grad/prof degree	3.8	4.6
Household size (1-12)	3.8 persons	3.6 persons
Work Type (%)		
Year Round	86.2	86.7
Other Arrangement	13.8	13.3
Currently a US Citizen? (%)		
Yes	59.1	58.8
No	40.1	40.5
What country were you born in? (%)		
U.S.	40.5	37.7
Mexico	58.9	47.1
Central American country	1	10.1
South American country	1	3.0
West Indies/Puerto Rico	1	1.2
Other		
Parent or legal guardian of a child under age 18? (%)		
Yes	56.5	56.6
No	43.5	43.4
Marital status (%)		
married/living as married	59.1	60
single/divorced/widowed/other	40.1	39.9

Table 3.3. Mexican Origin Demographic Characteristics, Women and Men

Demographic Characteristics	Mexican Origin Women (n=278)	Mexican Origin Men (n=493)
Age (18-78)	36.9 years	34.2 years
Education (%)		
<High school grad	28.7	37.1
High school grad	28.0	31.8
Some tech school/Some college	23.3	18.9
Tech school grad	3.3	2.0
College grad	11.6	7.2
Post grad/prof degree	5.1	3.1
Household size (1-12)	3.7 persons	3.8 persons
Work Type (%)		
Year round	83.1	86.6
Other arrangement	15.1	12.8
Annual household income (all sources) (%)	9.4	7.3
<\$10,000	23.7	21.5
\$10,000- <\$20,000	16.2	20.3
\$20,000-<\$30,000	7.2	14.4
\$30,000-<\$40,000	7.6	9.3
\$40,000-<\$50,000	12.2	10.2
\$50,000-<\$75,000	13.3	9.9
>\$75,000		
Currently a US Citizen? (%)		
Yes	71.6	52.1
No	28.1	46.9
What country were you born in? (%)		
U.S.	51.1	34.5
Mexico	48.2	64.9
Parent or legal guardian of a child under age 18? (%)		
Yes	58.6	55.4
No	41.5	44.6

Table 3.4: Mexican Origin Demographic Characteristics, U.S. born and Mexico born

Demographic Characteristics	U.S. born (n=312)	Mexico born (n=454)
Age (18-78)	34.7 years	35.4 years
Education (%)		
<High school grad	34.0	51.2
High school grad	30.6	2.8
Some tech school/Some college	20.3	12.1
Tech school grad	2.5	2.2
College grad	8.8	4.3
Post grad/prof degree	3.8	2.2
Household size (1-12)	3.9 persons	4.2 persons
Work Type (%)		
Year round	86.3	84.0
Other arrangement	13.7	16.0
Annual household income (%) (all sources)		
<\$10,000	8.5	10.3
\$10,000- <\$20,000	24.5	31.5
\$20,000-<\$30,000	20.5	25.2
\$30,000-<\$40,000	12.8	14.2
\$40,000-<\$50,000	9.5	6.8
\$50,000-<\$75,000	11.9	6.8
>\$75,000	12.2	5.1
Currently a US Citizen? (%)		
Yes	--	31.2
No		68.8
Parent or legal guardian of a child under age 18? (%)		
Yes	56.7	61.0
No	43.3	39.0
Marital status (%)		
married/living as married	59.1	62.7
other	40.9	37.3
Yrs lived in U.S. (%)		
1-10	--	35.4
11-20		37.4
21-30		18.4
31+		8.7

DESCRIPTIVE STATISTICS

Cross tabulations were conducted to examine the relationships between dependent and independent variables. Table 3.4 shows the relationships between the dependent variables and independent variables for all Mexican origin respondents. Table 3.5a shows the relationships between the dependent variables and independent variables for women, Table 3.5b shows the relationships between the dependent and independent variables for men, while Table 3.6a shows the relationships between the dependent variables and independent variables for those born in the U.S., and Table 3.6b shows the comparable relationships for Mexico born respondents.

Results

Logistic regression analysis was conducted to examine health care access as measured by having one particular place for health care, health insurance and going outside of the U.S. for medical care using citizenship, marital status, work type and age as predictors. The analysis reveals that predictors vary for each dependent measure for all Mexican origin respondents, women and men, and respondents born in the U.S. or Mexico.

DATA COLLECTION

I conduct semi-structured, in-depth interviews in English or Spanish with 15 employed Mexican Origin individuals in Southern California. Fourteen were in person and one was via telephone. I ask questions regarding employment history in the U.S. and Mexico; health insurance and health care experiences in the U.S. and Mexico [see Appendix B for summary of interview questions].

I recruit participants in California through convenient sampling. Key informants were used to recruit study participants. Once an individual within the research criteria is found, I schedule a face-to-face interview with the participant and any interested family members. The interviews are scheduled on an individual basis with each family member, preferably. The preferences of the participants are honored when possible.

I ask all research participants to give informed consent, and the interview occurs in the language preferred by the research participant in English, Spanish or both. (See Appendix A for informed consent procedures in English and Spanish). Telephone interviews may be used if an in-person appointment is not available for reasons beyond the control of the researcher or the research participants, and then a verbal consent process will be established in this situation. When authorized by the research participants, face-to-face interviews are being tape recorded, transcribed and coded. All possible means are used to maintain confidentiality of the data during the writing process, including assigning pseudonyms (by the researcher or by the research participants) to the study participants. During the taped version of the interview, the use of names is avoided when possible. Due to the possible sensitive nature of the data, tapes and notes of

interviews are kept in a locked file cabinet, and will be erased upon completion of the study. IRB approval has already been established and expires June, 2011.

The Sample

Fifteen Mexican and Mexican American family members were interviewed regarding their work and health care histories in the U.S. and Mexico. Those born in Mexico have lived in the U.S. an average of 20.8 years. The ten women and five men live in the Los Angeles/Orange County metropolitan areas of Southern California. Twelve of the respondents were married, one woman was a widow, one woman divorced, with her adult children residing in Mexico, and one woman was single. Twelve of the respondents had children, and all but one of the respondents was working or had worked in the U.S. at one time. All the respondents were long-term residents of California, having lived in California eight years or more. Ten respondents were home-owners, three lived in rental apartments and two lived with relatives. One elderly respondent lived with the family of her daughter and son-in-law, while another lived with her aunt. Five respondents were born in the U.S., three were naturalized citizens, three were U.S. residents, three were undocumented, and one respondent did not mention if she was a U.S. citizen or a legal resident. Of the currently married women respondents, all were working or had worked at some point during their marriages. Of the male respondents, two were working and two were forced to retire due to health issues. At the time of the interviews, four respondents had Medicare, two were uninsured, and the rest of the respondents had medical coverage through the VA or through their own or a spouse's

employer sponsored health insurance. The interviews took place in the metro Los Angeles-Orange County area of Southern California between 2006-2009.

Several of my respondents were child care providers, and had affiliations with, what I will call, The Latino Services Organization (LSO), one of the largest human services foundations in the nation. This organization has been helping low and moderate income Latinos for more than 40 years. One program trains women to become licensed day care providers in which they care for children from the LSO program (for subsidized rates) and can care for children from outside the program as well.

TABLE 3.5: Description Of Respondents

Participant	Occupation	Age	Citizenship ¹	Years in U.S.	Insurance ²	Class ³
1 Mrs. G	Teacher/ wife	97	C	30	Med	M/UC
2 Doña Maria *	Business prof.	66	C	37	Med	M/UC
3 Peter *	Military/ret/	71	U.S.	-	Med/VA	M/UC
4 Mario	Admin/non- profit	58	Res	8	Ins	WC
5 Flora	Admin/non- profit	58	Res	8	Ins-Sp	WC
6 Gwen	Adm./ Civil Service	70	U.S.	-	Med	M/UC
7 Veronica	Factory/ Child care	45	Res	23	Un	WP
8 Margarita *	Student	21	DK	15	Un	WP
9 Minerva	Child care	65	UD	8	Un	WP
10 Enid	Factory worker/wife	54	C	31	Ins-Sp	WC
11 Monica *	Adm/ Small business	31	U.S.	-	Ins	M/UC
12 Wendel*	Accountant	34	Res	8	Ins	M/UC
13 Reynoso*	Construct/ ret.	70	U.S.	-	Med	M/UC
14. Robert*	Admin/smal l business	39	U.S.	-	Ins-Sp	M/UC
15 Clare	Child care/ Wife	52	UD	18	Un	WP

* Interviews were conducted in English or mostly in English

¹U.S.=US Born

²Med=Medicare

³WP= Working Poor

C=Naturalized Citizen

Ins=Insured

WC= Working Class

Res=U.S. Resident

Un=Uninsured

M/UC=Middle/Upper class

UD=Undocumented

VA=Vet Adm

DK=Unknown

Sp=Spouse

DK=Unknown

Coding and interview analysis

All in-person interviews were taped with permission and transcribed into English or Spanish. Spanish transcriptions were later translated into English. Each transcript was coded to reflect major themes discussed in the literature and by the respondents themselves. Many of the themes discussed by the respondents reflect concerns in the literature, while others contradict the master narratives of Latinos seeking health care access. Pseudonyms were used to protect the identities of the respondents and affiliated organizations.

ANALYTIC STRATEGIES

How the organization and delivery of health care in the U.S. shape the access and health care experiences of Mexican origin family members, with a special emphasis on insurance and employment.

In chapter four, “Work, and health insurance as trajectory,” I examine the themes generated by the qualitative interviews regarding health insurance and employment, and I use quantitative data to examine the importance of work and health care access along citizenship lines. Hypotheses 1 and 2 For All Mexican origin respondents: 1) There is no relationship between the independent variables and health insurance, 2) There is no relationship between the independent variables and health care access with a specific clinic or health care provider

How Mexican origin women’s and men’s health care experiences differ.

In chapter five, “Gender, work and health care access” I examine the experiences of the mostly women interviews, and use the quantitative data to inform the differences between women’s and men’s health care access

Hypotheses 3 and 4 for Men and Women:

1) There is no relationship between the independent variables and health insurance, 2) There is no relationship between the independent variables and health care access with a specific clinic or health care provider

How immigration status and citizenship shape access to health care for Mexican origin family members, and what types of strategies are used to access care in the U.S. and Mexico

In chapter six, “Strategies and negotiations” I examine the strategies used to access health care through the qualitative data and examine the impact that birth country

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and citizenship have on health care access via the quantitative data. I did not formally ask immigration status of the respondents, and residency status is not included in the data. I construct this through the use of birth country and citizenship status.

Hypotheses 5 and 6 for U.S. born/Mexico born

1) There is no relationship between the independent variables and health insurance, 2)

There is no relationship between the independent variables and health care access with a specific clinic or health care provider, and

Hypotheses 7, 8, 9 for All Mexican origin, Male/Female and U.S. born/Mexico born

3) no factors are associated with accessing healthcare outside of the U.S.

GAINING ACCESS

My “insider-outsider” status may allow easy access to research participants, but it may also lead to data collection problems. In terms of access to my research community, insider status allows me a lens through which to see a different social reality and ask questions outsiders could not (Baca Zinn, 1979). Yet, the possibility also exists that participants will be hesitant to discuss their status with me due to my organizational relationship with the university. One could argue that I am only considered an insider by the academic community because of my Mexican American origin. Since I am U.S. born, individuals in the Mexican immigrant community in Los Angeles often contest my “Mexicanness”, seen through my accented use of the Spanish language. My mother’s ties are directly linked to Guadalajara, and her ties often serve as a buffer for me in this situation. When asked, “¿De dónde eres?”/“Where are you from?” my response, “Mi mamá es de Guadalajara” /My mom is from Guadalajara,” seems to suffice. (My father’s family is from Texas, since it was Mexico.) Similar to the experiences of Naheed Islam (2000), I find myself balancing hostilities due to my class background, gender and place of birth, with the ability to ask questions that “outsiders” could never ask. Patricia Hill Collins contends that “outsiders within” intellectual communities, in choosing to investigate social life from their unique social locations, have several advantages including:

- A kind of ‘objectivity’ that is a peculiar combination of nearness and remoteness, concern and indifference.
- A tendency for people to confide in a stranger in ways they would not with each other.
- The ability of a stranger to see patterns those immersed can’t see.
- The creativity that is spurred by marginality (as quoted in Weber & Parra-Medina, 2003: 197).

By social location, I mean the social “ ‘place’ of an individual or group in the race, class, gender . . . hierarchies as well as other critical social hierarchies, such as age, ethnicity, and nation”(Weber, 1998: 18).

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SUMMARY/CONCLUSIONS

In examining how the social institution of health and medicine are shaped by work, citizenship and gender, I aim to understand these relationships and the meanings that these processes hold for Mexican origin family members as they negotiate health care. Based on the literature, I assume that Mexican origin family members face barriers to health care, although they find ways to access formal or informal health care in some manner. Many of the routes to care reflect changes in social and demographic characteristics, such as bilingual community and private clinics. The “strategies” these family members employ, the circumstances in which they are able to gain access to the health care system, and what occurs when they are not able to access health care are also important to examine. I use the statistical data to triangulate information about the different aspects of health care access, and I expect this process to both elaborate and complement the other (Brannen, 2005).

In chapter four I examine several themes revealed in the research findings, including the health coverage myth, the trajectory of health care, language and confidence, and critiques of the health care system.

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CHAPTER 4: ORGANIZATION AND DELIVERY OF HEALTH CARE

The Experiences of Having and Not Having Health Coverage

First research question: How does the organization and delivery of health care in the U.S. shape the access and health care experiences of Mexican Americans? What impact do insurance and work have on health care access?

My analysis is organized to provide a larger picture of the link between Mexican origin health insurance access, medical care, and work within a political economy framework, and from the perspective of Mexican Americans using an intersectional perspective.

In part one of this chapter, I illustrate the experiences and feelings that result from our current health care system in which working family members remain uncovered while employers benefit from their labor.

In part two, I examine the role of health insurance, work and marriage in the quantitative data. Given these findings, I argue in part three of this chapter that it is not sufficient to focus on the implications of the health care delivery system, which vary along work, citizenship and social class lines, and contribute to unequal health care access. These findings in fact implicate not only a market-based health care delivery system along with employers who put profits over the health of their employees (Rylko-Bauer & Farmer, 2002), but also a class and race-based system which perpetuate structural inequalities (Becker 2004).

I address several themes in this chapter constructed from the literature and grounded in the interviews of the respondents. They include:

- 1) The health coverage myth of marriage and family
- 2) Language and Confidence

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3) Respondents critique the health care system

Part I

SOME OF US DO, SOME OF US DON'T: THE HEALTH COVERAGE MYTH OF MARRIAGE AND FAMILY

As discussed in chapter two, the literature on marriage, family and health care among Latinos has contributed to contradictory images of family life for Mexican Americans. One portrayal of Latino families in the literature suggests that *familism* impedes health care access, while another suggests that Latinos are tight-knit and there is something “protective” about Latinos culture (Baca Zinn, 1993; Hayes-Bautista et al., 1994; Segura & de la Torre, 1999). Similarly, policy discussions regarding health insurance and economic-based models are based on the assumption that employment based health insurance coverage offered to employees also covers families (Fronstin, 2010; Harrington Meyer & Pavalko, 1996; Karas Montez et al., 2009). However, findings from this study are more in line with structural theories found in the sociological literature that link “lack of insurance to occupational and industrial features that define the distribution of employment-based health insurance” and to “labor market characteristics that determine who is and who is not offered health insurance as an employee benefit (Harrington Meyer & Pavalko, 1996).” Occupational segregation along race and gender lines influence health care access via health insurance (Seccombe & Amey, 1995; Seccombe & Beeghley, 1992). Mexican Americans and immigrants face disadvantages in the labor market as few service jobs offer health insurance. And those jobs which do offer health insurance often require large premiums for family coverage.

Jobs that do not provide coverage are unlikely to provide wages which would allow private insurance to be purchased (Angel & Angel, 2006).

Health insurance coverage is described as dynamic by the respondents in this study, and often varies from family member to family member, over time and under various socially determined contexts which include occupational location, income, age, marital status and immigration status. Below I describe the experiences of several respondents in order to illustrate the structural aspects that construct and prevent health coverage for individual family members. Far from being the result of individual preferences, as health care in a capitalist system suggests (Doyal & with Imogen Pennell, 1979/1994) or immigrating to the U.S. because of health care as suggested in the popular discourse (Menjívar, 2002), these experiences suggest a more pervasive and systematic denial of health care access, which is controlled by employers in many cases, by market-based health insurance brokers in others, and influenced by occupational segregation .

Santos and Enid

U.S. citizens

28 years in the U.S.

Working class home-owners

2 children at home, boy age 17 and girl age 20. Married daughter lives out of the home with her own daughter and husband.

