

# **Health Care Access by Immigrant Women**

**-- A Comparison of California, Florida and New York**

Ju Wang

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Dr. Deborah J. Milly, Chair  
Dr. Timothy W. Luke  
Dr. Charles L. Taylor

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## **Abstract**

Recent data show that immigrant women<sup>1</sup> in the U.S. are generally in poorer health than U.S.-born women and immigrant men<sup>2</sup>, and many immigrant women encounter some difficulties in obtaining health care assistance, such as health insurance. Yet American researchers are only beginning to make a contribution to this area of scholarship. This thesis examines in detail the health status of immigrant women, the means by which immigrant women obtain health insurance, and several factors that are likely to influence their health care access.

I mainly examine the associations between three factors (public policy, employment status, and marital status) and access to health care assistance. I do so because employers and government-sponsored health care programs are both major insurance providers, and being married is an important factor in accounting for immigrant women's health insurance coverage. The project consists of case studies in three states – California, Florida and New York – using both qualitative and quantitative research methods. The data come from two rounds of the National Survey of America's Families

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<sup>1</sup> According to the National Survey of America's Families, people are divided into three groups by the immigrant status – U.S. born citizens, foreign-born naturalized citizens, and non-citizens. I label the group of female foreign-born non-citizens as immigrant women. Foreign-born women who have been naturalized are excluded from this category. In addition, the health care status is composed of two aspects: physical health status and mental health status. Mental health status is an interesting research topic and has not been studied too much. But since physical health status is more directly related to health policy and one of aims of this research is to do policy analysis, this study examines the physical health care of immigrant women.

<sup>2</sup> See table 1.

(NSAF 1997 and NSAF 1999) and documentation of welfare reform rules. The results of this study demonstrate that all three factors contribute to immigrant women's health insurance coverage and that anti-immigrant sentiments are inadequate for explaining immigrants' health care circumstances.

## Table of Contents

<b>HEALTH CARE ACCESS BY IMMIGRANT WOMEN .....</b>	<b>II</b>
ABSTRACT .....	II
TABLE OF CONTENTS.....	IV
LIST OF FIGURES.....	VI
LIST OF TABLES.....	VII
PREFACE & ACKNOWLEDGEMENTS .....	VIII
<b>CHAPTER 1: INTRODUCTION .....</b>	<b>1</b>
OVERVIEW.....	1
IMMIGRANT WOMEN’S HEALTH .....	3
RELATED LITERATURE .....	7
ORGANIZATION OF THE THESIS .....	10
<b>CHAPTER 2: RESEARCH DESIGN.....</b>	<b>11</b>
HYPOTHESES .....	11
RESEARCH METHOD.....	13
RESEARCH OBJECTIVE AND SIGNIFICANCE.....	15
LIMITATIONS .....	16
<b>CHAPTER 3: POTENTIAL FACTORS.....</b>	<b>19</b>
POLICY FACTORS.....	19
<i>Background of Welfare Reform.....</i>	<i>19</i>
<i>Specific Restrictions for the Immigrant Population.....</i>	<i>20</i>
<i>Decentralization.....</i>	<i>22</i>
<i>Separation.....</i>	<i>23</i>
<i>Results of Welfare Reform.....</i>	<i>25</i>
<i>Arguments against Welfare Reform .....</i>	<i>30</i>
SOCIODEMOGRAPHIC FACTORS .....	33
<b>CHAPTER 4: CASE STUDIES.....</b>	<b>35</b>
CASE ONE: CALIFORNIA .....	35
<i>Demographics.....</i>	<i>36</i>
<i>Health Policy for Immigrants .....</i>	<i>37</i>
<i>Economy and Employment.....</i>	<i>40</i>
<i>Conclusion .....</i>	<i>43</i>
CASE TWO: FLORIDA.....	44
<i>Demographic .....</i>	<i>45</i>
<i>Health Policy .....</i>	<i>47</i>
<i>Economy and Employment.....</i>	<i>49</i>
<i>Conclusion .....</i>	<i>51</i>
CASE THREE: NEW YORK.....	52
<i>Demographics.....</i>	<i>53</i>
<i>Health Policy .....</i>	<i>54</i>
<i>Economy and Employment.....</i>	<i>57</i>
<i>Conclusion .....</i>	<i>59</i>
<b>CHAPTER 5: TESTING OF HYPOTHESES .....</b>	<b>61</b>
POLICY FACTORS.....	61
FACTOR OF EMPLOYMENT STATUS.....	65
FACTOR OF MARITAL STATUS .....	67
OTHER FACTORS .....	68
<b>CHAPTER 6: CONCLUSION .....</b>	<b>72</b>

