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INFLUENCE OF SOCIAL NETWORKS AND SUPPORT ON ACCESS TO HEALTH INSURANCE AMONG MEXICAN FOREIGN-BORN ADULTS

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ABSTRACT

Immigrants to the United States consistently lack the opportunities to obtain health insurance due to the lack of citizenship status, financial ability, and knowledge of how to access and utilize different programs and services. Ultimately, the lack of health insurance can lead to worse health outcomes among a population. Using the March 2010 Supplement of the Current Population Survey, I examine social determinants in health insurance coverage among Mexican foreign-born adults between the ages of 35 and 64. In particular, the analysis looked at the significance of social networks and support through the measures of spouse citizenship, state laws concerning immigrants' access to health care, the size of the Mexican immigrant population in the state, and access to other public programs. Living in a state with a large Mexican population and participation in other public programs do not lead to a higher usage of health insurance. However, being married to a spouse who is a United States citizen, naturalized or U.S.-born, was significantly and positively associated with insurance coverage. Further analysis needs to be conducted concerning the influence of state laws on rates of health insurance coverage.

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CHAPTER 1:

INTRODUCTION:

As immigration has reemerged at the top of the nation's agenda, new research is being conducted to more fully understand this growing segment of the population. Particular concern has been raised about the extent to which immigrants are able to access special programs and engage in society (Ku 2008). Over the past years, assimilation and acculturation have been the primary areas of interest in sociological research among immigrants. Assimilation, or an active engagement in mainstream society, has typically been associated with the adoption of majority culture through language, length of residency, and country of origin (Solis et al. 1990). However, an important aspect of immigration is ignored through the measures of assimilation and acculturation. In a world expanding through the processes of globalization, communication and patterns of migration have been altered—in particular, communication and migration have become much easier with the inventions of the last century (Alba and Nee 1997). This has led to the expansion of social networks among foreign-born, has altered the flow of information between different families and communities, and has redefined how immigrants adapt to life in the United States.

With the increase in the immigrant population over the past two decades, attention has shifted towards analyzing the usage and access to governmental programs among this population. In the United States, health insurance remains restricted—even while recent attempts by the Obama administration to provide affordable care to all Americans begin to be implemented (The White House 2011). Boundaries exists which limit one's ability to not only afford health insurance, but to access any governmental assistance programs. In fact, health insurance can be described as "a privilege." Health is not a guaranteed right, which has raised

concern from every corner of the health care debate. In particular, extreme controversy is created when immigrant rights surrounding health are discussed. Health insurance has the potential to be used as a measure of assimilation among foreign-born populations. Having some form of health insurance indicates further acceptance into American culture and an understanding of how to effectively access and use governmental programs (Cheng, Chen, and Cunningham 2007). Immigrants are continuously being denied care or are even unable to obtain care because of their financial situation, their lack of identification, and their lack of knowledge about how to attain assistance (Lessard and Ku 2003). Many simply do not have the means to pay for full coverage and comprehensive health plans. As health insurance has become more privatized and premiums have continued to rise, insurance coverage has continued to decline for those of lower incomes (Ku 2008).

Among members of the lowest socioeconomic group are immigrants new to the United States, particularly Mexican foreign-born (Morales et al. 2002). Immigrants come to this country searching for economic advancement. The instability of life for immigrants also contributes to the lower usage of health services. Many foreign-born do not have a particular place of residency or a fixed income. Because of this, they enter the country with little to no financial background or identity. The lack of financial stability inhibits access to health care (Solis et al. 1990). Basic necessities such as food, shelter, and clothing are needed before any additional money can be spent (Shipler 2004). So, in order to afford care, those new to the country first have to build assets and compile resources. This prevents individuals from seeking health care until necessary and discourages individuals from pursuing information about obtaining health insurance (Livingston 2008). Due to this process of obtaining financial security, immigrant populations remain at risk for small health problems becoming large, costly medical procedures,

or life threatening situations for extended periods of time after arriving in the United States (Ku and Freilich 2001).

Health care access among natural-born citizens and immigrants varies tremendously. It seems that the lack of knowledge of available health care options and the inability to obtain health insurance are some of the major causes of this health disparity. In moving to a new country, immigrants confront a steep learning curve that obstructs access to social institutions and challenges assimilation to the majority culture (Morales et al. 2002). Understanding how to use the private and governmental resources made available to individuals across the country remains a large problem among the immigrant population, particularly in accessing health care (Xu and Borders 2008).

Hispanics remain the ethnic group with largest rate of uninsurance. Among foreign-born Hispanics, the rate of uninsurance has risen to nearly 50% (Rousmaniere 2010). However, this rate includes all Hispanic ethnicities. Some will have much higher rates of insurance, while other segments of the population will have much lower rates that fall significantly below 50%. When compared to the general United States population, which has a rate of uninsurance of 16.4%, the Hispanic disadvantage becomes immediately apparent (Mendes 2011). Because of this staggering figure, particular emphasis has been put on the ever increasing Latino population in the United States and the quality of care that this population is obtaining in this country. Latinos are currently the largest minority in the United States. Outside of Asian populations, they represent the fastest growing minority, and it does not appear that this flow of individuals from Spanish descent is going to stop any time soon (Witt 2008). Hispanic have better health than the average United States white population despite higher poverty rates, less education, and limited access to health care (Cho et al. 2001). This phenomenon has been named the Hispanic

Health Paradox because it does not fundamentally follow the other patterns that have been found in society. It breaks the health-wealth variant and raises questions about the real impact of discrimination on health (Franzini, Ribble, and Keddie 2001). However, despite having better overall health, they are dying at a higher rate than the average population once contracting a disease.

Health concerns are emerging in this population as they continue to become a larger and larger portion of the population. The prevalence of obesity, heart disease, and diabetes is rising (Center of Disease Control and Prevention 2004). Unlike other groups of immigrants past and present, who have experienced better health outcomes over time, the overall health of Latinos is declining. Assimilation and acculturation were traditionally associated with positive effects on health. Acculturation tends to be accompanied by higher language proficiency, more stable living environments, greater time in the host country, and, in most instances, increased wealth (Ponce et al. 2006). These factors have been associated with better health statuses. However, Latinos do not demonstrate the benefits of acculturation, at least immediately after immigration. Their health, in fact, is negatively impacted by adopting the main stream culture. Certain behaviors are being changed that lead to increased rates of chronic and debilitating disease (Fennelly 2007).