Santos and Enid, both born in Mexico, are naturalized citizens. They own their own home in an industrial area in Los Angeles. Santos works for a produce wholesaler in Los Angeles, and Enid takes care of her grandchild at home during the week, and often her elderly parents, who live in another county, on the weekends. Enid worked for 10 years at a costume jewelry factory when her children were little, but was laid off, along with 300 others, for refusing to take a \$1/hour pay cut. She and her husband currently

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have health insurance through his employment. They pay about \$400 for the monthly premium. Santos has always had health insurance through work, and Enid had access to health insurance through her previous job, although she has always paid for her coverage through her husband's work. Their 17 year old son is covered through Healthy Families (the State Children's Health Insurance Program in California) until he turns 18 years old (or until funding is cut by the State). Healthy Families is a low cost health insurance for children and teens. It provides health, dental and vision coverage to children who do not have private health insurance, or qualify for Medi-Cal.⁹ Their 20 year old daughter has her own health insurance coverage through work. Enid tells me that they prefer to use Healthy Families insurance for their son because it is more affordable and more expansive than their private health coverage, including dental and vision coverage. In this context, marriage contributes to health coverage for a spouse, yet the teenage son has state coverage, which ultimately benefits the employer.

Veronica and Miguel

23 years in the U.S.

Home owners, working poor, U.S. residents

3 children: girl 18, boy 13, boy 11

Marriage does not help wife with health coverage

Veronica works as a child care provider in her home, while her husband Miguel has a full-time factory job. "I work from 6am-6pm or even 10pm if the parents need it, but one has to be aware that you work when you have kids or that there are times when you won't have kids, like now." She is licensed for eight children, which allows her to take children from the program (discussed in chapter 3) or private children whose parents pay her directly. Miguel has HMO health insurance through his employment. The kids are currently covered through Healthy Families. They used to be covered through Medi-

⁹⁹ Taken from the website, <http://www.healthyfamilies.ca.gov/Home/>, accessed December, 2009.

Cal, but an increase in their incomes has recently made them ineligible for Medi-Cal but eligible for Healthy Families, although they still don't make enough money to cover Veronica. She has not had any health insurance coverage for the past four years because they cannot afford to cover her. Veronica and Miguel pay about \$35 a week for the husband's insurance alone. To cover her as well would cost more than 4 times this amount—around \$150 or \$160 a week, which they cannot afford she tells me. "Health insurance is very expensive. One has to limit." She does not always have children to care for, so they have to think of her income as something just to help with extras. Overall, their current financial situation worries her.

My daughter is working now and she gives her little money to my husband. . . what can I tell you, we are maintaining (i.e., hanging onto) the house, like now, we are fine, the only one without work is me. That's the only thing, sometimes I say, oh no, oh no, one never knows, right?/ *Mi hija ya esta trabajando y le da su dinerito a mi esposo. . . que le puedo decir, estamos sosteniendo la casa, como horita, estamos bien, la unica que no tengo empleo soy yo. Eso es la unica cosa, a veces digo hay no, hay no, uno no sabe nunca, ¿verdad?*

She is always shopping for an individual plan, but they are too expensive for their combined incomes, although she tells me that they make too much money for her to qualify for public health insurance. Before this four year period of being uninsured, she had always been insured through her own employment. She worked at a Goodrich plant for 10 years, where she had health insurance coverage for herself, and the rest of her family had coverage through her husband's job. In the year that her husband and daughter had to return to Mexico for (emotional) health reasons, she went to Las Vegas to work with her other two children, staying with relatives there. She could only afford to

cover the health insurance premium from her employment for herself, and Medi-Cal covered two of her children, as her income was low then.

They (her children) had Medi-Cal for a total of about 4 years. And that was when my husband wasn't working. Oh no, he was working where he's working now, but it's very expensive for the family. And anyway, they qualified for Medi-Cal, so they were OK there, they were OK there./*Alli estaban bien*.

When Veronica and her family first moved to Los Angeles, she began working at a nearby factory. She worked there for 12 years, and stopped working after her youngest son was born. Her three children were born in California while she was working at that factory, so her health insurance covered all three births. Veronica tells me that she studied and worked in Mexico before arriving in CA.

Although Veronica and her husband are both legal immigrants, and she and her husband both work and have both worked, marital status does not protect her from being uninsured as it may for other higher income couples. This both supports and contradicts the literature. In general, the public health and policy research on health insurance assume that marriage is another way to access health insurance for women (Bernstein et al., 2008; Harrington Meyer & Pavalko, 1996), while sociologists find that the link between employment and marital status is more complex for Mexican origin women (Karas Montez et al., 2009), as demonstrated here. Mexican origin married couples who work may have lower income which prevents them from being able to pay for private health insurance coverage, and allows the children to qualify for state health insurance. Similar to Enid and Santos, Miguel's employer benefits from this situation, and Veronica is impacted the most as she is left without health coverage.

Rob and Roberta

U.S. born and born in Puerto Rico
Home owners, middle class
1 son, age 8
Marriage helps husband with health coverage

Rob, a 39 year old Mexican American man has been married to his 40 year old Puerto Rican wife, Roberta, for ten years. She works as a social worker at a private agency, and he works at a small business (2-4 full-time employees) in an industrial section of Orange County. Rob started at this small business part-time while in high school, and then became full time after graduating. While working full-time, he eventually graduated from college with a bachelor's degree in business by going to school nights and taking extended time to fulfill the university requirements. Roberta has a master's degree in social work. He and his wife pay for their health coverage through her employment, but he tells me that they cannot afford to cover their 8 year old son as well with this expensive policy. Her company contributes 20 percent of their health insurance premium (a flat rate), and the couple pay 80 percent of the policy themselves. So they have purchased an individual plan for their son, JV. Rob and Roberta own their own home in northern Orange County. Rob did not have health insurance prior to marriage. I ask him about his health care experiences before getting married:

Before I had health insurance I would go to a private office and just pay out of pocket. I didn't go that much, but I did have a few emergencies. I looked around for health insurance but I had financial issues and I needed other things. Had to prioritize. [Did you or your boss ever look into small-business health coverage plans?] Small business health insurance is very expensive. . . more than individual plans"

Similarly, one point during our talk, Rob mentions that Roberta's father is a doctor, so before they were married, and before he had health insurance, Rob would talk to Roberta's father about the need to seek care.

These three scenarios exemplify different health insurance experiences along nationality and class lines, and the balancing acts that Mexican origin families face as they try to provide health care access for their families. These family members—immigrants, nationalized citizens and U.S. born--worry for the health of their loved ones, but they are constrained by their incomes, health insurance policies at work, and government “bureaucracy” regarding income guidelines for state health coverage. Similarly, government guidelines structure which Rob and Roberta have more options than the other respondents mentioned, since they have higher incomes and other resources. But health care access is more than just income. Health coverage is priced out of reach for dependents by employers or brokers, or not offering health coverage, benefits each employer. These scenarios also shatter any myths concerning married parents with health benefits being able to cover their families. The literature suggests that marriage is helpful in accessing health insurance coverage, and here we see that this may be the case for the middle class. Among the working poor, spouse and child dependents may not be as fortunate. Employers often fail their employees’ families by failing to provide affordable health coverage. In fact, this is the crux of the for-profit health care system.

The picture that begins to unfold from the voices and experiences of the respondents is that access to health insurance and other methods of accessing health care access changes over time, and is related to employment, having a family, marital status, immigrant status, gender, and the organization of health care delivery. The uninsured have long working histories and often had health insurance in the past, as previously

described. Those who are currently insured also have periods in their lives when they were not insured. Health care access is a pervasive worry for many of those interviewed

LANGUAGE AND CONFIDENCE

Mrs. G, age 93
U.S. citizen, in U.S. almost 30 years
Lives with daughter's family
Medicare

Mrs. G says that her current doctor doesn't speak Spanish, but it was never an issue because "the girls in the medical office (consultorio) do, and I speak and understand English. My daughter or granddaughter take me to the doctor so I don't worry." Her doctor and his staff are very professional and attentive ("me atendien bien") and she likes to go there. She also says that her family takes care of her, so she has never worried about a language barrier. She doesn't worry about medical care at all, in fact, because if something ever happened here in the U.S., she could always go back home. The doctors she grew up with are the best—good education, very intelligent, ("sumamente preparados"/ very well prepared) and the care in Mexico is just as good, if not better, than the care here, because more people have access there, she tells me. She has told me about her family doctor many times—"el Dr. Carlos Ramirez Esparza" she again tells me, has been her family doctor in Mexico since 1955.

Flora and Mario
U.S. residents
Working class, rent apt.
2 children: son in Mexico, married daughter in Canada.

Flora, a 55 year old woman, legal resident, mother of two grown children who live in Canada and Mexico, describes her current employment and long work history in Mexico. She and her husband rent a small one-bedroom apartment in a mixed

Vietnamese-Latino neighborhood in northern Orange County. Flora currently works part time at a small non-profit (less than 20 employees) dedicated to helping children with special needs. The non-profit is grant driven and charges minimal fees to the participants, so if Flora calls in sick or goes to the doctor, she does not get paid. She and her husband worked at several jobs when they moved to California. The other jobs she had before this were temporary or short time, with no benefits. The only other full time work she found made her feel like an outsider, like she wasn't wanted there, so she took a job where she feels treated well. "At least now my husband only has to work one job," she tells me. Her husband works full time, and they get their health insurance coverage through his employment. They did not have health insurance before he started his current job. It costs \$300.00 a month to cover her, which she feels is a lot on their income. She has several chronic problems, including high blood pressure and arthritis, for which she uses several prescription medicines monthly. Although she speaks some English, she tells me that "when it is about my health, I prefer to speak Spanish." (I've known Flora a long time, and I think her English is great, certainly well enough to get by. But I know she lacks confidence speaking English. We did the interview in English and Spanish). All of the doctors at her current medical group are bilingual (she didn't specify Spanish English, I just assume—it is important to note that bilingual could mean English Vietnamese or Chinese, other predominant languages in the area), and she feels very comfortable with her care at this medical group. She says that they are attentive, they know her, and they aren't cold. She has feelings of *confianza* (confidence)¹⁰ with them.

¹⁰ There are two phrases that Spanish speakers used to describe their health care experiences (with me specifically, but that in general, I hear all the time in research settings) that I think are important to discuss, or at least that English speaking health researchers need to keep in mind: 1) "confianza" and 2) "me atienden bien". The direct translations of these terms are 1) having confidence and 2) being taken care of

She has been with this medical group for two year and she feels that “they have excellent treatment. The doctor, who is Romanian, is a geriatrician.” She wishes she could get health insurance through her own employment though, so that they could save the \$300 they pay to have her covered under her husband’s policy. They have been in the U.S. 8 years, arriving as legal residents. They waited 10-12 years for their residency papers before moving to the U.S..

Other Spanish speaking respondents *with insurance* (n=4) reported not having difficulty communicating with their health care providers as well. Perhaps this is because the medical providers speak Spanish, the respondents speak enough English, and/or they have been in the U.S. long enough to know how the health care system works (anywhere from 8-28 years). Survey research which looks at the association between English language proficiency and health care experiences suggest that low English proficiency is linked to difficulties communicating with providers, issues of timeliness to care and less preventive services (DuBard & Gizlice, 2008; Pippins et al., 2007). While these respondents did not express language barriers to the extent reported in the literature, these same respondents had other complaints about the health care system, including the high cost of prescription medicines, the difficulty dealing with the bureaucracy, and interpersonal relations with medical providers. These issues will be discussed in the next section.

While it has been suggested that language preference within the health care setting are matters of acculturation or even proxies of cultural belief (Lara et al., 2005), anthropologists suggest that in fact, this relationship is more complex. Chavez,

well, or to be attended to, but the meanings behind their uses are more subjective. Having “*confianza*” in someone or something connotes feelings of family, kinship and respect and “*me atienden bien*” suggests care in a respectful manner or environment, beyond just friendliness or professionalism.

McMullin, Mishra, and Hubbell (2001) examine structural variables and cultural beliefs on health behaviors such as cancer screening and find that both do in fact influence cancer screening behaviors, although cultural beliefs do not undermine help seeking behavior

RESPONDENTS CRITIQUE THE HEALTH CARE SYSTEM

Respondents in this study had strong feelings regarding the medical care they received. Regardless of insurance status, immigration status and class background, all respondents felt that changes needed to be made to the system. Some felt that the entire system needed to be changed. (Their recommendations for changes to the health care system will be discussed in chapter seven).

A common critique voiced by the respondents is that their medical providers dismissed their symptoms. Enid describes several complaints:

. . . What happened was I wasn't feeling well. I had a headache, I was feeling dizzy and I went to the doctor. They did some tests and they said everything was fine, that only my cholesterol was high. But they didn't tell me to do anything for my cholesterol. He said that the symptoms I was experiencing was menopause, the doctor told me. After that my husband said we should go to Tijuana to see a doctor."

She explains that she keeps on feeling poorly and ended up going to the emergency room several times.

Sometimes I get very strong heart palpitations every so often, not always, like two or three times a year, and they (the doctors) say that they don't know the cause. They had given me a monitor, that thing to monitor the heart for 24 hours, and they gave it to me for almost a month because I had to change it because they didn't put it to record, and then they see that it is normal, that my heart is normal, and then they gave me an echocardiogram and it was normal too. . . so really they don't know why this is happening to me, and this last Thursday I got very sick late at night and they (my family) took me to emergency and the doctors tells me that I should have an angiogram. . . .

An additional frustration is dealing with the health insurance bureaucracy.

I think it is their responsibility, of the doctors, to help everyone, I think, whether they have insurance or not, to attend to them, because an emergency situation has to be attended to, and believe it or not, it isn't like that! One time I was with my daughter at a Kaiser (Permanente) and I began to feel sick. I told her I wasn't feeling well, she asked what was wrong and I told her I was having heart palpitations and then we (my daughter and I) told the nurses there and they said sorry, does she have Kaiser insurance? We said no, Blue Cross, and they said

they couldn't do anything for me and I was so sick, *so sick*, with them on the third floor and so sick and they were saying 'Señora, sit here, inside. We can't put her outside (in the hallway) because if anything happens we are responsible.' And me, when I'm sick and I can't be sitting, I start to feel desperate, so they didn't do anything, they didn't attend to me at all. Instead they called the paramedics, the paramedics arrived, the firemen and everything to attend to me and they took me to another hospital, far from there, in Glendale. . . so that someone would attend to me, but someone could die waiting for attention!

Flora describes the effects of changes within the medical group:

I was with B Medical Park Group before this (current insurance and medical group) for four years. I had to change (medical groups) because they changed the insurance. But there it was less expensive and the prescriptions cost less. I got choose an internist who spoke Spanish, but then she left the group after months and I was given a doctor who didn't speak Spanish."

She switched primary care doctors, but eventually had to switch medical groups

altogether as a result of a change in health insurance. These findings suggest that, at the macro level, political and economic factors impact the experiences of Mexican origin respondents.

POSITIVE EXPERIENCES

Insured respondents have many positive descriptions of their health care experiences as well. Doña Maria:

Before I didn't like my doctor. My mother and I used to go to this woman doctor, but she moved and then her patients transferred over to her father, who is also a doctor, so now my mom and I see him, and so does my husband. That's how we got our doctor. Now I like them. It is a small medical office—one doctor, 2 nurses, one office manager and sometimes the doctor's wife is there. They take us quickly, and they schedule according to your own time. Somehow they always see us. And the office manager makes appointment for us and says to come at the same time as your husband and your mother, which makes it easy, and if I can't go with her then one of my daughters will. If I have to call in an emergency they always help me—I take them presents, like Easter baskets with chocolates.

According to Rob,

A lot of people used think that things used to be bad at Kaiser (Permanente), but it has been OK for us. I like that you can go to any Kaiser that is open. I needed an ENT specialist for my son. I called one (Kaiser location) and they were open late (until 7pm). I got a same day appointment, which rarely happens. (And how did you find that place?) All you do is call a number to make an appointment, but I like that there's another way, you can talk to a nurse practitioner on the phone after hours or go to the ER.

Rob continues,

As a baby, my son had acid reflux. He wouldn't sleep, he saw several specialists and they couldn't find what was wrong. But they didn't hide anything or negate the problem. After three appointments, they found that he was anemic and gave him some pills to help. Everything was fine.

In the next section I examine quantitative data.

Part II: Quantitative Results

MEXICAN ORIGIN DESCRIPTIVES

Table 4.1 reveals that many factors are associated with health care access for the Mexican Origin subpopulation, including years lived in the U.S., work type, marital status, birth location and citizenship. Having lived in the U.S. for 10 years or less, is statistically associated (weakly), with not having a particular place for health care, while having been in the U.S. 31 years or more is statistically associated for having a particular place for health care ($p < .0005$).¹¹ This statistically significant pattern can also be seen for health insurance.