<b>TABLES .....</b>	<b>76</b>
<b>APPENDICES .....</b>	<b>82</b>
<b>REFERENCES .....</b>	<b>85</b>
BOOKS.....	85
JOURNALS AND ARTICLES .....	88
<b>CURRICULUM VITAE .....</b>	<b>102</b>

## **List of Figures**

Figure 1. Insurance Status in California in 1997	36
Figure 2. Insurance Status in Florida in 1997	45
Figure 3. Insurance Status in New York in 1997	53
Figure 4. Medicaid Coverage in the U.S. in 1999	62
Figure 5. Medicaid Coverage for Immigrant Women in the U.S. from 1997to 1999	63
Figure 6. Employment and Employer-sponsored Insurance in the U.S. in 1997	66
Figure 7. Marriage and Employer-sponsored Insurance in the U.S. in 1997	68

## **List of Tables**

Table 1. People in “Fair or Poor” Health in 1999	76
Table 2. Health Insurance Coverage	77
Table 3. Sample Characteristics in 1997 and 1999	79
Table 4. Logistic Regression: Factors to Health Insurance Coverage for Immigrant Women in 1999	81

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## Chapter 1: Introduction

### Overview

The United States is known as an immigrant country. During the 1990s, an average of 1,300,000 immigrants entered the U. S. annually.<sup>3</sup> As a result, the foreign-born share of the entire population reached 10 per cent in 2000. Few other developed countries have such a high rate of foreign-born population (Boeri, Hanson and McCormick, 2002).

Partly due to the hard work and intelligence of immigrants, the U.S. has become an influential nation in the world today. As President Bush has stated, “America is a stronger and better nation because of the hard work and the faith and entrepreneurial spirit of immigrants. ... They bring to America the values of faith in God, love of family, hard work and self reliance – the values that made us a great nation to begin with” (President Bush, January 7, 2004).

However, immigrants’ access to public health care assistance is extraordinarily limited, in contrast to their contribution to the development of the U.S. A snapshot of the 1999 National Survey of America’s Families reveals that immigrants were more likely to be uninsured and more likely to be in poor health than U.S.-born citizens. In particular, immigrant women were tremendously likely to be uninsured, – almost three times as likely as female U.S.-born citizens.<sup>4</sup> Many immigrant women lack access to basic health

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<sup>3</sup> The data included one million legal immigrants and 300 000 illegal immigrants.

<sup>4</sup> See table 2.

care services they need, including preventive and prenatal care. As a result, immigrant women are in worse health than American citizens and even immigrant men.<sup>5</sup>

There is a growing recognition that research on the health care of immigrants is extremely significant. Yet, there is relatively little systematic research focusing on the health care access by immigrant women in the U.S. Most of the substantive research has been undertaken on the health care of children in immigrant families (Capps, Kenney & Fix, 2003; Reardon-Anderson, Capps and Fix, 2002; The Urban Institute, 2001; Capps, 2001; The Urban Institute, 1999). Compared to children who generally qualify for public health care assistance, immigrant women are less likely to be eligible for those health care programs. For these reasons, how immigrant women receive health care aid and whether their health care needs are satisfied are questions worth studying.