More importantly, social networks and levels of social support have typically been ignored as access to health care among foreign-born populations is examined. Acculturation has continued to be used in research through several main proxy measures such as language, time spent in the United States, and increased affluence, which neglects the importance of knowing other individuals and using their experiences and knowledge to one's benefit. Vast and expansive social networks could potentially provide the knowledge that enables individuals to

gain health insurance, particularly if the social network provides valuable information and leverage to help its members access health insurance (Hagan 1998). In this analysis of Mexican immigrants between the ages of 35 and 64, I examine the association of social networks with health insurance coverage. The potential size and value of social networks will be measured through a variety of variables, including the citizenship of the spouse, state laws concerning immigrant rights, Hispanic population at the state level, and the use of other public programs.

CHAPTER 2

THEORY:

Social capital theory deals with the value of social networks and the benefits derived from social relations. There are various dimensions of social capital theory that have evolved over time. At the foundation of this theory is the core idea that an exchange or reciprocity will occur between both similar people and diverse people when brought together in a community or social situation (Coleman 1988). Various sociological theories deviate in opinion about which type of social network and relationships are most beneficial. A smaller, cohesive social network is often juxtaposed with a larger social network with weaker ties. Recently, however, more sociologists have begun arguing that a combination of these two types of networks is most beneficial to newly arriving immigrants (Granovetter 1973). Several prominent aspects of this theory will be outlined. Understanding the theory surrounding social capital can provide valuable insight into the role of social networks on immigrant access to formal health care and insurance.

Social capital is distinct from human capital. Human capital results from changes in a person during the development and cultivation of skills and capabilities, whereas social capital

refers to changes in and creation of relations among people (Coleman 1988). Those relations provide individuals with an investment and the use of embedded resources or social capital (Lin 2000). James Coleman, a leader in the emergence of social capital theory, declared that actions are shaped by an individual's social context. In other words, the actions that an individual can take are guided by the amount of social capital one has. Individuals enter into relations that provide some sort of benefit—be it emotionally, socially, or financially. In order to make being a part of a social group or network worthwhile, there must be profit derived from membership (Portes 1998). Coleman identifies three central benefits of social networks: 1) flow of information; 2) occupational mobility; and 3). trustworthiness and obligations.

All of these aspects mentioned by Coleman are affected by the depth and closure of a network. Since the beginning of human history, groups have formed around those with similar characteristics such as location, ethnic identity, and family ties. This has also been called homophily by sociologists (Lin 2000). Groups provide various aspects of support to an individual. However, there are varying opinions about what type of social network is best. Coleman argues that closure of network, meaning that norms are perpetuated and carried out, strengthens social capital and increases individual resources. Mark Granovetter and Nan Lin focus on the importance of "weak ties" or extended networks. Theorists of this perspective define the strength of tie in a network by the combination of time, emotional intensity, intimacy, and reciprocal services that exist (Granovetter 1973). There are benefits to be gained from having a variety of weak ties that require less of the above characteristics, and there are actually more weak ties within a network than strong (Granovetter 2005). The advantage from weak ties, argues Granovetter and Lin, lies in the more novel and diverse information that is obtained. Flow of information has been pinpointed by Granovetter as the most important aspect of an

extended network. Lin continues to examine weak ties through an investigation on the inequality of social capital. Those with an awareness of their disadvantage will be motivated to create vaster networks and establish ties with more resource liberties. This provides the individual with better information and greater influence in their immediate families, kin, and communities (Lin 2000). The more social capital one has access to, the greater likelihood of mobilizing resources for personal gain and benefit. Simply, with more contacts, one obtains a better understanding of one's surroundings and a greater opportunity for success (Granovetter 2005).

Returning to the benefits outlined by Coleman, occupational mobility and obligations can be examined for their impact on social action. Occupational mobility results from informal social networks that have information about obtaining jobs and providing jobs to those within their networks. As mentioned previously, information remains one of the key aspects of social capital and is enhanced through the extension of one's network. Jobs and advantages flow through social networks (Granovetter 1973). By having a wider network, the opportunity for greater vertical mobility is created (Lin 1999). More opportunities for advancement are made available. Knowing a large amount of people brings jobs from outside your immediate circle into your awareness. "Networking," as it has come to be called among society today, uses social relations for economic and professional growth. More bluntly, individuals have learned to manipulate those they meet and create ties with to achieve their ultimate goals. This carries over to the trustworthiness and obligation component of social capital. When entering into a group, an understanding is created that resources will be shared and support will be provided (Coleman 1988). Within one's immediate network, trust is integral to the continuation of norms and the function of the group as a whole. Trust and obligations to share resources provides the foundation for social capital and perpetuates the necessity for social ties.

Immigrant enclaves exhibit the importance of trust and obligations greater than a typical social network. Communities created around a cultural and ethnic identity provide a stepping stone into the American economy for newly arriving immigrants (Portes and Sensenbrenner 1993). Without established communities, integration into the United States would be much slower. There would not exist a flow of information or social support needed to become successful. Alejandro Portes has examined the role of social capital among immigrants in depth. He has shown that immigrants colonize a particular sector of the labor market and are able to employ those within their community and kin that do not have other opportunities. This is particularly relevant to individuals who lack the extended networks described by Lin and Granovetter. Immigrants new to the country compensate for the lack of outside networks through emphasis on family systems and relationships (Portes and Sensenbrenner 1993). Another obstacle cited for immigrants is the extent of networks beyond the inner city. Because most enclaves are located in city centers, there is a lack of information from the outside which makes its way to the closed social networks of immigrants (Portes 1998). Despite the obligation to provide jobs to family and community, immigrants are placed at a distinct disadvantage concerning fresh information and the opportunity for vertical mobility.