Health insurance is positively associated with having lived in the U.S. 31 years or more, and negatively associated with having lived in the U.S. 10 years or less ($p < .005$).¹² Working other than year round is negatively associated (weakly) with having a particular place for health care ($p < .006$).¹³ and with having health insurance ($p < .0005$).¹⁴ Being single/never married is weakly associated with not having a particular place for health care ($p < .019$).¹⁵ Statistically significant, yet slight, relationships are seen between being born in Mexico and not having a particular place for health care ($p < .019$).¹⁶ and not having health insurance ($p < .0005$).¹⁷ Non-U.S. citizens are less likely to have a particular place for health care than U.S. citizens ($p < .0005$).¹⁸, less likely to not have access to

¹¹ Cramer's V= .221

¹² Cramer's V= .366

¹³ phi= -.100

¹⁴ phi = -.158

¹⁵ phi= -.135

¹⁶ phi= -.135

¹⁷ phi= -.294

¹⁸ phi= - .203

health insurance ($p < .0005$)¹⁹. The relationship between not having a particular place for health care and not having health insurance is statistically significant ($p < .0005$).²⁰

¹⁹ $\phi = -.352$

²⁰ $\phi = .262$

Table 4.1 Univariate Analysis of Mexican Origin subpopulation

	Particular place for care?	Health insurance?
Yrs lived in US (%)		
1-10	28.6	25
11-20	37.2	37.9
21-30	22.3	23.9
31+	11.9	13.3
	$X^2(3)=21.996, p<.0005$	$X^2(3)=45.922, p<.0005$
Work Type (%)		
year round	88.8	89.8
other	11.2	10.2
	$X^2(1)=7.605, p<.006$	$X^2(1)=18.986, p<.0005$
Marital status (%)		
Married/living as married	62.2	61.2
Not married	37.8	38.8
	$X^2(1)=5.506, p<.019$	
Birth location (%)		
US	45.7	50.3
Mex	54.3	49.7
	$X^2(1)=14.061, p<.0005$	$X^2(1)=66.204, p<.0005$
Citizenship status (%)		
US	66.9	70.9
Mex	33.1	29.1
	$X^2(1)=31.457, p<.0005$	$X^2(1)=74.754, p<.0005$
Particular place for care? (%)	-----	
Yes		72.8
No		27.2
		$X^2(1)=52.875, p<.0005$
Health insurance? (%)		
Yes	78.5	-----
NO	21.5	
	$X^2(1)= 52.875, p<.0005$	
Med care outside of US? (%)		
Yes	9.5	8.0
No	90.5	92.0

MULTIVARIATE FINDINGS OF MEXICAN ORIGIN SUBPOPULATION

Health insurance

Table 4.2 reveals a test of the full model against a constant model for all Mexican Origin respondents was significant, indicating that the set of variables reliably differentiate between those who report having health insurance and those who do not ($X^2(4) = 113.298, p < .0005$). Nagelkerke's R^2 of 19.9 percent indicates a slight relationship between prediction and predictor variables. The Wald statistic suggests that the prediction of having health insurance increases for U.S. citizens (79.912, $p < .0005$), for those who are married or living as married (3.744, $p < .05$) and those who have year round work type (13.211, $p < .0005$). Age was not a significant predictor of having health insurance for all Mexican origin respondents. The estimated odds ratio (exp B) of having health insurance access for a U.S. citizen is 4.8 times the estimated odds for a non-U.S. citizen respondent, 1.4 times the estimated odds for a married person compared with a single, divorced or other status person, and 2.5 times the estimated odds for a respondent working year round, compared with working seasonally or having another status.

Particular place for health care

Table 4.3 reveals tests of the full model against a constant model all Mexican origin respondents ($X^2(4) = 56.470, p < .0005$), which reliably differentiates between those who have a particular place for health care and those who do not. The Nagelkerke R^2 of 10 percent suggests a slight relationship between prediction of having a place for health care and predictor variables. The Wald statistics provides evidence that the prediction of having a particular place for health care increases for those Mexican origin respondents

who are U.S. citizens (24.429, $p < .0005$), are of older age (15.737, $p < .0005$) and have year round work type (4.483, $p < .03$). The estimated odds ratio (exp B) of having a particular place for health care is 2.2 times higher for a U.S. citizen than for a non-U.S. citizen, 1.61 times higher for those working year round, and shows a very slight increase (1.03) for each additional unit (year) of age. Marital status was not a significant predictor of having a particular place for health care for Mexican origin respondents.

Table 4.2. Results of Logistic Regression for the probability of Health Insurance, All Mexican Origin

Variable	Estimate	Wald	Std. Error	Exp B
Citizen (1)	1.57*	79.912	.176	4.801
Marital Status (1)	.348***	3.744	.180	1.417
Work (1)	.856*	13.211	.236	2.354
Age	.014	3.099	.008	1.014
Constant	-1.373*	14.609	.359	.253

* $p < .0005$

*** $p < .05$

Table 4.3. Results of Logistic Regression for the probability of Particular Place for Health Care, All Mexican Origin

Variable	Est.	Wald	Std. Error	Exp B
Citizen (1)	.794*	24.429	.161	2.211
Marital Status (1)	.263	2.539	.165	1.301
Work(1)	.478 [†]	4.483	.226	1.612
Age	.030*	15.737	.008	1.031
Constant	-1.424*	17.783	.338	.241

* $p < .0005$

[†] $p < .03$

DISCUSSION

In this chapter I examine how the social organization and the link between health care and work constructs the health care access experiences of Mexican origin family members. These factors occur primarily through work, insurance access, income and citizenship. The images of health care experiences of Mexican origin family members that develop from these findings suggest that health care access is far more complex than those portrayed in the dominant narratives.

Qualitatively I find that U.S. citizenship and having health insurance are extremely important aspects of health care access, as other health research shows. But this is only a partial aspect. Social class is an important aspect as well. Having a job that provides health coverage is not helpful if it isn't affordable. Similarly, family members regularly have different types of coverage at different times, for different reasons. Additionally, some research suggests that marriage may increase the likelihood of having access to health coverage, but only for some higher income spouses (Harrington Meyer & Pavalko, 1996; Karas Montez et al., 2009). In this study, as will be discussed in the next chapter, three respondents have health insurance through a spouse—two women and one man. The insured man and one woman work but pay for their own insurance through their spouse's employment since their job doesn't offer health care benefits or it is too expensive. The third person, a stay at home mom, pays for health insurance through her husband's employment. And while two of the three respondents are characterized more by being working class than being in a "higher income" category, the qualitative research suggests that marital status may or may not play a role in health care access, since marriage would only play a role if a spouse has a job in which employment based health

insurance is offered and is affordable. For married service or factory workers, employment based health insurance may not apply. Similarly, four of the respondents were older and eligible for Medicare. This is independent of marital status.

Quantitatively, many factors emerge that are associated with accessing health care for Mexican origin family members, including years lived in the U.S., work type, birth location and citizenship. The logistic regression findings suggest that marital status work type and citizenship are important for health care access while citizenship, work and age are important predictors of having a particular place to go for health care. These findings suggest that researchers need to examine beyond full and part time work to include the impact of alternate work arrangements in health care models. But this is only a partial portrait. The findings also indicate that older Mexican American/Chicanos and Chicanas are more likely to be able to access health care than their Mexican born and young male counterparts.

SUMMARY/CONCLUSION

Several of the undocumented, documented and citizen respondents (n=5) have coverage sporadically or worry about losing their insurance, but all respondents (n=15) believe that coverage is important, contrary some notions of Latinos. Most (n=9) mentioned that it is an inconsistent system and that not everyone benefits equally—even those who have several layers of coverage. Health coverage is precarious.

Although the sample size is small (n=15), the findings which suggest that low income family members are more likely to face being uninsured than others in their families, including their insured spouses is not surprising within a political economy framework. Similarly, having employment which offers health insurance coverage doesn't necessarily translate to the being insured or to all family members having health coverage. Low income Mexican origin families are especially vulnerable to having uninsured family members. Contrary to the popular notions of family health care, or of immigrants avoiding or using too much health care, social class and immigration status seem to be larger contributing factors in who has health care coverage than marriage.

While on the surface this chapter highlights the complexity of health care access for Mexican origin family members, it also suggests the importance of examining health care access and work over time, as a trajectory. An unexpected theme uncovered by these interviews is that health care access is not static—it changes over time and place, for the most vulnerable (n=3) and for the most privileged (n=2) in the study—it changes according to life cycle for all. Child policies to age 18, Medicare coverage at age 65 for those legal residents or U.S. citizens who are eligible, and varied experiences in between.

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Again we find that medical resources are allocated along unequal lines (Chávez et al., 1992). All of these issues intersect with work and country of health care socialization.

A special note on work arrangements

The quantitative findings show us that non-traditional work arrangements make health care access difficult. This can be seen in the stories of the child care providers in the study. They like the opportunity to work from home. One even tells me that she wished she would have known about the program when her kids were younger because child care was difficult for her to arrange since she and her husband both worked. While they are happy for the opportunity, they all struggle with the low income generated from their employment, and the difficulty accessing health care. This program essentially makes them business owners, which means that theoretically they could purchase small business health insurance, or get health insurance through a spouse. All mentioned that they could not afford individual plans. Two are ineligible for public health insurance due to their immigration status, and one because of her income, as her husband works full time. These types of non-traditional work arrangements makes health care access difficult.

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CHAPTER 5: MEN AND WOMEN: WORK & HEALTH CARE ACCESS

What factors intersect with gender, age and work to shape health care access? How do the experiences of the uninsured differ from those of the insured?

This chapter examines the various health care issues among the uninsured (n=3) and undocumented (n=2, one unknown) in part one. While our health care system includes a “safety net” or a “loosely organized collection of publicly subsidized hospitals, local health departments, clinics and individual clinicians (Becker 2004, 260),” this safety net should not be considered a substitute for health insurance or quality health care. Access to health care is class-based and race-based—while the system is set up to distinguish between those who are “worthy” of care and those who are not, these respondents struggle because they feel they are “worthy” of care, because they work and contribute to society (Becker 2004).

In part two, quantitative findings related to gender and health care access are examined. While citizenship is statistically significant for women of Mexican origin, citizenship and work are found to be statistically significant for men. For having a particular place for health care, citizenship is statistically significant for women while citizenship, marital status, work and age are statistically significant predictors for men. This may suggest that health care access is more complex for men.

As suggested by the evidence, in part three, I argue that future health research needs to continue to examine how the intersection of work and health care contribute to access difficulties for women, men, immigrants and the U.S. born.

Several themes are examined in this chapter, including the following.

1) What Safety Net? Perspectives from the uninsured and the undocumented

2) Work and health care for the undocumented and the uninsured: “It’s not fair, we pay taxes”

3) Dual perspectives: Immigrant perspectives on U.S. health care delivery

Part One

WHAT SAFETY NET? PERSPECTIVES FROM THE UNINSURED

The uninsured are the most vulnerable in our society. The interviews I did with the uninsured families were the most disheartening, as well as the most rewarding. The uninsured experience health care difficulties, have less access to preventive care, and higher mortality rates. The uninsured struggle with this burden on a daily basis, and worry of the effects of this on themselves and their families. One should bear in mind that being uninsured is not an individual problem, as portrayed in the health literature. In fact, being uninsured and having minimal access to health care is a social problem, a condition induced by social conditions that harm segments of the population (Eitzen & Baca Zinn, 2004).

Veronica
U.S. resident
day care provider

The uninsured in this study are concerned for their health, especially in terms of accessing preventive care. Veronica has been uninsured for 4 years, although she had health insurance coverage prior to this. Two years ago she went to a local community health clinic funded by the state for a “women’s exam” (pap exam and mammogram). She knows the state will help cover the cost of the mammogram, and the pap exam may

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be about \$40, or at least that is how much it was the last time she went, but she still worried about the costs. (Do you get check-ups/exams on a regular basis?)

Well I want to, I want to do the checkups for women (breast and pap) . . . I know it's not that much—the pap, the most is \$40, they put a special program (CHDP?). . . they charge the state. . . the mammogram. . . But you know that the state has a program for the mammogram, but the pap I'm not sure if they cover it or not, but I can say that I don't have a lot of income because I don't have kids to take care of right now. They do a balance and they charge me. . . the last time, they said it was \$30 which really isn't that much for every 2 years. It's not that much, and regardless, one has to pay.”

When Veronica gets sick she goes to a public health clinic (part of the LA County Health Department, has a sliding scale).

The last time I went here to the clinic, it's like through the government, they help people with low income, they don't charge a lot. . . (what's it called?) I think it's part of the government because there was a social worker there last time I went, and she took my income estimate, and if my income was higher they were going to charge me, for example, \$40, and if I had lower income it would have been free, they don't charge you anything, and I remember she did it last time and they didn't charge me, because my income was at the limit. . . you have to prove, I have to take my husband's paycheck, my own, but I don't think I was taking care of kids yet, and the house, since we are paying, that counts as well, and these little houses here, that's income too, so then you have to prove how much your income is, and your payments, and that's why I think it's like the government because in other places you have to just pay and that's it. . . . The last time I went to another clinic, around here, because my eye was red (a little vein broke maybe) they charged me \$25 for the visit and the drops. I paid there. But it also wasn't that expensive. Because not all places charge that little. One has to find an affordable place for oneself. *Uno tiene que encontrar un lugar economico para uno.* Veronica worries about her own health, and about the financial and health insurance

constraints the family currently faces. She hopes she will eventually be able to find health insurance coverage to cover her own health care expenses she tells me.

Minerva
Undocumented
9 years in US
Working poor, apartment renter
Grown children in Mexico

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Minerva is a 65 year old child care provider who has been in the U.S. 9 years (without documents). Her brother is a citizen and has lived in Los Angeles 40 years. She tells me that she didn't come to the U.S. "for the American dream" because she was doing fine in Mexico up until the mid 1990s. Minerva was from the upper-middle class in Mexico, the owner of an exclusive clothing boutique selling designer clothes. She lost everything due to the credit/finance fiasco in Mexico, and came to Los Angeles at her brother's urging. Her adult children stayed in Mexico. She worries about her health and her livelihood. She has been studying child development and needs 2 more classes to get her degree. She is always looking for health fairs, and affordable places to get health care. In the past she has paid out of pocket for a private doctor, which was too much at \$100 just for the office visit. Every two or three years she goes to a community clinic for women's exams and says that she has been to several. She continues talking about her fear of getting sick by saying, "I always try to prevent the flu—I take vitamin C, I ask someone to buy me "aderejil" (a homeopathic medicine) in Mexico when they go, I take royal jelly, which I've been taking for years, I get a flu shot. . ." In describing the last time she was sick and had to go to a medical clinic, Minerva adds,

I was sick a few years ago, one of the little girls (for whom she provides child care) had the flu and she passed it on to me. I started out just taking over the counter pills and syrup, but after 8 days I wasn't getting better, I couldn't breathe and I had to close the day care. I went to this place (medical clinic) that I trust—I made an appointment and I went. They left me like an hour—just waiting. They gave me 2 injections and an inhaler. I was in the exam room 2 hours by myself. It was \$200 in medicines (total cost?), thank goodness it wasn't something more serious. The little girl kept coming to me. I worried about something more serious in my lungs—where else would I go? I couldn't pay \$400 each time."

These scenarios show the difficulties the uninsured (women in these cases) family members face regarding accessing preventive and urgent care. When faced with an

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urgent situation, they go to a place they know, often close to their homes or recommended by friends. Cost is a large consideration. These uninsured women share their concerns with me, knowing that preventive care is necessary, but the costs often make it a low priority when they have other priorities that need to be taken care of with their low incomes. All three told me that they have looked and continue looking for individual health care policies that are affordable, to no avail. Similarly, several reasons were brought up that explain why working family members may not be insured including: the coverage offered by the employer of a spouse is too expensive to cover the whole family, they do not qualify for public health insurance, and individual health plans are prohibitively expensive. Also, legal status is an issue. The “safety net” has large gaps and doesn’t guarantee access timely or affordable access (Becker, 2004). And our health care delivery system is especially consequential for the working poor. In fact, some research indicates that the working poor are more likely to be uninsured than the poor who are not working (Seccombe & Amey, 1995). “Bert and Wilensky (1987) justifiably conclude that being employed may in fact serve to restrict access to medical care for the poor rather than enhance it “(as quoted in Seccombe & Amey 1995, p. 169).

Clara and Rogelio

Undocumented, 18 years in the U.S.

Working poor-home owners

2 children at home, 19 year old daughter, 24 year old disabled son

1 employee

One undocumented and uninsured family truly represents the frustrations and difficulties working families face, and the importance of ensuring that health care is accessible to all. The 52 year old wife and mother, and her 58 year old husband, have lived in the U.S. for 18 years. They own their home, and they work as child care workers

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in their home, although they have both had full-time jobs in the past. They have two children, one, and their 24 year old son with cerebral palsy. Since he is undocumented, the only care he can receive is that which is specifically linked to his condition. So if he has a seizure he can see a neurologist, but he cannot see a gastroenterologist for his digestive problems. The family cares for him in their home because they do not qualify for most programs due to their legal status. Clara worries about her son's health and taking care of " 'the rhythm of life' making sure his stomach acids are balanced, giving him his medications, sometimes every few hours." And his health affects the health of the family. Clara and her husband wear back braces because they lift their son from the bed to the wheelchair to the couch because of their sciatica pain, pain that occurs in the nerve that runs from the lower back to the leg.