CHAPTER 3

LITERATURE REVIEW:

Social networks create a distinct advantage in many different arenas for those new to the United States. In obtaining jobs, financial security, or access to governmental programs, knowing numerous other people and learning from their experiences increases the likelihood of success and integration into mainstream culture. Throughout all the various waves of migration

in the past, immigrant groups have encountered similar problems of adjustment to the rules of interaction and behavior in their new country and have exhibited the similar patterns of settlement (Alba and Nee 1997). Due to lack of financial identity, social connections, and cultural awareness, foreign-born individuals from the same country tend to construct ethnic communities in cities around the United States. These cities are typically found in areas where new immigrants from that country would arrive, such as New York City for Italians, Miami for Cubans, and San Francisco for Chinese. These "ethnic enclaves" that were constructed by immigrants are situated by ports and centers of travel because it saves money for those arriving to the United States and those travelling back to their home country. They have become the epicenters of social networks for immigrants to the United States (Portes and Sensenbrenner 1993).

Social networks have been defined as personal relationships between an individual and immediate and extended family, friends, and community. Networks provide a vast array of support through organizational, financial, and emotional means (Massey et al. 1987). One of the most important aspects of social networks is the circulation of information. This seems to be particularly important among immigrants to the United States, who do not have a complete understanding of cultural patterns, social structure, and accepted behaviors. Extended networks of kin and community provide avenues for success. Not only do they facilitate migration, but networks place a variety of resources within the reach of immigrants new to the United States (Menjivar 2002). Housing and jobs become easier to obtain, and the processes of society are understood faster. For example, relationships outside of immediate family and outside of one's ethnic group have been shown to increase knowledge and empower individuals to seek

legalization (Hagan 1998). Having acquaintances and friends already in the country provides an immediate advantage.

Similarly, the financial and social stability helps immigrants adapt to the new societal patterns and behaviors. Many immigrants come to the United States without the means to obtain housing or to support their families. With a strong social network, there exists an inherent promise to help the other individuals within your community. This creates a "web of rights and obligations" (Tilly 2007). It is a reciprocal exchange, in which commodities and services are shared between groups and individuals (ʻIaupuni et al 2005). Therefore, there is the expectation that eventually these gifts of financial and social support will be repaid—either to the individual directly or to other immigrants of the same ethnic background entering the community. The impacts of these gifts and strong social networks have greater influence on poorer families, who do not have the opportunities to afford daycare, lack transportation, and are not able to speak English fluently (ʻIaupuni et al. 2005). Social support in these instances opens up greater opportunities and promotes better mental health among immigrants.

Social networks have typically been examined in research as connections that provide support financially, emotionally, or mentally. Charles Tilly (2007) approaches his research of networks in migration as being integral to the range and variety of opportunities available to new immigrants. If a social network is diverse and has numerous weak ties, new connections are continuously being made. This allows for original and fresh information to enter the network, which can provide the key to understanding access to various governmental programs. Jacqueline Hagan (1998) also found that weak ties to individuals outside of the immediate ethnic community increased rate of immigrant legalization. This demonstrates the power of outside information on individual action and knowledge of the United States' programs and regulations.

Current available research has approached the use of social networks and health from a variety of ways. In the areas surrounding flow of information, especially concerning access, there have been a few primary studies that have paved the way. Cecelia Menjivar (2002) examined women's networks and accessibility to formal health care resources in her ethnographic and qualitative examination of Guatemalan immigrants. She discovered that when formal health care was needed or desired, the women sought information and ways to obtain formal health care through their social networks. Communities also provided non-traditional medicines and links to the more trusted healthcare system of their home country. Similarly, Felicia Leclere, Leif Jensen, and Ann Biddlecom (1994) found that a use of formal health care was constrained by a lack of information, limited resources, and overall care seeking behaviors in immigrants. However, enabling factors such as personal characteristics (SES, education, length of residency) and families became the gateway to formal care. This team of researchers found that living in a community that was composed of unrelated ethnic individuals or kin was important in accessing health programs. Finally, Shawn 'Iaupuni et al. (2005) examined the effects of social networks and support on the health of children in Mexico. It was found that the greater the number of people within one's immediate family reduced chances of financial support, but the greater number of extended kin created resource diversification. This team of researchers also discussed reciprocal exchange, or the passage of commodities and services, as integral to the sustainability and value of social networks.

Although health is distinct from access to health care, social networks influence the outcomes of both. Besides providing avenues of support and information, social networks reinforce certain behaviors and cultural practices. Outside individuals influence diet and exercise and determine social acceptability of behaviors and disease, such as smoking, obesity,

and diabetes (Vega, Rodriguez, and Gruskin 2009). By simply altering the health behaviors of those around an individual, drastic change in health status and future outcomes can result (Morales et al. 2002). However, studies focusing on acculturation and health outcomes tend to neglect the importance of behaviors learned and practiced in the home on health. The impact of family and community is not included in the creation of measures of assimilation. Perez-Escamilla and Putnik (2007) push for an understanding of the family structure, support systems, and the impact of cohesion on acculturation and health outcomes. Moayad et al. (2006) focused on family cohesion and acculturation while examining diabetes among Mexican Americans. They discovered that high family cohesiveness and low acculturation were protective against the most severe forms of diabetes. Other studies have found that regardless of acculturation level, Latinos perceive a high level of familial support. By examining the family, patterns of care giving, beliefs in institutions, and the desire to provide care for their family members emerge (Weiler and Crist 2007). This is important in the overall understanding of access and the impact of social networks on overall health.

CHAPTER 4

HYPOTHESES:

The influence of social factors on rates of health insurance in various populations has been clearly established in previous research. Links between assimilation, socioeconomic status, and educational attainment and increased rates of health insurance among immigrants to the United States are the most commonly investigated topics. However, there remains room in the literature for further investigation on the impact of social networks and geography on insurance among immigrants, particularly among Mexicans, which accounted for 7.5 percent of the 12.5

percent Hispanic population in the United States in 2000 (Guzman 2001). In beginning my analysis, I developed several specific research questions surrounding these issues and created hypotheses that would help guide the formulation of the thesis and direction of the study. Those include:

1. *Rates of insurance will be greater among those with spouses, particularly those who are married to United States citizens.* This hypothesis addresses the overall question concerning the impact of social network on rate of insurance. The spouse and their citizenship status serve as a measure of access due to increased assimilation and knowledge based on social contacts.
2. *Mexican foreign-born living in states with expanding rights will be more likely to be insured.* State laws will serve as a proxy for geographic social support. States with friendlier policies towards immigrants should have a greater system of support available to those populations and may offer avenues to obtaining coverage.
3. *The larger the Hispanic population within the state, the greater the rate of insurance will be among Mexican foreign-born adults.* The Hispanic population within the state will serve as a measure of how vast the network of support is within a particular geographic area. The more Hispanics in a geographic area, the larger the opportunity will be for a network of information concerning access to health insurance to be established that benefits the Mexicans living in that state.
4. *Access to other social programs will enable access to governmental programs for health insurance.* This hypothesis taps into the degree of Mexican foreign-born savviness, or in other words, their ability to use governmental programs to their

advantage. Those with greater understanding of how to access programs may better be able to gain access to government provided or subsidized health insurance.