WORK & HEALTH CARE: "IT'S NOT FAIR, WE PAY TAXES"

As Clara recounts to me her indignation about their difficult financial and immigration situation, she insists, contrary to the collective image constructed of the undocumented, that "... [W]e are contributing to society, we are good people, we work, and we raise our family here. Our daughter goes to a community college because we cannot afford the needed out-of state tuition for a 4 year public university." I think this indignation serves her and her family well. Not only does it allow her to resist the dominant negative "illegal" narrative, but it also allows her to construct a comparison between "us hard working immigrants" and "those (other "minorities) who get health care from the state who do not really deserve it, who are just taking advantage." She says, "we are suppose to be business owners, but we, the 4 of us, do not have health

insurance, we could if we paid more than \$1000 a year, which is too much for us, but the money that we spend on mortgage, taxes to the IRS of the business, my daughter's school, after that,

you see by looking at my tennis shoes that we don't even have enough for shoes (laughs). We are of the large group of people who work very hard, difficult hours, and barely cover our basic needs, we have (been here) 17 years and we haven't taken a vacation, haven't gone out to sight see (pasear) or to any place to rest, outside of work--like we know (conocemos) Pasadena, Anaheim, maybe I know (have been to) Santa Monica, but I don't know (haven't been to) Santa Barbara. . . 17 years here, we don't know many things, not hiking in the mountains in San Bernardino. I'd love to go hiking in the mountains in San Bernardino. We don't go out for the weekend because it's like spending what we would eat in a week. . . to keep our sanity, we go to church, we do what we have to do here at home, we play dominos. . . our daughter goes out with her friends, we invite them here to BBQ, and these are our only diversions. And we also have to think what to do if we go somewhere, got to transport F (the son). Right now my husband and I don't have severe problems, sometimes we just feel tired, or maybe my blood pressure goes up or down, and when this happens I just go lay down for 15 or 20 minutes, we get up and keep working because we don't have any other options. Actually we don't know if we are diabetics. Whenever they have a health fair, to test for. . . that's when we find out about our health, and that way we know we don't have high cholesterol. Let's say we're a little anxious. If we had a tumor, we wouldn't know we couldn't go to the doctor. . . We worry, so we try to eat as healthy as possible— vegetables, fruit, try to eliminate red meats, and we worry very much about our health, but we count on the fact that, how can I say it, we worry about the financial and legal factors that don't allow us to. . . The curious thing is that, because of our legal status, we don't have access to a health program that we *have a right to*, but even given our legal status, the IRS doesn't mind taking our taxes. We pay our taxes they tell us to pay with our federal ID number, we pay between \$6000-\$8000, I have proof. I have the copies of the bills to the IRS, but we don't have access to medical care.”

She continues, telling me the family pays taxes directly through their child care business, and indirectly, through their purchases and bills, yet does not have access to health insurance, “and so then that's the part that one considers unjust, right?”

DUAL PERSPECTIVES: IMMIGRANT PERSPECTIVES ON U.S. HEALTH CARE

Of the respondents who were born in Mexico (n=9), all of them at some point during the interview mentioned the good health care they have or had received in their country of origin, and the ease of access to health or dental care.

Mario and Flora

U.S. residents

8 years in the U.S.

Working class-apartment renters

2 adult children-daughter in Canada, son in Mexico

I ask Mario to give me some background about his work history in Mexico and how this related to his health care. He tells me that he worked in business administration at his first job in the public sector (the government railroad) for 15 years, and at his second job in a private firm for 19 years. The railroad sector has its own physicians/hospitals/specialties for employees and families in the industry. His two children were born there, and his son had open heart surgery at a government hospital as a baby. I get the feeling he tells me this to show that he had confidence in the hospitals.

We have dental and vision coverage here. I go to Guadalajara to see the dentist. I went to the dentist here 2 years ago. It didn't work well, it hurt me and I did it again over there. I prefer to go to the dentist over there—the cost is less, they do a better job, and it has the same risk. It ended up being about \$2000. The dentist gave a guarantee—he gave an implant with new technology

His wife Flora's story is a little more complex. Growing up, Flora's family had connections to California. Her mother brought her family here illegally in the 1960s after Flora's dad died. Flora says that her mother struggled to find work then. She had been a housewife with three small children. They struggled for a year while her mom worked at a Los Angeles factory where they made bathing suits, before returning back to

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Guadalajara. Flora studied a technical career in Mexico (*carera técnica*), working as a clinical lab tech at a hospital in Guadalajara for 8 years during her marriage, and then working in various clinical labs when her husband got transferred to smaller towns. Later she taught computer classes for a few years, until she stopped working to help out at her mother's business in Guadalajara, before emigrating to the U.S.. During her marriage, she used the social security hospitals (*el seguro social del trabajo de mi esposo*) via her husband's employment, which was easier and nicer in large cities like Guadalajara, where her children were born, than in smaller cities where they lived later in their marriage due to work transfers. She preferred to pay for a private dentist and gynecologist when her husband got transferred to smaller cities.

Doña Maria

U.S. citizen 36 ½ years

middle/upper class homeowner

Cares for elderly mother

2 grown daughters, one married, one in college

I have had health insurance in the U.S. since 1975. If my husband and I didn't have it, we would never go to the hospital, nobody would go—we would be dead today. You know when people don't have--go to the ER to say goodbye. . . And if we didn't have health insurance then we could go to a military hospital. My children were born in military hospitals. But in Mexico, as long as you work you can see a doctor. They have nationalized health care. With some health insurance, you can go there and here.

In the next section, I examine the quantitative data regarding women and men

Part Two

DESCRIPTIVES OF MEXICAN ORIGIN WOMEN AND MEN.

Table 5.1a shows a statistically significant (yet weak) relationship, between being a non-U.S. citizen and not having a particular place for health care for women ($p < .022$)²¹. For

²¹ $\phi = -.137$

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women, not having health insurance is also related to not having a particular place for health care ($p < .0005$)²². For men, the factors associated with having a particular place for health care are much more complex. Having lived in the U.S. for 10 years or less, is statistically associated with not having a particular place for health care, and living in the U.S. for 31 years or more is statistically associated with having a particular place for health care ($p < .0001$)²³. For Men having, other than year round work type is associated (slightly) with not having a particular place for health care ($p < .0001$).²⁴ Being single/not married is statistically significant and slightly associated with not having a particular place for health care in men ($p < .0005$).²⁵ This relationship is not seen in women. Men born in Mexico are not likely to have a particular place for health care ($p < .042$)²⁶, while not being a U.S. citizen is weakly associated with not having a particular place for health care ($p < .0005$).²⁷ It is not surprising that there is a statistically significant relationship between not having health insurance and not having a particular place for health care ($p < .0005$)²⁸ for men. For women, there does not seem to be a statistical association between having a particular place for health care and years lived in the U.S., work type, marital status, or country of birth.

For health insurance there doesn't seem to be a relationship between work type, and marital status.

²² $\phi = .319$

²³ Cramer's $V = .225$

²⁴ Cramer's $V = .225$

²⁵ $\phi = -.149$

²⁶ $\phi = -.092$

²⁷ $\phi = -.172$

²⁸ $\phi = .232$

Table 5.

Yrs live
1-10
11-20
21-30
31-

Work
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Married
Married
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Citizen
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Table 5.1a. Univariate Analysis of dependent and independent variables, women

	Particular place for health care?	Health Insurance
Yrs lived in US (%)		
1-10	26.9	16.9
11-20	37.5	39
21-30	19.2	22.1
31+	16.3	22.1
		$X^2(3)=19.856, p<.0005$
Work Type (%)		
year round	86.1	86.5
other	13.9	13.5
Marital status (%)		
Married/living as married	54.2 45.8	55.7 44.3
Not married		
Birth location (%)		
US	54	62.7
Mex	46	43.3
		$X^2(1)=37.393, p<.0005$
Citizenship status (%)		
US	74.8	84.2
Mex	25.2	15.8
	$X^2(1)=5.236, p<.022$	$X^2(1)=57.713, p<.0005$
Particular place for care? (%)	-----	
Yes		89.2
No		10.8
		$X^2(1)=28.314, p<.0005$
Health insurance?		
Yes	79.7	-----
NO	20.3	
	$X^2(1)=28.314,$ $p<.0005$	

5.1b. Univariate Analysis of dependent and independent variables, male

	Particular place for health care?	Health Insurance
Yrs lived in US (%)		
1-10	29.7	28.3
11-20	37	37.45
21-30	24.2	24.6
31+	9.1	9.6
	$X^2(3)=15.882,$ $p<.0001$	$X^2(3)=27.514, p<.0001$
Work Type (%)		
year round	91	91.8
other	9	8.2
	$X^2(1)=8.038, p<.005$	$X^2(1)=20.11, p<.0005$
Marital status (%)		
Married/living as married	69 31	64.7 35.3
Not married	$X^2(1)=10.815,$ $p<.0001$	
Birth location (%)		
US	38.7	42.8
Mex	61.3	57.2
	$X^2(1)=4.144, p<.042$	$X^2(1)=29.648, p<.0005$
Citizenship status (%)		
US	60.4%	62%
Mex	39.6%	37.2%
	$X^2(1)=14.399,$ $p<.0005$	$X^2(1)=42.891, p<.0005$
Particular place for care? (%)	-	
Yes		62.8
No	-----	37.2
		$X^2(1)=26.482, p<.0005$
Health insurance? (%)		
Yes	77.4	-----
NO	22.6	
	$X^2(1)=26.482,$ $p<.0005$	

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MULTIVARIATE FINDINGS OF MEXICAN ORIGIN WOMEN AND MEN

Health Insurance.

Table 5.2 reveals tests of the full models against a constant model for women ($p < .005$) and men ($p < .005$) was significant, each indicating that the sets of variables reliably differentiate between those who report having health insurance and those who do not. For women, Nagelkerke's R^2 of 26.7 percent indicates a modest relationship between prediction and predictor variables. The Wald statistic suggests that the prediction of having health insurance increases for U.S. citizen women (46.145, $p < .0005$). Marital status, work type, and age were not significant predictors of having health insurance for Mexican origin women. The estimated odds ratio (exp B) of having health insurance access for U.S. citizen women is almost 8.5 times the estimated odds for a non-U.S. citizen woman in the study. For men, Nagelkerke's R^2 of 17.8 percent indicates a slight relationship between prediction and predictor variables. The Wald statistic demonstrates that the prediction of having health insurance increases for U.S. citizen men ($p < .0005$) and men who work year round ($p < .0005$). The estimated odds ratio (exp B) of having health insurance access for a U.S. citizen man is 3.7 times the odds for a non-U.S. citizen man in the study, and 3.3 times the odds for a Mexican origin man who works seasonally (and not year round). Marital status and age were not significant predictors of health insurance access for Mexican origin men.

Particular place for care.

Table 5.3 reveals tests of a full model compared with a constant model for women ($p < .0005$) and men ($p < .0005$) of Mexican origin, with both male and female full models differentiating (slightly for women) between those who have a particular place for health

care and those who do not. The Wald statistics suggests that citizenship (11.795, $p < .001$), marital status (7.475, $p < .006$), having year round work type (5.622, $p < .02$) and age (5.680, $p < .02$) result in being important predictors of the probability of having a particular place for health care for men, compared with only citizenship (4.248) for women. Marital status, work type, and age are not significant predictors of having a particular place for health care for women of Mexican origin. The estimated odds ratio (exp B) of having a particular place for health care is almost two times higher for U.S. citizen men than for non-U.S. citizen men (1.940), more than three-fourths higher for those men who are married or living as married compared with single, divorced or other men (1.766), twice as high for men who have year round work type compared with those who have seasonal or other work (2.006), and suggests a slight increase (1.023) in each additional unit (year) of age. The estimated odds (exp B) ratio of having a particular place for health care is 4 times higher for U.S. citizen women compared with non-U.S. citizen women.

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Table 5.2 Results of Logistic Regression for the probability of Health Insurance, Women & Men

Variable	Woman				Men			
	Est.	Wald	Std. Error	Exp B	Est.	Wald	Std. Error	Exp B
Citizen (1)	2.135*	46.145	.314	8.457	1.31*	36.767	.216	3.711
Marital Status (1)	.394	1.586	.313	1.482	.303	1.736	.230	1.354
Work (1)	.243	.355	.408	1.275	1.183*	15.448	.301	3.264
Age	.007	.245	.013	1.007	.019	3.065	.011	1.019
Constant	-.970	2.297	.640	.379	-1.660*	13.691	.449	.190

*P<.0005

Table 5.3 Results of Logistic Regression for the probability of Particular Place for Health Care, Women and Men

Variable	Women				Men			
	Est.	Wald	Std. Error	Exp B	Est.	Wald	Std. Error	Exp B
Citizen (1)	.681#	4.248	.330	1.975	.663^^	11.795	.193	1.940
Marital Status (1)	.062	.037	.321	1.064	.569##	7.475	.208	1.766
Work (1)	.467	1.343	.403	1.596	.696^	5.622	.294	2.006
Age	.018	1.682	.014	1.018	.023^	5.680	.010	1.023
Constant	-.047	.005	.642	.954	-1.845*	18.941	.424	.158

*p<.0005

##p<.006

^^p<.001

=p<.04

^p<.02

Part III.

DISCUSSION

This study is designed to examine the social context in which health care access, defined as having health insurance, having a particular place for care and accessing care outside of the U.S., and work intersect and are experienced by Mexican Origin family members. The images of Mexican origin health care that develop from these findings suggest that health care access is far more complex than those portrayed in the dominant narratives.

In the qualitative interviews, family members did not mentioned specifically coming to the U.S. for health care, contrary to the popular notion that Latinos use “free” health care (Chávez, 2008; Menjívar, 2002). One family member did mention emigrated from Mexico because she and her husband thought life would be easier for their disabled son. They had prior links to Los Angeles. According to this family, both countries have good and bad qualities—the good in the U.S. is that the disabled are helped and able to live good lives, and the good in Mexico is that everyone has access to health care. According to all Mexican born family members interviewed (n=8), health care in Mexico is more accessible than health care in the U.S.

The quantitative results for Mexican origin women and men are similar to what was said by the respondents, yet not what I expected from the literature. Overall I find that U.S. citizenship and having health insurance are extremely important aspects of health care access, as other health research shows. Work type also emerges as an important factor in the ability to access health care access for Mexican origin men, but not for Mexican origin women. Similarly, marital status is an important predictor of

having a particular place for health care for men, but not for women. This suggests not only that researchers need to examine beyond full and part time work to include the impact of alternate work arrangements in health care models, but that perhaps Mexican origin women experience specific barriers not experienced by U.S. born White or African American women.

Social location influences health care access. Although the findings suggest that Mexican origin men are slightly more likely to have year round work and to be married or living as married compared with Mexican origin women, contrary to the literature, this population of men are also portrayed as being more vulnerable to lacking accessing to medical care. Mexican origin men in this subpopulation have a lower educational attainment compared with their female counterparts, are more likely to be born in Mexico, and are less likely to be U.S. citizens than women.

The differences in health care access according to country of birth are quite drastic. While marital status and having a particular place for health care are predictors of health insurance for the U.S. born, and in turn, health insurance predicts having a particular place for health care, the situation is more complex for those born in Mexico. Those who have lived in the U.S. for 10 years or less, are less likely to have a particular place for health care or health insurance compared with those who have lived in the U.S. for 31 or more years. Work type and citizenship are important factors in accessing care, and marital status is important in determining a particular place of care for those born in Mexico.

The logistic regression findings allow us to summarize the situation even further. For the two most important variables of health insurance and having a particular place for

care, citizenship is the most important predictor of health care access. Work type and age are also important for Mexican origin men and Mexico born women.

Again, these findings suggest that all Mexican origin family members are not the same when it comes to accessing care. Examining differences along gender lines and place of birth are important in order to ensure health care access for this population.

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CHAPTER 6: STRATEGIES & NEGOTIATIONS AND IMMIGRATION

The family members I interviewed for this study show amazing resilience in the face of daunting political and social barriers, such as laws barring health care access for the undocumented, state public insurance income guidelines, state and market policies which contribute to individual insurance policies being priced out of reach of working families, as well as health care laws that include exclusions for factors that would (pg. 169) “prove detrimental to the business (Seccombe & Amey, 1995). Others express a more practical “it’s good and necessary but expensive sometimes” approach. All respondents, either explicitly said or implied, the precariousness of health insurance access and medical care coverage.

As discussed in earlier, family members use strategies, or adaptations to deal with or negotiate the difficulties they face, based on their available resources. Without reifying the term strategy as decisions made with a collective goal in mind (Wolf, 1991), I use it in this research to identify points of resilience and resistance to social and political constraints faced in the quest to access health care. The family, immigration and medical literature suggest that family members engage in various strategies to adapt to economic and other life situations. For example, Menjivar (2002) finds that Guatemalan women develop networks or uneven “patchworks” that link them to information, formal care providers, informal treatments and to obtain pharmacy products. Along these lines, Heyman, Nuñez and Talavera (2009) find that unauthorized immigrants in their study develop networks through other immigrants but also through trusted institutions, such as schools, other healthcare providers and outreach programs. Other similar strategies include accessing medical care at the border, asking Mexican doctors to make house calls

in the U.S., and asking trusted family members to obtain needed medicines at Mexican pharmacies (Heyman, Nuñez and Talavera 2009). According to the literature, Latinos have less access to health insurance compared with other racial-ethnic groups, and struggle with other barriers to access care, yet these findings suggest that family members still find ways to access formal medical care. But under what circumstances? As Baca Zinn and Eitzen (2005) state, inequality structures life chances, or the context in which families develop conscious and unconscious solutions to social constraints. Exploring the internal dynamics of family life within the social context, such as changing economic and political structures, sheds light on how lifestyles often reflect adaptive and strategic responses to structural conditions. This is especially true for family members who have been defined in racial terms, such as Mexican heritage families (Baca Zinn, 1993). Along these lines, I suggest that Mexican origin families respond to structural constraints to health care access in adaptive and strategic ways. Although the use of this concept has been controversial, I use it in order to exemplify how family members act in their own interests even when faced with socially constructed constraints, such as occupational location, lack of health coverage or low income.

Moen and Wethington (1992) describe “family adaptive strategy” as a hypothetical concept that emphasizes family response to structural barriers and stressful events. This concept has been emphasized in several approaches to family research. The structural approach emphasizes the ways that larger social structural forces constrain the repertoire of available adaptations. The rational choice approach underscores the role of choice within the confines of structural constraints in an effort to maximize family wellbeing. The life course, the approach taken by the authors Moen et al (1992) points to

the importance of historical time, life stage, and context in delimiting both family problems and the possible strategies to deal with them.

In the family economy literature, what families do to achieve or maintain economic well-being or other objectives can be depicted as adaptive strategies at the micro level. Thus the critical issue becomes discovering what leads to the change or the strategy. For example, the family responds to shifting economic circumstances—what do families do in an effort to lessen the gap between family needs and available resources?

Most demographic studies look at the macro-level social changes when drawing on the notion of strategy. Family strategies in this instance are not guided exclusively by economic needs, but by the interaction of economic exigencies and cultural values.

Use of the term “strategy” becomes a way of talking about social continuities and social changes (or maybe ways of responding to political, economic and social change). In this case, adaptive strategies of families or family members seems an appropriate way of examining what family members do to access care. Health care access decisions are made at the individual, household or family level (not always rationally), while the barriers to health care are defined, shaped and constructed by the laws and policies of the state and the country. In other words, who has access and when they have access are socially constructed. Regardless of the barriers, individuals decide how to gain access. The family members adapt to the circumstances constructed by our society and strategize, or find ways, to access care when necessary.

Moen et al. (1992) suggest that there are three methodological issues that need to be contended with when using this concept: 1) the level of analysis, 2) the unit of analysis, and 3) problems of operationalization. The level of analysis of family strategy

for this study is the micro level. In the literature, the unit of analysis is frequently at the family, household or individual level (Moen et al 1992). In this research, I interview a family member about the strategies used by the family, which may include the household or family external to the household. This is possible since I focus on the process itself, not on broad patterns of collective behavior. I *operationalize* family health care strategy to be the actions families and family members devise for coping with, if not overcoming, the challenges of accessing the health care system, and for achieving this goal on some level in the face of structural barriers. Family health care strategies could be formal or informal and may relate to one incident or may be long term.

Several themes emerged during the course of the interviews will be discussed in part one. These themes include: 1) Everyday strategies, 2) “Transnational medical care” and 3) Special issues. I begin this chapter discussing the everyday strategies discussed by various participants. These strategies vary along income level, health insurance status, immigration status and familiarity with local and Mexican health care systems. It is apparent from these qualitative responses that these participants do what they need to do in order to seek care. One main strategy discussed along incomes lines is accessing health care in Mexico. This occurred mainly among those who had previous experience with the Mexican health care system. This occurred in three different ways. One way included “taking advantage” of an already planned trip or vacation to Mexico. While in Mexico the respondent would see a medical doctor or dentist or buy some medicines at a pharmacy. A second method of “transnational medical care” suggested by the respondents included going to the border town of Tijuana specifically when the U.S. health care system was unresponsive. A third manner in accessing the health care system

in Mexico was via proxy—asking a friend of family member to purchase known medicines when in the other country.

In part two, I examine the larger context of health care among the U.S. born and Mexico born. In other words, I examine the relationships between work type, and marital status on having a particular place for health care, having health insurance and accessing medical care in Mexico. I include time lived in the U.S. for those born in Mexico. In part three, I examine medical care outside of the U.S. for those born in the U.S., those born in Mexico, and for women and men of Mexican origin. I discuss the findings of the chapter in part four.

Part One

EVERYDAY STRATEGIES

Several strategies emerged for the respondents, many of them along income, immigration and country of birth lines. For the lower income and older respondents, paying out of pocket expenses is difficult. Some ask family members to help cover the cost of equipment or procedures not covered by insurance policies, some parents pay for their adult children's health insurance and others have been relegated to using money earmarked for school to cover necessary expenses. One older U.S. born husband, Reynoso and wife Gwen who are both covered by Medicare when I visit them, and who both have chronic health conditions, continue to struggle with health care expenses when faced with the Medicare prescription coverage cap or "donut hole"²⁹. Medicare part D covers a set limit of prescriptions for the year. Once that amount is reached, the retiree who does not have supplemental insurance is expected to cover the full amount of the

²⁹ For more information on the Medicare part D "donut hole" gap, see http://bulletin.aarp.org/yourhealth/medicare/articles/understanding_and_dealing_with_the_coverage_gap_aka_the_doughnut_hole_.html, accessed January, 2010

prescriptions until catastrophic coverage kicks in, whereby 95 percent of the prescriptions costs are covered until the end of the year. Over time, these fees have been paid in various ways, through savings and through government supplement programs when available. Some pharmacy companies also have special assistant programs that cover their medications. The couple get assistance with filling out the paperwork from state programs and for special offers via the drug companies themselves, from the staff at physicians' offices, neighbors and their grown daughters.

On the other extreme, one particularly family—Maria, a semi-retired CPA and her retired military husband Peter, both have military and employer-based HMO coverage. Additionally, Peter has Medicare. He continues using the HMO insurance they have paid into their entire working careers, still accessing his military benefits from time to time when he gets fed up with insurance red tape, he tells me. He gets frustrated by the HMO/Medicare bureaucracy (although he seems to face VA bureaucracy as well he told me) but he likes just being able to go to the VA and make appointments without getting authorization. A few years ago, Maria went to a military hospital emergency room when traveling out of state, and was happy that, “they knew everything about me. Everything was in the computer in Texas.” Peter, the retired military man, has many health issues, and using one health insurance or another for different occasions seems to serve him well. Because he sees several doctors—cardiologists, podiatrist and primary care doctor and often needs special tests or medical equipment such as prosthetic shoes, waiting for authorization for a referral or to see a specialist can be difficult. Sometimes he just goes to the VA to see “my provider” he says. When I first interview him, he prefers to use his HMO insurance to see his cardiologists and primary physician, but then several scenarios

occur which encourage him to switch to using his Medicare coverage. He had to get daily therapy for a diabetes related condition and there was only one location in the county which would take his HMO insurance. His family members took him every day for several months, and with 2 weeks left in his treatment, the medical center stopped taking all types of HMO health coverage. He had to cease his therapy. Then two other doctors stopped taking his type of HMO coverage, while his cardiology group continued taking it. He couldn't change his HMO coverage because this would mean changing his cardiology group. His primary physician agreed to take Medicare. So now he uses Medicare for two of his physicians and his HMO coverage for his cardiology group.

An additional strategy that emerged is an ongoing shift in health coverage, depending on cost of the program and stage of life. For example, in the case of one young couple, a U.S. born woman married to a Canadian man, who both work full time, were covered through her employment when they got married. Later when she quit her job to care for a family member, they paid for their health insurance through her mother's small business health insurance. Later, after the relative passed away and the woman got another full time job, the couple switched their health insurance to her new job. The husband's company offered health insurance the whole time they have been married, yet it was always too expensive for them.

The strategies used by the most vulnerable families, the uninsured or the undocumented, to get immediate care include going to a nearby family clinic and paying out of pocket, or going to the county health department and paying on a sliding scale. Care may be free or low cost for some services at public health clinics based on income requirements, but all documents showing proof of income and residency need to be

presented. Preventive care for women may be covered through state programs. One family goes to community health fairs to gauge their health status. Other types of care, such as physicals, blood tests for cholesterol, diabetes, and female exams are put off. With regret.

In the case of legal residents who may be uninsured, the periods of being uninsured changed based on employment. One strategy employed by an uninsured mother of two small children who works as a day care provider, and who previously had health insurance through her full time factory jobs, is to make sure her children are covered, first through Medi-Cal, then through Healthy Families when the family income increased a little. Her husband is covered through his full-time work. She became a day care provider to be able to make some money while caring for her two small children. She says that even though she cannot afford health insurance for herself right now, she can at least contribute to the house payments.

Everyday negotiations

Prescriptions costs are a large concern, even to those with health insurance. Respondents engage in different strategies to cover their prescription medicine and medical equipment costs. These include asking the doctor to double the dosage, then using half the medicine necessary to ensure it lasts, asking a relative with better pharmacy coverage to get a prescription for a name brand ointment from her own physician, using samples from the physician for name-brand medication, settling for (\$15) generic medication when a (\$50) name-brand prescription is preferable³⁰, but

³⁰ In general, name brand and generic medications may perform the same function, but in some cases, name brand medication may have special qualities that make it appealing, such as having to take less dosage per day. Similarly, some people may not be able to tolerate a generic version and can only take the name brand. Sometimes the name brand medication does not exist in generic form. In this case, the name brand

financially out of reach, and using the drug-manufacturer discount programs to reduce the price of necessary prescriptions.

In the case of Mrs. G, a U.S. citizen, transnational elderly respondent who lived in the U.S. (she is now deceased), started out buying all of her medication in Mexico and bringing them back with her or having relatives bring her medications to California. While this was sometimes costly and bulky, she was able to have medication for a significant time. Over time, with the shift in Medicare prescription requirements, and with her increased comfort in U.S. doctors, she later began taking her medication with her to Mexico when she would visit. This would require negotiation with her physician and pharmacy for stays longer than 30 days.

“TRANSNATIONAL MEDICAL CARE”—MORE THAN JUST CROSSING THE BORDER

For those who have previous experience with another health care system, specifically in Mexico, two strategies emerged: one, I previously suspected, based on personal family experience and anecdotal evidence, I call “*transnational medical care*.” In this scenario, Mexico born U.S. residents or citizens who have health insurance, “take advantage” (*aprovechar*) of their vacations to Mexico, to visit family or during the holidays, to see the dentist, get medicines at the pharmacy, or seek medical care for an unresolved issue. Veronica gets her teeth cleaned, or maybe a cavity filled when she goes on vacation because “I don’t have a dentist here, and it’s more economical there.”

was a time-released version of the medication, and the generic version has to be taken twice a day. The time-release version will not be available in generic form until sometime later this year.

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Mario, a 58 year old U.S. resident who was born in Mexico, says that dental care is too expensive here, and prefers seeing the dentist in Mexico when he is there. A similar situation is seen with those respondents who do not have health care. (Or do at one point and don't at another).

Mrs. G, a 93 year old U.S. citizen grandmother and great-grand mother who was born in Mexico, had Medicare at the time of her interview. (She is now deceased). She came to the U.S. from Mexico in the 1980s, as a legal resident, to be with her daughter, several years after her husband died. Mrs. G's history in Mexico suggests that she never worried about getting medical care there. Her husband had a good job, so she and her family could go to the private sector hospitals, or they could get private medical consultations, which is what they usually did. Mrs. G was as a teacher when she was younger, and stopped teaching school in the early years of her marriage. She has six children, 20 grandchildren and nine great-grandchildren. Since first moving in with her daughter's family, she would return to Mexico at least once a year to see her other children and see "her doctor" when she was there. She did not have U.S. health care coverage. As she got older and began to experience declining health, she continued going "home" to visit her family and see her family doctor. Mrs. G tells me that she is diabetic and sometimes her knees hurt, but otherwise she is healthy. Her daughter mentions that before Mrs. G had U.S. health coverage, they used to buy her medications in Mexico and bring them back to the U.S. Eventually Mrs. G became a U.S. citizen and later received Medi-Cal. Then when Medicare began, she saw a U.S. primary physician on a regular basis, going with her daughter or granddaughters to see the doctor. At this point, Mrs. G tells me, she would take her U.S. medications with her to Mexico when she

visits. The only problem she has now with her medication is if her trip would exceed 30 days. If her trip exceeds 30 days, Medicare will not give her more medication, so someone will either “get it” to her in Mexico, or she will ask her son or daughter-in-law to buy the equivalent medication there. “It is all the same brands.”

The second kind of *transnational medical care* scenario involves seeking care in the border town of Tijuana specifically for an unresolved issue. Enid describes a time when her dizzy spells weren’t resolved after seeking treatment with her HMO physicians, so she and her husband agreed to go to see a doctor in Tijuana that they heard advertised on a Spanish-language radio station.

The consultations were expensive, and so was the medication that the doctor prescribed to me.” [Where did you get the medication? Was it easy to get?] “The medication was right there, I bought it from his office (consultorio).” [Did the medication make you feel better?] I felt better while I was taking the medication but I had to stop a few months later, because it is not easy to go all the way over there (Tijuana) from here (Los Angeles) on a regular basis (laughing).

When I ask how she’s been feeling since then, she said that she still has her dizzy spells.

Similar to Enid’s experiences, Margarita, a 21 year old student who lives with her aunt, describes her frustration with her doctor as she describes her excruciating headaches that start behind her eyes. “They keep telling me it’s sinus infections, but nothing is working. So I go to Tijuana to see doctors there. Doctors here only focus on the symptoms. Doctors in Mexico focus on the whole person.”

A related strategy, practiced by U.S. born and Mexico born respondents, is to ask a friend or relative going on a Mexican vacation (and in general, any Latin American country) to bring back a specific medicine or medical product. These can be prescription,

cosmetic or just something known to the respondent. They may be maintenance prescriptions or something used on a routine basis by the individual or family. In fact, as I was in the process of writing this chapter, I overheard my mom talking with my cousin Patty. Patty is a legal resident residing in Phoenix, AZ although she was visiting her parents and siblings in Mexico for the holidays at the time of the call. In the course of the phone conversation with my cousin, my mom recounts a story about our neighbor (an older Mexican American woman born in Texas) who is using a retin-A .05 percent ointment (sold here in the U.S. by prescription) on her face to prevent wrinkles. The ointment was purchased in Mexico (I did not ask by whom). My mom asks my cousin to bring back several tubes of the ointment for herself and for the neighbor³¹.

In the next section I examine the quantitative findings for the U.S. born and Mexico born

Part Two

DESCRIPTIVES FOR U.S. BORN AND MEXICO BORN

Table 6.1a show the statistically significant, and weak, negative association between marital status and health insurance for US born respondents ($X^2(1)=6.194$, $p<.013$, $\phi = -.141$). The statistically significant relationship between having a particular place for care and health insurance is stronger ($X^2(1)=29.309$, $p<.0005$, $\phi=.306$). We fail to reject the null hypothesis of no association for particular place for health care and the independent variables, for seeking medical care outside of the U.S. and the independent variables, as

³¹ Personal communication, E. Acosta, December, 2009. My parents have great prescription coverage. When I asked her for permission to use this story, I also asked why she just didn't check to see if her insurance would cover it, she said that this was just as easy.

well as health insurance and work type, and health insurance and seeking medical care outside of the U.S. The results for the Mexico born are more complex.

For those born in Mexico, the findings in table 6.1b suggest a statistically significant association between having a particular place for health care and years lived in the U.S. ($X^2(3)=22.076$, $p<.0005$, $\phi = .222$), work type ($X^2(1)=6.386$, $p<.012$, $\phi = .119$), marital status ($X^2(1)=5.507$, $p<.019$, $\phi = -.111$), citizenship ($X^2(1)=18.016$, $p<.0005$, $\phi = .200$), and health insurance ($X^2(1)=29.309$, $p<.0005$, $\phi = .200$). While the relationships between the dependent variable, work type and marital status are weak (and negative for marital status), the relationships with the dependent variable and years lived in the U.S., citizenship and health insurance are stronger. A rather strong relationship between health insurance and years lived in the U.S. is shown ($X^2(3) =45.232$, $p<.0005$, $\phi = .318$), and a negative and weak association between health insurance and work is suggested by the analysis, ($X^2(1)=10.103$, $p<.001$, $\phi = -.150$). A statistically significant negative association is found between health insurance and citizenship status ($X^2(1)= 29.845$, $p<.0005$, $\phi = -.258$), while a positive and statistically significant association is seen between health insurance and particular place for health care ($X^2(1)=18.146$, $p<.0005$, $\phi = .200$). The null hypothesis of no association cannot be rejected for medical care outside of the U.S., and years lived in the U.S., type of work, marital status, citizenship, particular place for care, and health insurance.