DATA AND METHODS:

I used the March 2010 Current Population Survey (CPS) as the source of my data. The CPS is a survey administered monthly by the United States Census Bureau to nearly 50,000 households to gather information used by the Bureau of Labor Statistics. Information on the primary characteristics of the labor force is collected for individuals in the household at least 15 years of age. A variety of demographic questions are included that provide age, sex, race, marital status, and educational attainment (U.S. Census Bureau, 2010). In particular, the March Supplement of the CPS includes information concerning health insurance. Questions in the supplement focus on health care coverage, source of health care, and various governmental programs available to individuals. The advantages of using CPS are: (1) it included a wide variety of variables to measure health insurance coverage; (2) it contained a large number of Mexican respondents; (3) asked questions concerning citizenship; (4) state of residence was provided; and (5) data about spouses was available as well.

My sample includes Mexican foreign-born adults, ages 35 to 64, who participated in the Current Population Survey during March of 2010. The sample was restricted to those born outside of the United States and Puerto Rico because I was interested in studying how those who move to this country acquire health insurance. Mexicans born in the United States would have greater access to governmental programs due to their citizenship status and were, therefore, excluded. Likewise, I selected the age group of 35 to 64. This provides a sample which controls for the large number of uninsured in their twenties and early thirties found in the general

population, while excluding those, who at 65, qualify for Medicare. By limiting the sample to individuals with these particular characteristics, the final number included in the analysis was 4,533 (N=4,533).

KEY VARIABLES:

Health Insurance: Health insurance was the dependent variable of this project. Health insurance was measured through a simple categorical yes/no question in the March 2010 Supplement of The Current Population Survey. Although there were additional questions that examined type of insurance, I was concerned with overall access to health insurance. Particularly with a population is characterized by rate of insurance coverage that is significantly lower than the average United States' rate (24.7% in this analysis), it was more effective to look at what characteristics determined as opposed to whether an individual had health insurance than type of insurance.

Spouse Citizenship: As a measure of social support and networks, spouse citizenship was used and evaluated for rates of insurance. Among married people, spouse citizenship was broken down into three distinct categories. First, spouse born within the United States or Puerto Rico were classified as citizens. Spouse born outside of the United States and Puerto Rico are recognized as foreign-born. The foreign-born population was further divided based on naturalization status: foreign-born citizen spouses and foreign-born non-citizen spouses. Unmarried individuals were coded in a separate category, "not married."

State Laws: Geographic location was asked in the CPS, but I further wanted to know what role geography, as a means of social support, played on access to health care. Originally, an overall scale for state attitudes toward immigrants was desired. However, lacking

available resources and a sufficient measure, I created a new variable which examined state laws surrounding immigrant health care rights. State laws were evaluated on whether immigrant rights were contracting, expanding, or remaining constant based on information provided by the Migration Policy Institute (Migration Policy Institute 2011). States with laws expanding rights to health care for immigrants were coded with 1, while states with contracting rights were coded as 2. States that had no laws concerning immigrant rights to health care passed or did not have laws that clearly fell into either of the two categories were coded as 0. These finding were then attached to the state variable already included in the data set.

State Population of Hispanics: In combination with the interest in geography, I wanted to look at the size of Mexican populations in an individual's state as a means to try to determine whether this influenced access to health insurance. Although the state was provided in the CPS, I had to create an additional variable that included state population of Mexicans as collected in the 2009 American Community Survey. I estimated this number using the table-making tool available at the IPUMS-USA website (Ruggles 2010), which provides the number of persons of Mexican heritage estimated to be living in each state in 2009. The state populations were then linked to the respective state of each individual.

Access to Social Programs: The use of social programs and the impact that it has on access to health care was an area of interest in the evaluation of this data. In the CPS survey, there are several questions that measure use of governmental programs. The variables for receiving reduced lunches, public housing, and food stamps were added to measure access and knowledge of accessing government and publicly provided support.

Other Variables of Interest: There were several other variables that were included in the general analysis in regards to health insurance. These following variables capture various aspects of demographics and social support that provided additional insight into my hypotheses surrounding health insurance. Educational attainment is the first social variable that was included. Level of education was recoded into five categories, which included: less than 8th grade; 9-12th grade; high school graduate; some college/associate degree; and bachelor degree or above. Class of worker, which divided the workforce into fields of employment, was also included for analysis. Field of employment was divided into the following three categories: private/governmental worker; self-employed; works without pay or never worked. Another important characteristic for foreign-born Mexicans was year of arrival to the United States. Ranges in time were created along 5 year intervals beginning in 1990. All those arriving prior to 1990 were placed in their own category. Self-reported health was also used to see what relationship this had with rates of health insurance. Individuals were asked to report their level of health on the scale of: excellent; very good; good; and fair/poor. Finally, the number of persons in the household served as a measure of social support.

Descriptive analyses were first conducted on the data. The descriptive analyses are weighted using the final March supplement sampling weight, and they provide a picture of the general Mexican foreign-born population that is currently living in the United States. Fundamental characteristics, such as education, class of worker, and age, were examined. The unweighted number (N) and weighted percentages within categories and groups can be found in Table 1. Next, I conducted a series of cross-tabulations to determine the percentage of insurance within each variable and characteristic. The results are presented in Table 2. Finally, two

logistic regression models were conducted to determine likelihood of being uninsured based on the previously analyzed characteristics. These models are located in Table 3. The reference group in each category is the group listed last. It is also demarked by (ref) next to the group's name. The rates and ratios are all in comparison with the reference group of each characteristic. The first logistic regression was run without the state population and law variables. State population of Mexicans and state laws about immigrants were included in the second analysis to determine what impact, if any, they had on the rates of insurance net of other characteristics. I did not weight the logistic regression models.