Table 6.1a Univariate Analysis of dependent and independent variables US born

	Particular place for health care?	Health insurance?
Work Type (%)		
year round	90.2	91
other	9.8	9
Marital status (%)		
Married/living as married	56.4	56.6
Not married	43.6	43.4
		$X^2(1)=6.194, p< .013$
Particular place for care? (%)		
Yes		
No	-----	78
		22
		$X^2(1)=29.309, p< .0005$
Health insurance? (%)		
Yes	92.5	-----
NO	7.5	
	$X^2(1)=29.309, p< .0005$	
Med care outside of US? (%)		
Yes	3.6	4.1
No	96.4	95.9

Table 6.1b Univariate Analysis of dependent and independent variables, Mexico born

	Particular place for health care?	Health insurance?
Yrs lived in U.S. (%)		
1-10	28.5	24.9
11-20	37.5	37.9
21-30	22.1	23.8
31+	12.0	13.5
	$X^2(3)=22.076, p<.0005$	$X^2(3)=45.232, p<.0005$
Work Type (%)		
year round	87.6	88.6
other	12.4	11.4
	$X^2(1)=6.386, p<.012$	$X^2(1)=10.103, p<.001$
Marital status (%)		
Married/living as married	67.2	65.9
Not married	32.8	34.1
	$X^2(1)=5.507, p<.019$	
Citizenship status (%)		
US	38.8	41
Mex	62.2	58.9
	$X^2(1)=18.016, p<.0005$	$X^2(1)=29.845, p<.0005$
Particular place for care? (%)		
Yes	-----	67.5
No		32.5
		$X^2(1)=18.146, p<.0005$
Health insurance? (%)		
Yes	66.5	-----
NO	33.5	
	$X^2(1)=29.309, p<.0005$	
Med care outside of US? (%)		
Yes	14.5	12
No	85.5	87.9

MULTIVARIATE FINDINGS ON U.S. BORN AND MEXICO BORN

Health insurance.

Table 6.2 reveals tests of the full models against a constant model for U.S. born ($X^2(3)=8.684$) and Mexico born ($X^2(4)=51.341$, $p<.0005$) respondents in the study, with only the Mexico born full model reliably differentiating between those who have health insurance access and those who do not. The Nagelkerke R^2 of 14.9 percent indicates a slight relationship between prediction and predictor variables for Mexico born respondents, compared with a Nagelkerke R^2 of only 5 percent for those Mexican origin participants who are U.S. born. The Wald statistics suggests that the prediction of having health insurance increases for Mexico born respondents who are current U.S. citizens (18.522, $p<.0005$), have year round jobs (10.223, $p<.001$), and for older Mexican born respondents (7.813, $p<.005$). The estimated odds ratio (exp B) of having health insurance access for a U.S. citizen Mexico born respondent is 2.9 times that of a non-U.S. citizen Mexico born respondent, 2.5 times for a Mexico born respondent who works year round, compared with a Mexico born respondent who works seasonally, and increases slightly (1.030) for each additional unit (year) of age. Marital status was not a significant predictor of health insurance access for the Mexico born.

Particular place for care.

Table 6.3 reveals the results of logistic regression analysis for a full model compared with a constant model, for U.S. born respondents ($X^2(3)=8.502$, $p<.037$) and Mexico born respondents ($X^2(4)=38.516$, $p<.0005$). The Nagelkerke R^2 of 11.4% suggests a slight relationship between prediction of having a particular place for health care and predictor variables in the model for Mexico born respondents; The Nagelkerke R^2 of 4

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percent suggests a minimal relationship between prediction of having a particular place for health care and predictor variables in the model for U.S. born respondents. Wald statistics illustrate that current U.S. citizenship (9.17, $p < .003$), having year round work type (5.481), and age (10.113, $p < .001$), are important predictors of having a particular place for health care for Mexico born respondents. The Wald statistic for age (5.461, $p < .02$) in the U.S. born model suggests that it is an important predictor of having a particular place for health care in the U.S. born. Citizenship, marital status and having work type were not found to be important predictors. The estimated odds ratio (exp B) of having a particular place for health care is two times higher for U.S. citizens born in Mexico, compared with non-U.S. citizens, almost twice as high for those Mexico born respondents who work year round compared with those who work seasonally or have some other work arrangement, and shows a slight increase (1.034) for each unit (year) of age in Mexico born respondents. Marital status is not an important predictor for Mexico born respondents. For the U.S. born, the estimated odds ratio (exp B) for the probability of having a particular place for health care increases slightly (1.028) for each additional unit (year) of age

Part III.

MEDICAL CARE IN MEXICO

Mexican Origin Subpopulation

Table 6.2 documents the results of logistic regression analysis for a full model compared with a constant model, for all Mexican origin respondents ($X^2(4) = 15.590$, $p < .004$).

Nagelkerke R^2 of 4.3 percent suggests a slight relationship between the prediction of

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having gone to Mexico for medical care and predictor variables in the model for all Mexican origin respondents. The Wald statistic indicates that not being a current U.S. citizen (11.146, $p < .001$), and age (4.760, $p < .03$) are important predictors of having gone to Mexico for medical care. The predicted change in odds (exp B) of having gone to Mexico for medical care is lower for U.S. citizens than for non-U.S. citizens (.429), and a slight increase (1.024) in each additional unit (year) of age is suggested by the model.

Mexican Origin women and men

Table 6.2 documents the results of logistic regression analysis for a full model compared with a constant model, which is statistically significant for Mexican origin women ($X^2(4) = 24.297$, $p < .0005$) but not for Mexican origin men ($X^2(4) = 4.853$, $p < .303$). Nagelkerke R^2 of 18.7 percent suggests a slight relationship between the prediction of having gone to Mexico for medical care and predictor variables in the model for female Mexican origin respondents. The Wald statistic suggests that not being a current citizen (19.093, $p < .0005$) and age (4.236, $p < .04$) are significant predictors of having gone to Mexico for medical care for Mexican origin women. Marital status and work type are not found to be important predictors of the probability of having medical care in Mexico for women. The predicted change in odds (exp B) of having gone to Mexico for medical care is almost 8 times higher (7.938) for non-U.S. citizen women compared with U.S. citizen women, and a slight decrease (.961) in each additional unit (year) of age is suggested by the model for Mexican origin women.

Table 6.2: Univariate Analysis –Medical care outside of U.S.

	All Mexican Origin	Women	Men
Yrs lived in US (%)			
1-10	31.6	31.8	31.4
11-20	38.6	40.9	37.1
21-30	24.6	13.6	31.4
31+	5.3	13.6	-
Work Type (%)			
year round	85.3	88	84
other	14.7	12	16
Marital status (%)			
Married/living as married	64.9	48	73.5
Not married	35.1	52	26.5
			$X^2(1)=2.74$ $p<.098$
Birth location (%)			
US	20	44.0	24
Mex	80	56.0	76
	$X^2(1)=14.70, p<.0005$	$X^2(1)=17.13, p<.0005$	$X^2(1)=2.75$ $p<.097$
Citizenship status (%)			
US	41.9	32.0	46.9
Mex	58.1	68.0	53.1
	$X^2(1)=10.61, p<.001$	$X^2(1)=21.56, p<.0005$	
Particular place for care? (%)	62.7		
Yes	37.3	88.0	50
No		12.0	50
Health insurance? (%)			
Yes	57.3	48.0	62
NO	42.7	52.0	38
	$X^2(1)=5.78, p<.016$	$X^2(1)=8.73, p<.003$	

Table 6.3 Univariate Analysis-Medical Care outside of the U.S. (cont'd)

	U.S. born	Mexico born
Yrs lived in U.S.(%)		
1-10	-----	31.6
11-20		38.6
21-30		24.6
31+		5.3
Work Type (%)		
year round	93.3	83.3
other	6.7	16.7
Marital status (%)		
Married/living as married	53.3	67.8
Not married	46.7	32.2
Citizenship status (%)	-----	
US		27.1
Mex		72.9
Particular place for care? (%)		
Yes	73.3	65
No	26.7	35
Health insurance? (%)		
Yes	93.3	53
NO	6.7	46.7

Table 6.4 Results of Logistic Regression for the probability of Health Insurance, US or Mexico born

Variable	US Born				Mexico Born			
	Est.	Wald	Std. Error	Exp B	Est.	Wald	Std. Error	Exp B
Citizen (1)	--	--	--	--	1.076*	18.522	.250	2.932
Marital Status (1)	.825^	5.424	.354	2.281	.228	1.128	1.128	1.257
Work (1)	.721	2.544	.452	2.056	.902^^	10.223	.282	2.454
Age	-.004	.070	.013	.996	.029**	7.813	.010	1.030
Constant	.898	2.258	.598	2.456	-1.844*	16.813	.457	.158
^p<.020 ^^p<.001 *p<.0005 **p<.005								

Table 6.5 Results of Logistic Regression for the probability of Particular Place for Health Care, US born and Mexico born

Variable	US Born				Mexico Born			
	Est.	Wald	Std. Error	Exp B	Est.	Wald	Std. Error	Exp B
Citizen (1)	--	--	--	--	.727^^	9.117	.241	2.070
Marital Status (1)	.210	.603	.270	1.233	.344	2.642	.212	1.411
Work (1)	.152	.135	.415	1.165	.645^	5.481	.275	1.906
Age	.028^	5,461	.012	1.028	.033^^	10.113	.010	1.034
Constant	-.199	.145	.524	.819	-1.721*	14.696	.449	.179
^^P<.001 ^p<.02 ^^p<.003 *p<.0005								

Table 6.6 Results of Logistic Regression for the Probability of Medical Care in Mexico, US born and Mexico born

Variable	US Born				Mexico Born			
	Est.	Wald	Std. Error	ExpB	Est.	Wald	Std. Error	Exp B
Citizen (1)					-.396	1.467	.327	.673
Marital Status (1)	-.016	.984	.554	1.016	.182	.364	.302	1.200
Work (1)	.512	1.669	1.055	.599	-.042	.313	.377	.959
Age	-.004	.996	.023	1.004	+.030 [^]	5.252	.013	1.031
Constant	-.3292	.037	1.255	26.898	-2.929	5.252	.614	.053
[^] p< .02								

Table 6.7 Results of Logistic Regression for the probability of Medical Care in Mexico, Women and Men

Variable	Women				Men			
	Est.	Wald	Std. Error	ExpB	Est.	Wald	Std. Error	Exp B
Citizen (1)	-	19.093	.474	7.938	-.232	9.117	.306	.793
	2.072*							
Marital Status (1)	-.221	.245	.446	1.247	.429	2.642	.356	1.535
Work (1)	.705	1.121	.666	.494	-.289	5.481	.418	.749
Age	.040 [□]	4.236	.019	.961	.014	10.113	.014	1.014
Constant	-	10.180	1.000	24.268	-2.578	14.696	.630	..076
	3.189*							
*p<.0005 #p<.04								

Table 6.8 Results of Logistic Regression for the probability of Medical Care in Mexico, All Mexican Origin

Variable	Est.	Wald	Std. Error	Exp B
Citizen (1)	-.845 ^^	11.146	.253	.429
Marital Status (1)	.133	.257	.262	1.142
Work (1)	.006	.000	.351	1.006
Age	.023 [‡]	4.760	.011	1.024
Constant	-2.696*	26.728	.522	.067

^^P<.001 [‡]p<.03 *p<.0005

Part IV.

Discussion

This study is designed to examine the social context in which health care access, and work are linked, defined as having health insurance, having a particular place for care and accessing care outside of the U.S., occurs for Mexican Origin working families. The images of Mexican origin health care that develop from these findings suggest that health care access is far more complex than those portrayed in the dominant narratives of “choice.”

The voices of the respondents themselves lend to a complex web of patterns to describe ways of accessing health care. For the two lowest income respondents with no insurance who worry about their health constantly and describe their anxiety and resentment regarding their immigration status and lack of deserved and needed health care access, accessing the patchwork system is all they can really do, when they can afford to that is. While various other experiences emerge which suggest that those who are familiar with the U.S. and Mexican health care systems have a type of “back up” plan which can be accessed if their needs are not met by the U.S. system. Work in the U.S., have U.S. health insurance, yet if a procedure is too expensive or if a certain condition is not resolvable here, then they can “take advantage” of their travels and access the Mexican system when needed.

Quantitatively, I find that U.S. citizenship and having health insurance are extremely important aspects of health care access, as other health research shows. Work type also emerges as an important factor in the ability to access health care access for

Mexican origin families, suggesting researchers need to examine beyond full and part time work to include the impact of alternate work arrangements in health care models.

The differences in health care access according to country of birth are quite drastic. While marital status and having a particular place for health care are predictors of health insurance for the U.S. born, and in turn, health insurance predicts having a particular place for health care, the situation is more complex for those born in Mexico. Those who have lived in the U.S. for 10 years or less, are less likely to have a particular place for health care or health insurance compared with those who have lived in the U.S. for 31 or more years. Work type and citizenship are important factors in accessing care, and marital status is important in determining a particular place of care for those born in Mexico

What about accessing medical care outside of the U.S? This study suggests the importance of examining different types of health care access, including access in Mexico. Those born in Mexico, who are not U.S. citizens or who do not have health insurance are more likely to access care in Mexico. Age, not having health insurance and marital status for men are also indicative of accessing care in Mexico. What these findings suggests is that health care access in Mexico goes beyond “border studies” and should be examined as a transnational project, that is, as a process in which “immigrants forge and sustain multi-stranded social relations that link together their societies of origin and settlement” (Bash et al., 1997).

CONCLUSION

In order to illustrate how Mexican origin family members use and pay for health care, it is important to incorporate various levels of analysis. At the microlevel the findings suggest, even though these respondents come from different social locations, they have similar concerns about their health care access--How much does the insurance cost? How much does it cover? What happens if I lose my job and my coverage? Can I afford to pay at the local clinic?

The U.S. born

The U.S. born in this study seem to have the least barriers to health care access, which is supported in the literature. This may be because of higher class status and a better positioning within the U.S. labor market. Not only are they more likely to have access to U.S. health care compared with legal immigrants, they also have the choice of accessing the Mexican health care system directly, crossing the interior to purchase their own medicines or seek medical care, or indirectly via a friend or relative. These issues also seem to be true for immigrants who have settled in the U.S. for more than 20 years.

The uninsured

The uninsured are in a precarious situation regarding health care access, especially low income or undocumented uninsured. The uninsured get care through local clinics that they know of through word of mouth, or in the vicinity of their homes, and pay on a sliding scale. Others pay out of pocket at a private doctor's office. Most use the services at health fairs. Although they are forced to postpone check-ups they know they need,

they still engage in healthy behaviors, such as healthy eating and taking homeopathic medicines and vitamins. They may ask friends or relatives to get medication for them in Tijuana, since they cannot go themselves. Several told me they continuously look for individual coverage, yet it is outrageously priced. It is like they are paying the undocumented tax. I went to one meeting geared towards uninsured and undocumented Mexican Americans held at a Latino political organization in an incorporated part of Los Angeles, and not only was the coverage outrageously priced, I don't think it was true health coverage. I think it might have been a monthly supplement to health insurance.

Language as a barrier should not be outright dismissed. Putting these findings into context reveals that southern California has many store-front medical clinics geared toward Latinos. That's not to say that language isn't an issue. It is, but it is an issue of access. Health researchers need to put the language issues into regional context.

Another issue that is suggested by these findings is that several of the respondents themselves invoked the notion that undocumented immigrants come to the United States to use "free" health care, making it more difficult to access health care for everyone else. Several U.S. born participants lamented that immigrant Mexican families are the cause, or at least contribute to, the budget and health care crises in California while Spanish speaking families (citizens, residents and the undocumented) feel that they have a right to good, safe healthcare because they work and contribute to society and because they compare the U.S. system with the Mexican health care system, which is more egalitarian. Reminding us again that Mexican origin families should not be considered a homogenous group, let alone, all Latinos.

One surprising aspect suggested by these findings is that those who access medical care in Mexico are those who already have health insurance in the U.S. In fact, transnational health care access serves as a back up to health care in the U.S. for those legal residents and U.S. citizens who did not have dental coverage or who needed a second opinion, but had “regular” medical care. It was not engaged in by those born in the U.S. or by the undocumented, who are unable to leave the U.S. for fear of deportation upon their return. I assumed transnational health care would play a larger role for the uninsured and would be engaged in because of need, not because family members are taking advantage (aprovechar) of vacations.

The importance of having health insurance and medical providers cannot be overstated. As one 63 year old woman who has health care coverage told me, “If we didn’t have health insurance, my husband and I would be dead.” Those who do not have health insurance, find other ways to access care.