CHAPTER 5

RESULTS:

Basic Characteristics and Trends:

By conducting descriptive analyses, several important characteristics emerge within the responses provided by Mexican foreign-born in the Current Population Survey that have implications for coverage (Table 1). Only 24.7% responded as having any form of health insurance. This implies that there are various social determinants at work that are affecting ability to access and afford coverage. Four distinct areas in the results demanded my attention: Education was low in the sample. 82.4% had not received any form of education past graduating from high school. Of that 82.4%, 38.2% only received an education up to the eighth grade. That demonstrates the overall lack of advanced education within this segment of the population. Higher levels of education are associated with greater rates of insurance. This can be attributed to better understanding of how to access programs, greater availability of programs due to job, or the financial means to pay for insurance as a result of higher salaries.

Secondly, 34% were not married, while 37.7% were married to other individuals who were foreign-born and not citizens to the United States. 28.3% were married to either natural-born or naturalized United States citizens. Citizens are often afforded privileges that non-citizens are not. Access to governmental health insurance is one of those privileges. Those married to citizens may also be provided the ability to utilize these programs.

Next, private and governmental employment accounted for the majority of job types with a percentage of 61.1. 7.6% were self-employed and 25.3% worked without pay or never worked. State and federal governments are required to provide health insurance to employees. Although level of coverage and care does vary, the option is still open to any state or federal employee interested in purchasing health insurance. Private full-time employees typically have the ability to purchase insurance through their employer as well. In the coming years, all employers of a certain size will have to provide insurance for their employees under President Obama's health care law (The White House 2011).

Finally, over 50% of the sample had arrived before 1990, with a steady decline in percentage over each subsequent five year entry period. Year of arrival to the United States is typically used as proxy for assimilation or degree of exposure to knowledge about U.S. society. Those who have been here for a longer amount of time are thought to have a better understanding of the United States culture and ability to navigate various programs and services. Additionally, they will have had a longer period of time for the opportunity to establish themselves financially and socially. These are assumed to be associated with increases in rates of insurance among immigrants.

The descriptive statistics of this sample provide the foundations for evaluating rates of health insurance and significance of those percentages. Additionally, it establishes

understanding into causes for behavior, levels of assimilation, and opportunities to access health insurance. As rates of insurance were evaluated, these characteristics of the population provided significant insight into the implications of social determinants and overall coverage among Mexican foreign-born adults.

Rates of Insurance:

I next ran cross-tabulations to examine the rates of insurance coverage by each of the independent variables (Table 2). The rates of insurance remained low across all variables. Only in the instance of having a bachelor degree or even more advanced education did the coverage rate exceed 40%. Even in that instance, a large proportion still did not have any health insurance coverage. Insurance coverage does continue to increase with level of education, which is concurrent with previous research done in the field. Year of arrival also had a significant impact on health insurance. Those in the United States before 1990 had a rate of 32.3%, which dropped to 21.6% during the next span of 5 years. The pattern of declining coverage continued until the most recent years of entry, 2006-2010, which had a 2.5% higher rate of coverage than the previous segment of time.

Similarly, health insurance coverage is clearly associated with type of occupation. Those who worked for a private business or for the government had an insurance rate of 36.2%, whereas those who were self-employed had a rate of 6.5%. Likewise, benefits varied by marital status and spouse's citizenship status. Individuals married to someone who is a native-born citizen reported insurance rates of 39.3%. This dropped to 31.9% for those married to foreign-born citizens, 21.4% for foreign-born non-citizens, and 23.8% of those who were not married. The other results can be found on Table 2.

Binary Logistic Regression:

Two regression models were run to predict the logged-odds of uninsurance. The first contained the variables already analyzed in the previous two tables. The second contained two additional variables: state population of Hispanics and state laws concerning immigration. They were included in a separate regression model to see the impact of those variables on the other categories. Results were statistically significant if the p value was less than 0.05 ($p < .05$). There was hardly any change in the significance and odds ratios of the original analysis, which means that state population and the state laws did not mediate the influence of other social determinants on coverage.

Several categorical variables attained statistical significance on the whole. Those included: education, spouse citizenship, class of worker, age group, reported self-health, and year of arrival to the United States. Among the categories of these variables, there were variations in difference and significance from the reference group. The reference group was the last coded variable for each category. The various subcategories were compared against the reference group for significance.

As mentioned previously, 38.2% of respondents had an educational level of eighth grade or below. These poorly educated individuals are 2.75 times more likely to be uninsured than those with bachelor degrees or higher. The likelihood to be uninsured continues to decline through educational advances. However, those had received some college or an associate degree were still 1.45 times more likely to be uninsured than those with degrees from 4-year institutions. Within this variable, all categories were statistically significantly different from having a bachelor degree or more advanced education.

The class of worker dummy variables were significant as a group. Those working for private companies and the government were 91% less likely to be uninsured than those who claimed self-employment or were not working. In comparison with the reference group, the significance for private or governmental employment was $p < .001$. This demonstrates the opportunity provided for health coverage through class of work. Likewise, advantage seems to increase with amount of time spent in the United States, which is the measure of assimilation in this study. Those who were here before 1990 were 62% less likely to be uninsured than Mexicans who had entered the United States within the last four years. Again, the likelihood to be uninsured increases as the year of entry becomes more recent. There is no real difference between in rates of insurance in those who have arrived after 2002.

Results in relation to Hypotheses:

Specifically, the results of spouse citizenship in the logistical regression help to evaluate hypothesis 1. Rates of insurance were significantly higher for those with a native born United States citizen spouse ($p < .001$). In fact, they were 35% less likely to be uninsured than those with a foreign-born spouse who did not have United States citizenship. Even having a foreign-born spouse who had gained citizenship through naturalization lowered the rate of uninsurance. People with a naturalized spouse were 28% less likely to be uninsured in comparison with the reference group (having a foreign-born non-citizen spouse). Marrying a citizen, be it native-born or naturalized, creates a distinct advantage in accessing and obtaining health insurance. The privileges afforded to citizens and their families provide the ability to utilize a variety of services. Government provided health insurance is one of the areas. Not only is access provided to governmental programs, having a spouse who understands the culture and political system

may promote assimilation and access to health insurance. Based upon the output, this hypothesis is supported.

Hypothesis 2 concerned states laws involving immigrant rights. I had hypothesized that those states with laws expanding rights would have higher levels of insurance among Mexican foreign-born. The state laws were supposed to serve as a proxy measure of state friendliness and overall impact of geography on access. Insurance coverage in states with expanding rights was not significantly different from the reference group (states with contracting rights) at the $p = .05$ level, but the difference was marginally significant at the $p = .10$ level ($p = .064$). Those in states with expanding rights were nearly 20% less likely to be uninsured. This variable was created with a limited amount of available scholarly and political material. With a more carefully and accurately developed variable, this may have yielded even greater significance.

That size of the Mexican population in the state was not statistically associated with health insurance among Mexican foreign-born adults, which does not support the hypothesis developed about the size of networks. The size of the Mexican population did not have any real influence on the rates of insurance among the other variables, and the p-value was not close to being significant ($p = .441$). The population was evaluated as a continuous variable. Potentially, the states could be grouped into low, medium, and high Mexican populations to determine if that has any effect on access.

Finally, hypothesis 4 dealt with using social programs as a means to accessing various other governmental and social programs. This idea was tested using three different variables: receiving reduced lunches for children, participation in public housing, and receiving food stamps. Although significance was achieved among those who received reduced lunches and those who received food stamps, the results did not support the hypothesis. In fact, the results

showed that those who utilize these programs are significantly less likely to have health insurance. Disadvantage breeds disadvantage. Those people are typically struggling, which is why they are participating in these other social programs. They may know how to use the programs that exist, but affording those programs, even at subsidized and reduced prices, could still be a difficulty for many. In fact, those participating in either one of those programs were over 2 times more likely to be uninsured than those who did not participate. Therefore, this hypothesis can be rejected.

CHAPTER 6

CONCLUSION:

Levels of health insurance among Mexican foreign-born adults were extremely low in comparison with the general United States population and even among the Hispanic population in the United States. In particular, no characteristic analyzed cause health insurance rates to rise above 44%. This highlights the fact that there is a fundamental difference between the general population, of whom 16.4% are uninsured, and the Mexican foreign-born (Mendes 2011). Social networks and support were analyzed through proxy measures of spouse citizenship, state laws, and access to other governmental programs. In the analysis of these variables and other descriptive characteristics, several social determinants of access and opportunity to obtain health care were found to be statistically significant, which may lead to various implications and potential issues in the future.

To examine the impact of social networks, citizenship of spouse was selected as a proxy measure. Citizenship provides avenues to access. Citizens and their families are offered governmental provided health insurance such as Medicaid and Medicare, for those over 65 years

of age. It also can demonstrate a wider breadth of individuals from various backgrounds who may have additional information and opportunities to obtain health insurance that benefit these immigrants. Those with spouses who were citizens were significantly more likely to have health insurance. However, this rate still remains much lower than the overall insurance rate in the United States.

Secondly, state laws were used to determine the atmosphere of friendliness to immigrants in each state. This was done to measure the impact of geography. States laws served as a proxy measure of social support. Those states that have implemented extending legislation were hypothesized as having greater social support for foreign-born individuals. The more laws that are passed to create programs for immigrants were expected to be most likely to begin to extend to immigrants those privileges that were originally reserved for citizens, including health care. A friendlier environment may encourage participation in various programs, while actually providing a viable and affordable option. The results came back as marginally statistically significant. However, further investigation should examine the impact of geography on social support and what that means for rates of coverage with more accurate and stronger variables.

Similarly, the size of the Mexican population in the state was used to measure the extent of social networks. The size of the social network has been theorized and tested as a means of obtaining information and additional opportunities among immigrant groups in previously conducted research. The CPS did provide the state for each individual in the survey, as mentioned previously. The Mexican population among states was selected as the best measure of the extent of a social network that would work with the geographic information obtained the Current Population Survey: March 2010. At the state level, the analysis did not yield significant results. Therefore, the size of the Mexican population at the state level did not influence the rate

of insurance among foreign-born. Future studies should continue to investigate the role of extent of social support. It could also be studied at a small, more localized level. Those immediate communities will potentially have the largest impact on the spread of information and opportunities. Additionally, it would be interesting to see the differences between networks of all Mexicans and specifically Mexican foreign-born and what impact those have on access to health care, if any.

The final hypothesis that was examined was whether access to other programs and an understanding of how to access and utilize those assistance programs helped increase rate of insurance. It was developed as a measure of savviness. Those immigrants who had been able to use other public aid could potentially have better knowledge about how to navigate various departments and organizations than other groups of foreign-born. However, the results did not show any level of statistical significance. This can potentially be explained by the fact that those enrolled in various public programs have higher disadvantage and opportunities than other Mexican immigrants. Many of these programs are designed to help those who have financial needs afford the basic necessities of life, such as food stamps and reduced lunches. The people using these programs may not have the means to afford any level of health insurance. Health insurance is seen as not fundamental to daily life and is an additional burden on the person's budget. Therefore, they may choose to forgo purchasing health insurance. However, by controlling for poverty among this population, the results could be altered. Instead of measuring usage of other programs as a way to obtain health insurance, financial and social disadvantage was most likely being measured. Therefore, those who used those programs were at a lesser opportunity to access health care as those who did not need governmental aid. If the analysis was limited to the poor, perhaps a true measure of savviness could be obtained, which could

yield different results. The variations in advantage and opportunity would be mollified, allowing greater insight into what the outcomes of this variable truly mean.

Additionally, specific characteristics were determined to be significantly associated with having insurance. Increases in level of education and time spent in the United States contributed to increases in insurance. Both variables hint at a greater understanding of United States culture, experience and knowledge that could help navigate access, and higher levels of assimilation (years in the United States in particular). Class of worker also influenced access to care. Those who were employed in private business and by government were much more likely to have health insurance. Those types of jobs typically offer some level of health insurance to their employees.