CHAPTER 7: CONCLUSION

This study confirms that health care access is a precarious endeavor.

The 15 family members interviewed in the qualitative part of the study were relatively settled, with immigrant participants having lived in the U.S. more than 8 years, and on average for more than 20 years. The majority (n=11) owned their own homes, and all had had health insurance coverage at some point in their lives. The undocumented appeared to be the most vulnerable and represented the uninsured at the time of interview (n=3). There weren't many differences between U.S. residents and citizens since all families had been in the U.S. long term. The most urgent issue brought up was health insurance access and affordability, not language. This is true even for the predominantly Spanish speaking. The most "injustice" was declared by those respondents who have experience with dual health care systems. Even with health insurance, Mexican origin family members who engaged in transnational medical care did so as a supplement to their regular care, along the lines of Azevedo (2001).

The quantitative data similarly suggest a complex picture of health care access along the lines of nationality, gender and country of origin. As seen in Table 6.9 (Appendix C), when we examine the variables related to health care access, citizenship is an important factor. This is true for health insurance access for Mexican origin, women, men and for Mexico born. Citizenship also impacts having a particular place of care and seeking care outside of the U.S.

Yet when we examine health care access from the categories of Mexican origin, women, men and born in Mexico, new patterns emerge. Citizenship, marital status and work are important predictors of health insurance for all Mexican origin, while

citizenship, work and age are important predictors of having a particular place to go to for health care. Citizenship was found to be the most important predictor of health care access and having a particular place for care, compared with men. For men, citizenship and work were most important for predicting health insurance, while citizenship, marital status and work were found to be important predictors of having a particular place for care.

Health care access for the Mexico born category is slightly more complicated, with citizenship, work and age predicting health insurance access and having a particular place to get health care. A relatively simple pattern emerges for the U.S. born: Marital status predicts health insurance and age predicts having a particular place for health care. Contrary to other studies which focus solely on immigration status or health insurance access, this study finds that accessing care in the U.S is more complex. Similarly, while previous studies on gender , marriage or occupational segregation and health insurance suggest that marriage and work are important factors in accessing health insurance for women, these studies suggest that citizenship is the most important predictor of health care access for women, yet marital status and work are important for men, along with citizenship. Finally, one important area which still needs to be examined systematically is health care access outside of the U.S. Citizenship and age are found to be important predictors of accessing care outside of the U.S. (In Mexico) for women and all Mexican origin, while no such predictors were found for Men, Mexico born or the U.S. born. Perhaps this is because the sample of those who had accessed care in Mexico was so small.

A holistic picture begins to emerge—one in which race-ethnicity, occupational segregation, nationality and gender, intersect with the organization of health care to contribute to and hinder health insurance access and use of medical services. This study suggests that health care access is a complicated, socially constructed process, in which, although we are all socialized into it, we nonetheless experience it differently across and within our social locations. Sociologists and health researchers need to continue to ask different questions and construct our research by refocusing our assumptions in order to get beyond the notion that health care utilization is an individual preference or cultural trait. This can only be the first step in assuring health care access for all.

The strengths of this study emerge from its Mexican origin focus and combined methodologies. I am afraid that more questions have been raised than have been answered.

The contradictory notions that Latinos do not access health care, and the popular notion that immigrants come to the U.S. to use medical care, both seem unfounded. The most vulnerable, the undocumented who are not working in full time jobs with health coverage, and those who have alternate work arrangements, are not likely to have private or public coverage, and therefore only seek medical care in urgent situations in low-cost settings when possible, yet they continue seeking to find affordable health insurance coverage. Higher income Mexican origin family members, and those who have more social resources, may be able to choose which health coverage to use, for which situations.

For the most part, this research suggests that health care access changes over time, that health insurance is a trajectory, changing over the lifespan for most families (and

individuals), depending on employment, income, presence of children and military duty. Mostly importantly, health care access is dependent on political and economic factors. Political factors include eligibility requirements defined by state public insurance programs, as well as immigration policies regarding eligibility to health insurance. Similarly, political and economic factors determine the type of market based system which exists and funding cuts for public health programs.

Finally, the findings demonstrate the importance of examining health care access across different social locations. The findings suggest that political barriers to care are more daunting than any cultural belief discussed in the literature, with young, Mexico born men facing the most vulnerabilities. We will only gain different information if we ask different questions.

Limitations

As with any research, there are several limitations in this study. In the quantitative data, questions of non-U.S. citizens regarding legal status or residency were not asked, therefore undocumented or documented status was not determined and could not be used as predictors of health care access. Similarly, household income was asked as a categorical question, not as a continuous question, and contained missing data. Income could not be used as a predictor due to the high number of missing data, and could not be constructed through other sources. For instance, variables for 100 percent, 200 percent and 300 percent of poverty were included in the dataset, but I could not use them because I could not validate these measures with the total household income variable. Several health researchers have used federal poverty level data as health care

access predictors. Household income is an important factor in paying for health insurance coverage and for out of pocket health care expenses. Similarly, income is necessary to construct Medi-Cal eligibility. Qualitatively, the respondents were rather similar—they were all settled in California for some time, and most (n=13) were in married households.

Additionally, the findings indicate the need for future research into the processes that contribute to transnational health care. The results indicated here were based on a small number of cases, but the implication is clear—U.S. Mexicans access medical care in Mexico. I hope the findings in this matter, although small, will be an impetus to further examination of this important issue. Additionally, future datasets aimed at Mexican origin/Latinos should be inclusive of categorical and continuous data to allow for data manipulation.

Policy Implications

This study has several policy and research implications. Any type of health reform legislation that is implemented needs to include a way to increase health insurance for Mexican origin women and men regardless of citizenship in order to ensure the ability to obtain preventive and urgent care. Women and men access care differently. Reducing citizenship barriers to care would benefit women many Mexican origin family members, while ensuring access to health care through work would not necessarily benefit Mexican origin women in this study. Additionally, health policy experts need to take a closer look at how work, immigration status and health insurance are linked in the U.S. Perhaps more health insurance collectives need to be maintained to assist the uninsured and those with different work arrangements in accessing care. Finally, low income remains a large

barrier to having health care access and the ability to stay healthy. The working poor are often penalized for making “too much money” to qualify for public health care. These requirements need to be examined or more working family members will continue to be failed by the health care system.

Along these lines, perhaps more health insurance policies should cover health care that is received outside of the U.S. (if this is desired by Mexican origin families). While this may not be feasible due to the difficulties of oversight, creative solutions to our health care crisis need to be examined before being eliminated.

This study exemplifies the complexities inherent in having a system in which work and health insurance are linked even when year round employment does not increase health care access in the U.S.

Additionally, the findings indicate the need for future research into the processes that contribute to transnational health care. The results indicated here were based on a small number of cases, but the implication is clear—U.S. Mexicans access medical care in Mexico. I hope the findings in this matter, although small, will be an impetus to further examination of this important issue. Additionally, future datasets aimed at Mexican origin/Latinos should be inclusive of categorical and continuous data to allow for data manipulation.

Recommendations

Several of the respondents spoke passionately about the need to make medical care affordable and more readily accessible, not only for themselves, but also for other

Latino families, and in terms of the health care crisis in general. I spoke at length with one U.S. born married father of a young son with a background in business administration. Rob compared the price of individual health insurance plans to car insurance plans—he says, “I can get car insurance for \$100-\$200 by picking the options I want—why can’t we do that for health insurance? There are thousands of auto insurance companies. Why can’t health insurance be sold across state lines like auto insurance companies? We have to increase the competition. It seems that everywhere I go has the same price for health insurance.” Rob also suggests that maybe we should have different types of policies at different ages. The individual policy he purchased for his young son, for example, is less expensive than a policy he would buy for himself or his wife. When I ask him what people who don’t have health insurance should do, he laughs, saying, “How much can you afford?” Depending on someone’s age, maybe they could just get catastrophic coverage, he suggests. Rob was uninsured prior to getting married, so his insight is especially important. He used to just pay out of pocket at a private doctor’s office if he got sick. He is leery of state programs, suggesting that if his family lost their health insurance coverage, even if they qualified for state programs, which they wouldn’t, he says, since they make too much money, it would still take time to process the paperwork, and they do not offer very good service. He works for a small business, and tells me that his company does not offer health benefits because it would be too expensive, more than the cost of purchasing an individual plan, as he has done for his son.

Another participant suggested demonstrating *en masse* in order to get better health care legislation which would cover everyone, citizens, legal residents and the undocumented.

As it turns out, all of the immigrants in my study moved to the U.S. as adults and many had been to the U.S. as children, to see family members who lived here or to work. This is an important distinction because the respondents who had experience with the medical system in Mexico, those who worked and went to school there, mentioned that the health care was better in Mexico, and the system was more accessible to everyone.³²

It is evident that respondents want to have health insurance coverage and are willing to pay for it out of pocket, but income is the limiting factor. Until we have a more accessible system, perhaps it would be possible to have health insurance collectives, in which the uninsured and small-business employees are able to purchase their insurance at collective rates. This would especially improve health care access for Mexican origin families.

³² Mexico has a national health care system, implemented in the 1950s, which is based on the Swiss health care system. It is complicated compared with the U.S., but simply put, public sector employees can access care at public sector health settings available in most municipalities (*seguro social*); private sector employees can access care at private sector health settings also available in most municipalities. All employees contribute to the *seguro social*. Those who do not have health insurance can go to a civil hospital/health department setting, which cost minimal, but also include long waiting times. Public and private sector employees also have access to other types of health services, such as paid maternity time, disability, etc. Anyone can see a private physician or go to a private hospital and pay out of pocket. (personal communication, Armando Castillo, January, 2010). Armando Castillo (Jan 2010) Personal Communication Arredondo, A. and Nájera, P. (2008) Equity and accessibility in health? Out-of-pocket expenditures on health care in middle income countries: Evidence from Mexico, *Cadernos de Saúde Pública*, 24, 12, 2819-2826 Borges-Yáñez, S.A. and Gómez-Dantés, H. (1998) Uso de los Servicios de Salud Por la Población de 60 Años y Más en México, *Salud Pública de México*, 40, 1, 1-11..

EPILOGUE: LATINO HEALTH CARE POLICY IN THE ERA OF HEALTHCARE REFORM

Something historic occurred during the writing of this dissertation. President Barack Obama passed several health care reform bills intended to reduce costs and increase access to health insurance. But this reform left the current health care delivery system largely intact. Health insurance is still linked to work, marriage, and citizenship—the “safety net” system is still in place (assuming adequate funding) and the working poor will still struggle to access health coverage, albeit with tax credits for buying health insurance plans. But this dissertation suggests that Latinos will not benefit from this reform.

First, making health coverage available and mandatory does not translate to affordable health care. The working poor need access to low cost and good quality medical services. Similarly, the undocumented, even those who are working and integrated into U.S. society, are left out of this reform. The system remains unchanged. What are the solutions?

I posit that it is necessary to decouple insurance and work via insurance collectives or a universal health care system. Or, if the current employment-based health insurance system is going to remain intact, and there is no reason to assume that it will not, then employers must provide health insurance to all of its employees, not just the higher income ones, but to the janitors, cleaning crew and part time workers as well (Becker 2004; Seecombe, 1995). Health insurance collectives and coops exist—perhaps one non-profit option is to expand these, not market based insurance brokers.

Lastly, these reform bills are evidence that focusing on controlling costs does not eliminate health care inequalities, although it may increase profits for insurance

companies and other health care providers. Only changing the health care delivery system will reduce health care inequalities. In the end, isn't a healthier society made up of healthy individuals and families? As Quadagno (2005: 6) reminds us, "We will never receive the coverage we need, until we (as a society) view health insurance as a social right, and not as a consumer product."

APPENDIX A

Inequality and Health Care Access: A Mixed Methods Study of the Experiences of Mexican Origin Families in California Consent Form (updated Sept 2009)

The cost of getting medical care, medical insurance and actually seeing a doctor are important issues that are being discussed across the nation. In California, Latinos are the fastest growing population, very likely to be employed, but not likely to have health insurance. Not many people are studying why this is the case. So, as part of my Ph.D. studies, I am interviewing Latino families in Los Angeles and Orange County and asking them to share their experiences with me regarding their work, health insurance and medical care.

Your participation in the study is completely voluntary and you will receive a small gift of thanks (such as a travel size hand lotion, a box of tea bags or a small toy for a child) for participating in the research study. Participation will involve an in-person or phone interview, which will take about half an hour to an hour. You can choose not to answer any questions you feel uncomfortable with, or you can stop the interview at any time without any penalty. There is a slight possibility of some minor psychological risks associated with participating in this study, such as feelings of discomfort or anxiety that might occur as a result of the questions. I encourage you to ask questions before or at any time during the interview so that we may minimize these risks. Also, I'd like to tape-record the interview so that I can be more accurate when I write about the information that you give me. I will only tape-record the interview with your permission. If you don't want the interview to be tape-recorded, you can still participate in the study. I am the only person who will listen to the tapes. To protect your privacy, your name will not be used in any tapes or notes. Instead, I'll assign you a number throughout the study and then I'll use fake names when I write any reports. The tapes or any information you give me will be erased if you decide that you don't want to be a part of this study. If you decide to participate, I'll erase the tapes when the project is finished, but I will keep the transcripts and notes from the interviews because I may be able to use the information for writing more reports in the future. I will keep any and all information related to the study in locked files in my office. Your privacy will be protected to the maximum extent allowable by law.

So that you know, I will have to share this study with my dissertation advisors and other professors who will help me do a good job in representing your experiences. The dissertation, or report, that results from this study will be published and kept at Michigan State University's main library. I may also use the information gathered from this study to write articles, books, and to present papers at conferences.

I really appreciate your time and the information you're sharing with me. It is important and will help me understand and accurately represent the health care experiences of Latino families. The research will let people know that Latinos care about their health, the health of their families and what types of sacrifices have to be made to get medical care. If you have any questions about this study, please contact Dr. Steven

Gold by phone at (517) 353-6352, by e-mail at gold@msu.edu, or by mail at Michigan State University, Department of Sociology, 316 Berkey Hall, East Lansing, MI 48824.

Or, if you have concerns about this study or questions about your rights as a participant of this study, you can contact Judy McMillan, Ph.D., Director of the Human Research Protection Program by phone at (517) 355-2180, by fax at (517) 432-4503, by e-mail at irb@msu.edu or by mail at Michigan State University, 207 Olds Hall, East Lansing, MI 48224.

Thanks,

Pauline S. Acosta, MPH

Michigan State University

Sociology Doctoral Candidate

You will receive a copy of this form for your own records when you sign it.

Please sign and date below if you are willing to be a part of this research project.

Participant's Name (Please Print) _____

Signature _____ Date _____

Are you willing to be tape recorded? ____ Yes ____ No

Inequality and Health Care Access: A Mixed-Methods Study of the Experiences of Mexican Origin Families in California

Forma de Consentimiento

El costo de obtener cuidado medico, seguro de salud y realmente ver a un medico son tópicos importantes que están en discusión en la nación hoy día. En California, la población Latina es la población que esta creciendo mas rápido, probablemente tiene empleo pero es posible que no tengan seguro medico. No hay muchas personas que estudian porque es este el caso. Entonces, como parte de mis estudios de doctorado (Ph.D), yo estoy haciendo entrevistas con familias Latinas, preguntándoles de sus experiencias del trabajo, seguro de salud y del cuidado medico.

Su participación en este estudio es completamente voluntaria y por su participación, recibirá un pequeño regalo de gracias (como una crema chica, una cajita de te o un juguete de niño). Su participación incluye responder a un cuestionario que dura aproximadamente media hora a una hora. Hay una posibilidad que su participación en esta investigación resulte en una molestia psicológica, como sentimientos emocionantes o ansiosos. Pero yo le ruego que me haga preguntas antes o durante el cuestionario para reducir estos riesgos. No tiene que responder a cualquier pregunta que usted no desee, y puede dejar en cualquier momento de participar en esta investigación sin ninguna consecuencia. También, me gustaría grabar la entrevista para ser más exacto cuando estoy escribiendo acerca de la información que usted me proporcione. Yo grabare la entrevista solamente con su autorización. Usted todavía puede participar en este estudio, si usted no desea que la entrevista sea grabada. Yo soy la única que voy a oír las cintas. También para proteger su privacidad, su nombre no será usado en ninguna cinta o nota. En cambio, yo le asignare un número que será usado a lo largo del estudio y utilizare nombres ficticios al momento de escribir cualquier reporte. Las cintas, o cualquier otra información que usted me proporcione, serán destruidas o barradas si usted decide no seguir siendo parte del estudio. Si usted permanece como participante de este estudio, yo borrare todas las cintas cuando se concluya el proyecto, pero voy a retener las transcripciones y notas de las entrevistas porque yo podría utilizar esta información para escribir otros reportes en el futuro. Yo mantendré bajo llave, en los archivos de mi oficina, toda la información relacionada con este estudio. Su privacidad será protegida al máximo de acuerdo a lo permitido por ley.