These trends have implications on the overall health of Mexicans and Hispanics in the United States. As mentioned previously, health has been shown to decline over time among Hispanic immigrants to the United States, as in the Hispanic Health Paradox. Although Hispanics enter the country with better health than the average American, their health rapidly declines over time. Assimilation has been associated with this decline. However, the low rates of health insurance, particularly among Mexicans who compose the largest ethnicity of Hispanics, could be a contributing factor. Without a regular source of care or a way to afford treatment, small medical issues can be ignored and preventative care neglected. This causes a decline in health across a variety of factors and issues. It may also increase the burden on the citizens of the United States, who will then face higher premiums as the result of uncompensated care in hospitals treating the uninsured.

Fundamentally, this creates a disparity in health between this segment of the population and the general United States population. Although certain characteristics did enhance rates of

insurance, the rate remained well below the national average. This speaks to a variety of factors that must be inhibiting the ability to obtain insurance or are promoting the belief that health insurance is not necessary. Other studies have shown that social, financial, and governmental barriers impede Mexican foreign-born and Hispanic immigrant access to health insurance. In the end, the behaviors and opportunities in comparison with the majority culture are not equal. This study attempted to delve into the impact of various aspects of social networks and support through the analysis of data collected in the Current Population Survey of March 2010. The CPS did have some limitations that should be taken into account when reviewing the findings of this study. There were no direct measures of social networks, transference of information, assimilation, or social capital. Therefore, proxy measures were constantly being used. Those measures may not fully capture the intended variable. Additional components added to the development of a key variable could alter the interpretation and outcomes of the analysis. However, through a series of research questions and analysis of variables as developed in this study, it can be concluded that social networks do have some level of influence on obtaining health insurance. Theories surrounding social networks state that information and opportunities become more abundant with vaster social networks and larger social support due to knowing more individuals and the shared responsibility. This seems to hold true in this situation as well and to work in combination with other social characteristics to determine rate of health insurance.

As we move into the future, health insurance and immigration will continue to be two of the issues that dominate political conversations and rhetoric. Both are hot button and politically isolating issues. Addressing both of these issues, however, is important for the progression of our society and the overall health of our economy and people. In order to more fully understand

what opportunities are affecting patterns in coverage, investigation into various attitudes, values, and characteristics needs to continue to occur. More research should be done to continue to investigate the impact of social networks on Mexican access to health insurance in comparison with other Hispanic ethnic groups and other outside minorities. Additionally, research can be added to see what impact new health insurance policies, as passed under President Obama, will have on rates of health insurance among these various groups in the United States population. Hispanics will continue to compose a greater and greater percentage of the population, with Mexicans representing the largest ethnicity within that segment of the population. Investigating these issues will continue to be important and could have findings that ultimately lead to drastic changes in the spread of information to immigrants, programs offering coverage to foreign-born, and overall health of these currently disadvantaged groups.

Table 1: Characteristics of Mexican Foreign-Born Adults, Age 35-64

Continuous	**Mean**	**Standard Deviation**	**N**
Age-Single Years	45.66	7.93	4533
State Population	6,841,032.86	4,834,429.90	4533
Categorical	**Percent**		**N**
Health Insurance			
Yes	24.7		1181
No	75.3		3352
Sex			
Male	55.3		2361
Female	44.7		2172
Educational Attainment			
Less than 8th Grade	38.2		1751
9-12 Grade	20		915
High School Graduate	24.2		1076
Some College/Associate Degree	10.1		472
Bachelor Degree and Additional Education	7.4		319
Spouse Citizenship			
Not Married	34		1301
Native Born in USA or Puerto Rico	10.5		501
Foreign Born Citizen	17.9		863
Foreign Born Non-Citizen	37.7		1868
Class of Worker			
Private or Governmental Worker	67.1		3050
Self-Employed	7.6		337
Works without Pay or Never Worked	25.3		1146
Class of Worker-Spouse			
Private of Governmental Worker	40.8		2028
Self-Employed	4.4		210

Works without Pay, Never Worked, Not Married	54.9	2295
Age Groups		
35-39	27.5	1200
40-44	23.5	1090
45-49	18.4	880
50-54	13.3	607
55-59	10.1	452
60-64	7.1	304
Reported Self-Health		
Excellent	16.9	755
Very Good	27.5	1270
Good	39.3	1794
Fair or Poor	16.2	714
Spouse Reported Health		
Excellent	10.7	520
Very Good	17.9	922
Good	26	1268
Fair or Poor	11.4	522
Not Married	34	1301
Year of Arrival to the United States		
Before 1990	52.4	2364
1990-1995	19.3	906
1996-2001	16.4	767
2002-2005	7.6	318
2006-2010	4.3	178
Receive Reduced Lunches for Children		
Yes	33.2	1570
No	66.8	2963
Participate in Public Housing		
Yes	1.8	86
No	98.2	4447
Receive Food Stamps		
Yes	14.6	641
No	85.4	3892

Table 2: Insurance Rates among Mexican Foreign-Born Adults, Age 35-64

Category	Percent With Insurance	Percent without Insurance
Sex		
Male	31.6	68.4
Female	20	80
Educational Attainment		
Less than 8th Grade	19.2	80.8
9-12 Grade	23.2	76.8
High School Graduate	29.6	70.4
Some College/Associate Degree	36.9	63.1
Bachelor Degree and Additional Education	43.6	56.4
Spouse Citizenship		
Not Married	23.8	76.2
Native Born in USA or Puerto Rico	39.3	60.7
Foreign Born Citizen	31.9	68.1
Foreign Born Non-Citizen	21.4	78.6
Class of Worker		
Private or Governmental Worker	36.2	63.8
Self-Employed	6.5	93.5
Works without Pay or Never Worked	4.8	95.2
Class of Worker-Spouse		
Private of Governmental Worker	26.4	73.6
Self-Employed	24.3	75.7
Works without Pay, Never Worked, Not Married	25.9	74.1
Age Groups		
35-39	22	78
40-44	28.3	71.7
45-49	26.8	73.2
50-54	27.7	72.3
55-59	30.3	69.7
60-64	22	78