Para su información, y con el propósito de realizar un buen trabajo en la representación de su experiencia, yo voy a compartir este estudio con los asesores y supervisores de mi disertación así como también con otros profesores, quienes me ayudaran, con su experiencia, para lograr este objetivo. La disertación o reporte que resulte de este estudio será publicada y mantenida en la biblioteca principal de Michigan State University. Yo también podré utilizar la información obtenida en este estudio para escribir artículos, libros, y para hacer presentaciones en conferencias.

Aprecio mucho la información que usted esta compartiendo conmigo. Es muy importante y me ayudara a entender y representar las experiencias del cuidado de salud de las familias Latinas. Este investigación ayudara a la gente saber que los Latinos se

preocupen de su salud, el salud de sus familias, y de los sacrificios que hacen para obtener cuidado medico. Si usted tiene alguna pregunta acerca de este estudio, por favor llame al profesor Steven Gold al numero de teléfono (517) 353-6352, o por correo electrónico a gold@msu.edu, o mande un carta a Michigan State University, Department of Sociology, 316 Berkey Hall, East Lansing, MI 48824.

O, si usted tiene alguna preocupación acerca de este estudio o preguntas acerca de sus derechos como participante de este estudio, usted puede llamar a Judy McMillan, Ph.D., Director of The Human Research Protection Program por el teléfono (517) 355-2180, mandarle un fax a (517) 432-4503, o enviar un correo electrónico a irb@msu.edu o mandarle una carta por correo a Michigan State University, 207 Olds Hall, East Lansing, MI 48224.

Muchas Gracias,

Pauline S. Acosta, MPH
Michigan State University
Candidato Doctoral en Sociología

Le vamos a entregar una copia de esta hoja para su constancia después de que usted firme

Por favor a continuación firme y ponga la fecha si usted esta dispuesto a ser parte de este investigación.

Nombre del Participante (por favor escriba en letra de imprenta) _____

Firma _____ Fecha _____

¿Esta usted dispuesto a que se grabe la entrevista? _____ Si _____ No

APPENDIX B

Inequality and Health Care Access: A Mixed-Methods Study of the Experiences of Mexican Origin Families in California

Interview Questions: English Outline

Demographic questions/ Family history

- Age
- Gender
- # of family members in residence
- # of employed family members
- Birthplace/ length of time in U.S.
- Educational background
- Employment status
- location of family members/brief history of family

Workplace and health

- What kind of work do you do?
- About how many employees work there?
 - What's the size of your place of employment?
- How long have you been working here?
- Are you satisfied with your place of employment?
- Does your employer provide health insurance (general)?
 - Do you have health insurance through your employer?
 - Do other employees?
 - What are the criteria for coverage?
- Do you get sick pay or time off if you're sick?
 - What's the policy if you get sick?
 - What if one of your family members gets sick?
 - Is there a penalty if you take time off for illness?
- Experiences dealing with illness and work?
- If from Mexico: When you were working in Mexico, did you use the government health insurance/hospital (IMSS/seguro social) or did you pay to see a private doctor? Tell me about this.

Family and health

- Brief family health insurance history
- Do any of your family members have health insurance?
 - What kind?
 - How did they get it?
 - (Employer based) How much do you pay for it?
 - (State Health Program) How long will you have it? Criteria?

- Do you or any family members have the Mexican IMSS/*seguro social* ? Another health insurance you can use in Mexico?
- What happens when someone in your family gets sick?
How do you decide if it's important to go to a doctor or medical clinic?
How do you decide which doctor or medical clinic to go to?
Who makes the decision?
Do you see a medical provider for regular check ups? Other family members?
Who keeps track of the medical appointments for the family?
How do you and other family members get to the appointment?
Who keeps track of the medical bills/insurance papers? Are they difficult to understand?
 - Would this process be different if you did/didn't have health insurance?
What would be different?
 - Any family members chronically ill? (Asthma, diabetes, heart disease. . .)
 - Any family members taking medicines regularly? (above conditions, birth control pills, etc.)
 - How do you pay for medicines/prescriptions? What about the special things you need for your condition (like testing strips for diabetics, blood sugar monitor, etc.)
 - Have you ever gone to Tijuana for medical care or medicine?
Have you asked anyone to get medicine in Tijuana for you or a family member?
 - Have you gone to another place in Mexico for medical care or treatment?
Do you have family there?
 - Regularly or once in a while? What are some of the reasons? How did you decide?

Health care

- Do you have a doctor you see regularly, or a medical center to go to when you need to?
- Tell me about that place.
How did you find it?
How do they treat you?
Do they treat you like you have a choice of medical providers?
Are they polite and respectful?
- Do they speak your preferred language well? (Are there interpreters?)
- Is communication a problem with anyone in your family?
- What do you like about this place? What do you dislike?
- Do you have confidence in the medical staff?
- Where do the other family members go? How do you feel about this?
- When do you seek care? (Only for routine immunizations, when you feel sick, etc.)
Have you ever had to delay seeking care? For what reasons?
- Do you have to pay for any of your medical insurance or medical care?
Is it or has it been a problem?
Do you have trouble paying for your medicines? What do you do about this?
Are you a part of any programs that assist in getting medicine?
Do you have a "health savings account"?
- Has anyone in your family been very sick recently? Had surgery or been hospitalized?
- Has anyone in your family had a baby recently? Tell me about these experiences.

Possible Solutions

- Do you think that other Latino families get the care they need when they need it?
 - Do you know of any (other) family specifically who has had problems seeing a doctor?
 - Can you think of what can be done to help Latino families get care when they need it?
 - Should the government be involved? Should we change the health insurance system?
- Anything else you'd like to share with me about your family's healthcare, or anything else I should know?

Inequality and Health Care Access: A Mixed-Methods Study of the Experiences of Mexican Origin Families in California

Preguntas de Entrevista: Español

Demographic questions/Family History

- Edad
- Genero
- Numero de personas que viven en la residencia
- Cuántas personas tienen empleo (o son retirados) en la residencia
- ¿Donde Nació? ¿Cuánto tiempo tiene en los Estados Unidos?
- ¿Su nivel de educación?
- ¿Esta trabajando? ¿Cuántas Horas?
- Historia de familia (donde estan hoy?)

Workplace and Health

- ¿Que tipo de trabajo hace usted?
- ¿Cuántos empleados tiene la compañía?
(Es grande?)
- ¿Cuánto tiempo tiene allí?
- ¿Esta usted satisfecha con el lugar donde trabaja?
- ¿Su compañía ofrece seguro de salud? (general)
 - ¿Tiene usted seguro de salud con su compañía?
 - ¿Hay otros empleados que tienen seguro de salud con su compañía?
 - ¿Cual es el criterio para obtener seguro de salud con su compañía?
- ¿Le dan “horas de enfermo” (sick time) o tiempo libre de su trabajo cuando esta enfermo?
 - ¿Que pasa cuando uno esta enfermo en su trabajo? Cual es el plan, política?
 - ¿Que pasa si alguien en su familia se enferma?
 - ¿Si tiene que tomar tiempo libre porque esta enfermo, algo pasa?
- ¿Tiene usted experiencia con ser enfermo en su trabajo?
- Si trabajo en México: ¿Cuando estaba trabajando en México, uso Ud el seguro social/IMSS/hospital del gobierno? ¿O pago por un medico particular? Cuéntame.

Family and Health

- Brief family health insurance history
- ¿Alguien de su familia tiene seguro medico?
 - ¿Cual ?
 - ¿Como lo consiguieron?
 - (Empleo) ¿Cuánto pagan por el?
 - (Estado) ¿Por cuánto tiempo lo van a tener? ¿Cual es el criterio?
 - ¿Tiene Ud o su familia seguro social en México/IMSS? ¿U otro tipo de seguro Mexicano?
- ¿Que pasa cuando alguien de su familia se enferma?
 - ¿Quien decide si es importante ir con un médico o a la clínica?
 - ¿Quien decide a cual lado van?

- ¿Quien decide?
- ¿ Recibes cuidado medico regularmente? (Chequeos) ¿Y otros en su familia?
- ¿ Quien es responsable de hacer las citas médicos para la familia?
- ¿Cómo llegan Ud. y su familia a las citas médicos?
- ¿Quien es responsable con las cuentas medicas/ cuentas del seguro? ¿Toman trabajo para entenderlos?
- ¿Será este proceso diferente si tuvieron/ no tuvieron seguro medico?
- ¿Como? Cuéntame.
- ¿Alguien en su familia tiene una enfermedad como Asthma, Diabetes o problema del corazón u otra problema crónica?
- ¿Alguno en su familia usa medicina regularmente? ¿Como insulina, medicina de la presión alta o pastillas anticonceptivas?
- ¿Tienen problemas con el pago de sus medicinas/recetas? (Si Diabetes, ¿su aparato de checar su sangre??)
- ¿Ud ha ido a Tijuana para comprar medicina o ver un doctor?
- ¿Ha preguntado a un pariente que si pueden comprar medicina en México en su nombre?
- ¿Ud. ha ido a otro lugar en México para comprar medicina o ver un doctor?
- ¿Tiene familia allí?
- ¿Por cuales razones? ¿Como hizo ese decisión?

Health care

- ¿Tiene Ud un medico que ve regularmente, o una clínica medica o oficina donde puede ir cuando necesita?
- Cuénteme de ese lugar.
 - ¿Como lo encontró?
 - ¿Le tratan bien allí?
 - ¿Le tratan como si puede escoger su oficina medica?
 - ¿Son educados y respetuosos?
- ¿Hablar allí su idioma preferible? (Tienen intérpretes?)
- ¿Es una problema por alguien en su familia comunicarse con ellos?
- ¿Que le gusta sobre este clínica? ¿Que no les gusta?
- Tiene confianza en los empleados médicos de la clínica?
- ¿A donde van para cuidado medico las otras personas de su familia? ¿Como les gusta?
- ¿Cuando va usted a buscar cuidado medico—solo cuando es necesario? ¿O para un fisico?
- ¿En alguna vez, tuvo Ud. que esperar para ir con un médico?
- ¿Tiene Ud que pagar cualquier porción de su seguro de salud o su cuidado medico?
- ¿es o era una problema?
- ¿Es difícil pagar sus medicinas? ¿Que hace? (¿No los compra? ¿Va sin medicina?)
- ¿Es Ud. miembro de una programa que asiste en el compro de medicinas?
- ¿Tiene Ud. un “health savings account”—una cuenta de horarios específicamente para el salud?
- ¿Alguien en su familia ha estado muy enfermo últimamente? ¿Que tuvieron una operación o han estado hospitalizados?

-¿Alguien en su familia ha tenido un bebe últimamente?

Possible Solutions

-¿Piensa Ud. que otras familias Latinas tienen dificultades en conseguir cuidado medico?

-¿Conoce Ud. específicamente una familia que tiene este problema de ver un medico?

-¿Que piensa Ud. que podemos hacer para ayudar a las familias Latinas conseguir cuidado de salud cuando es necesario?

-¿Debe de hacer algo el gobierno? Debemos de cambiar la sistema de seguro medico?

¿Hay algo mas que me puede contar acerca de estas temas?

Appendix C

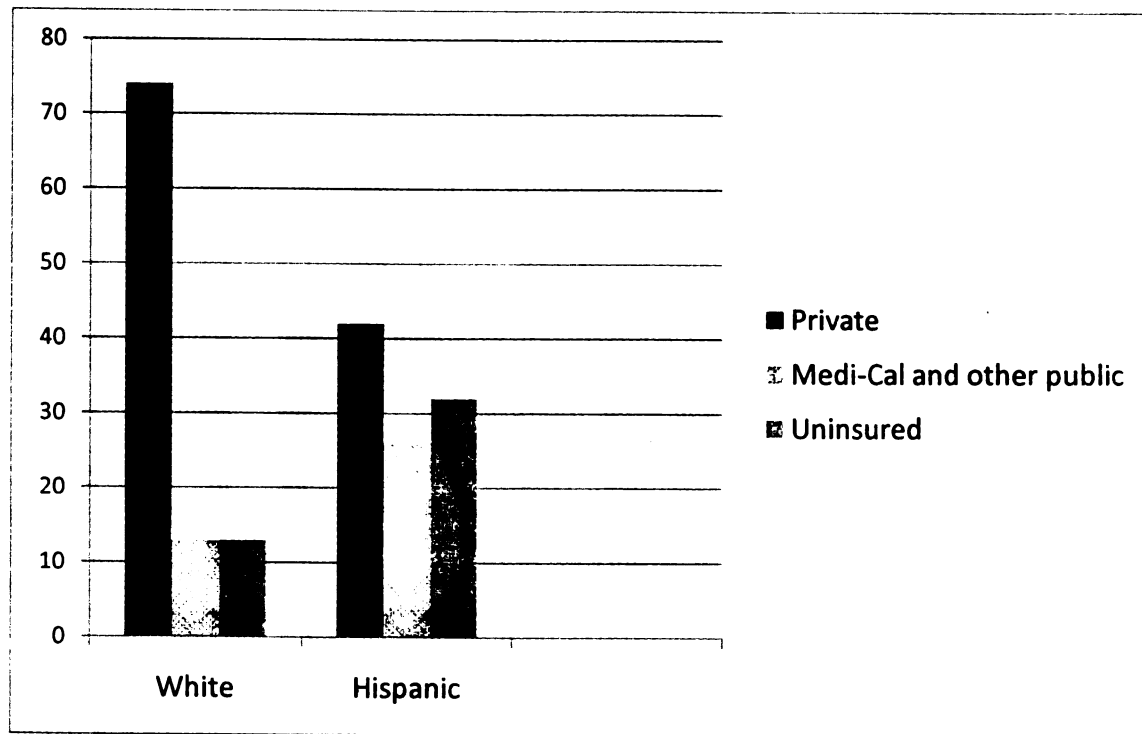


Figure 1: Health Insurance Coverage of the Nonelderly Population, 2008

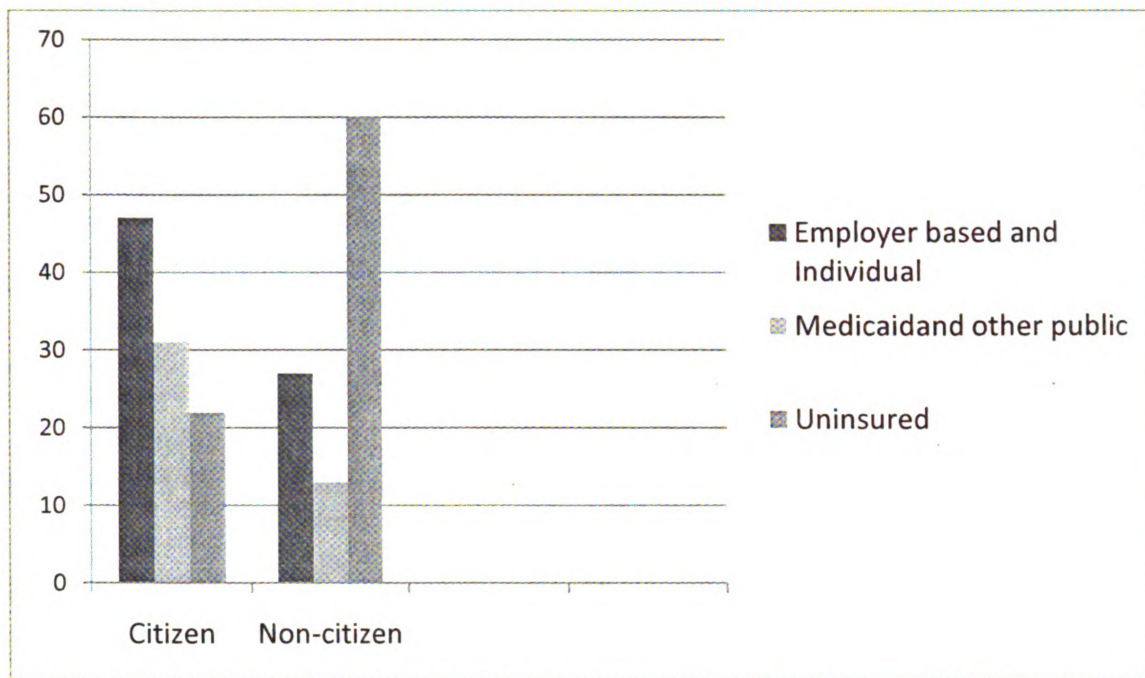


Figure 2: Health Insurance of the nonelderly by Hispanic Citizenship, 2008

Table 6.9. Logistic Regression Summary

	Health Insurance	Particular Place	Outside of U.S.
All Mexican Origin	Citizenship Marital Status Work	Citizenship Work Age	Citizenship (-) Age
Women	Citizenship	Citizenship	Citizenship (-) Age
Men	Citizenship Work	Citizenship Marital Status Work	--
Mexico Born	Citizenship Work Age	Citizen Work Age	Age
U.S. Born	Marital Status	Age	--

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