Reported Self-Health		
Excellent	32.7	67.3
Very Good	28.9	71.1
Good	24.5	75.5
Fair or Poor	17.9	82.1
Spouse Reported Health		
Excellent	29.4	70.6
Very Good	28.3	71.7
Good	25.4	74.6
Fair or Poor	25.9	74.1
Not Married	23.8	76.2
Year of Arrival to the United States		
Before 1990	32.3	67.7
1990-1995	21.6	78.4
1996-2001	19.4	80.6
2002-2005	13.8	86.2
2006-2010	16.3	83.7
Receive Reduced Lunches for Children		
Yes	15.1	84.9
No	31.9	68.1
Participate in Public Housing		
Yes	16.3	83.7
No	26.2	73.8
Receive Food Stamps		
Yes	9.2	90.8
No	28.8	71.2

Table 3: Logistic Regression Model of Insurance Coverage among Mexican Foreign-Born Adults, Age 35-64

	Model 1:			Model 2:		
	B	Odds Ratio		B	Odds Ratio	
Sex						
Female	-0.81	1.274	**	2.4	1.271	**
Educational Attainment			&			&
Less than 8th Grade	1.013	2.754	***	1.017	2.766	***
9-12 Grade	0.767	2.154	***	0.773	2.166	***
High School Graduate	0.592	1.808	***	0.604	1.830	***
Some College/Associate Degree	0.369	1.446	*	0.382	1.466	*
Bachelor Degree and Additional Education (Ref)						
Spouse Citizenship			&			&
Not Married	0.096	1.101		0.095	1.099	
Native Born in United States or Puerto Rico	-0.435	0.647	***	-0.452	0.637	***
Foreign Born and Citizen	-0.332	0.718	**	-0.334	0.716	***
Foreign Born and Not Citizen (Ref)						
Class of Worker			&			&
Private or Governmental Worker	-2.325	0.098	***	-2.331	0.97	***
Self-Employed	0.122	1.129		0.117	1.124	
Works without Pay or Never Worked (Ref)						
Class of Worker-Spouse						
Private or Governmental Worker	0.185	1.203		0.182	1.199	
Self-Employed	-0.106	0.900		-0.099	0.906	
Works without Pay, Never Worked, Not Married (Ref)						
Age Groups			&			&
35-39	0.205	1.226		0.213	1.238	
40-44	-0.115	0.891		-0.107	0.899	

45-49	0.035	1.035		0.040	1.041	
50-54	-0.110	0.895		-0.355	0.911	
55-59	-0.269	0.764		-0.262	0.796	
60-64 (Ref)						
Reported Self-Health			&			&
Excellent	-0.273	0.761		-0.282	0.754	
Very Good	-0.148	0.863		-0.154	0.857	
Good	0.017	1.017		0.011	1.011	
Fair or Poor (Ref)						
Year of Arrival to the United States			&			&
Before 1990	-0.961	0.383	***	-0.971	0.379	***
1990-1995	-0.603	0.547	*	-0.612	0.542	*
1996-2001	-0.347	0.707		-0.363	0.696	
2002-2005	0.060	1.061		0.047	1.048	
2006-2010 (Ref)						
Receive Reduced Lunches for Children						
Yes	0.833	2.300	***	0.830	2.293	***
Participate in Public Housing						
Yes	0.014	1.014		0.016	1.016	
Receive Food Stamps						
Yes	0.804	2.235	***	0.795	2.215	***
Number of Children Under 18	-0.081	0.922		-0.082	0.921	
Number of Persons in Family	-0.139	0.870	***	-0.140	0.669	***
Number of Persons in Household	0.138	1.148	***	0.142	1.153	***
State Law						
None Passed				-0.077	0.926	
Extending Rights				-0.221	0.802	+
Contracting Rights (Ref)						
State Population				0.000	1.000	

* p < .05 ** p < .01 *** p < .001 & : categorical variable significant as a group (p < .05) + : moderately significant

Intercept: 1.043 Sample: Mexican Foreign Born, Age 35-64 (N=4533)

R-Square: 0.307 Data: 2010 March Current Population Survey

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Academic Vita

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Education

B.A., Sociology (Spanish and Bioethics and Medical Humanities Minors), 2011, Pennsylvania State University, University Park, PA

- Thesis: Influence of Social Networks and Support on Access to Health Insurance among Mexican Foreign-Born Adult
- Thesis Supervisor: Jennifer Van Hook

Enrolled in the Masters of Public Health Program at the University of South Carolina, 2013, Columbia, SC

Honors and Awards

- PSU Presidential Freshman Award for academic achievement in the freshman year
- PSU President Sparks Award for academic achievement in the sophomore year
- The Evan Pugh Award for academic achievement in the junior year; awarded to the top 0.5% of students
- Eleanor Hoffer Kyle Scholarship: 2010-2011
- Roy C. Buck Liberal Arts Scholarship: 2010-2011
- William Kraft Undergraduate Scholarship for the College of Liberal Arts: 2010-2011
- Dean's List for Fall 2007, Spring and Fall 2008, Spring and Fall 2009, Spring and Fall 2010

Organizations and Activities

- Nittany Nation (Current Vice President)
- Alpha Kappa Delta/Sociology Club (Vice President: Junior Year)
- Golden Key International Honor Society
- Phi Beta Kappa

Research Experience

Schreyer Honors College Undergraduate Thesis **Fall 2009-Spring 2011**

- Examining data from the Community Population Survey and adding additional variables to obtain proxy measures of social networks.
- The thesis will examine access to health care within the Mexican immigrant population in the United States, with particular emphasis on the impact of familial and social support.

Related Experience

Harrisburg Office of Senator Arlen Specter **May-August 2010**

- Worked with constituents and community to address concerns surrounding state and federal legislation under supervision of Melissa Frey: Executive Director of the Harrisburg Region

PinnacleHealth System **Present**

- Currently working to develop an internship program to help promote and increase quality of community health in the Harrisburg area under supervision of the Vice President of Mission Effectiveness, Barbara Terry

References:

- Dr. Roxanne Parrott: Professor of Communication Arts and Sciences
- Dr. Jeffrey Ulmer: Associate Professor of Sociology and Crime, Law, and Justice at the Pennsylvania State University
- Dr. Jennifer Van Hook: Professor of Sociology and Demography