Therefore, I study the health care access by immigrant women in this thesis. Specifically, I examine the health status of immigrant women, the means by which they obtain health insurance, and the factors that likely influence their health insurance coverage. To explore these issues, I conduct analysis of survey data and public policy using both quantitative and qualitative research methods. I also choose three states – California, Florida and New York – as the bases for case studies. In view of the fact that little systematic research has explored the health care of immigrant women, I aim to map out a panorama that will reveal how several factors influence the immigrant women's access to health insurance collectively, such as public policy, employment status, and

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<sup>5</sup> 23.3 percent of female non-citizens, 12.4 percent of female U.S.-born citizens and 16.6 percent of female foreign-born naturalized citizens were in fair or poor health status respectively in the U.S. (NSAF of 1999). While about a quarter of female non-citizens are in fair or poor health status, only ninety percent of male non-citizens' health status were fair or poor in the U.S. (NSAF of 1999). See table 1.

marital status. In addition, I argue that policy responses based on widespread anti-immigrant opinions are inadequate to explain the health care access by immigrant women.

### **Immigrant Women's Health**

Immigrant women represent a large share of the population in the U.S. A brief review of the 1997 National Survey of America's Families reveals that one in twenty women was an immigrant in the United States. Not surprisingly, such immigrant women were more prominent in the places where immigrants were highly concentrated. About eighteen percent of women in California, eight percent of women in Florida, and ten percent of women in New York were immigrants in 1997.<sup>6</sup> The demographic importance is made even clearer by the data of the 1999 round of survey. Approximately one in sixteen persons in the United States in 1999 was an immigrant. One in five women in California and one in ten women in Florida and in New York was a foreign-born non-citizen (21 percent in California, 11 percent in Florida, and 12 percent in New York). A comparison between data of 1997 and those of 1999 indicates that the share of immigrant women of the population slightly increased in 1999 compared to in 1997. Such a large share of immigrant women suggests that most public policies that advantage or disadvantage immigrants are likely to have broad effects on immigrant women.

Beyond immigrant women's straightforward demographic importance, they have been identified as a vulnerable population that is at high risk for "fair or poor health"<sup>7</sup>. At the national level, immigrant women were more likely to be in "fair or poor" health than

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<sup>6</sup> 1997 National Survey of America's Families.

<sup>7</sup> In the 1999 round of survey, health status is divided into two categories: (1) fair or poor health and (2) good, very good or excellent health.

other relevant groups.<sup>8</sup> While about a quarter of immigrant women were in “fair or poor” health, only 19 percent of immigrant men’s health was “fair or poor” in 1999. Compared to female citizens and female naturalized citizens, immigrant women were also more likely to be in fair or poor health (23 percent, 12 percent and 17 percent respectively) in 1999. Again, this phenomenon was common in regions where immigrants were highly concentrated, though it was slightly different in three selected states: California, Florida and New York.<sup>9</sup>

The variable of health status has given us a vivid portrait of the health condition of immigrant women in 1999. Yet, some scholars have argued that solely using this variable is not reliable to study the health condition of immigrant women (Kramer, Ivey and Ying, 1999; Muenning and Fahs, 2002). Since it is a self-reported variable, immigrant women in a disadvantaged socioeconomic status will be more likely to exaggerate the degree of their poor health, in order to arouse others’ sympathy. Furthermore, these researchers believe that the health status of many new, voluntary female immigrants is actually better than that of some U.S.-born women and foreign-born naturalized women. These researchers argue that because female immigrants have experienced a self-selection process before their migration, it is likely that only the

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<sup>8</sup> See table 1.

<sup>9</sup> In general, the health status of immigrant women tended to be worse than other groups of people. By briefly reviewing these cases, I find that immigrant women apparently were in rather poor health status, while this varied among three cases. Immigrant women in California were in the worst health condition among all groups of people. 31 percent of California’s immigrant women were in poor health status in 1999, which is much higher than national average and that of other states (23%, 20 % and 21% for the Nation, Florida and New York respectively). Similar to the case of California, immigrant women in Florida were more likely to be in poor health status than female citizens and female naturalized citizens (20%, compared to 13% and 18%). Yet, different from the case of California, immigrant women and men in Florida were at almost the same level of health condition (20.0 percent and 20.6 percent). Immigrant men were even slightly more likely to be in poor health status than immigrant women. Interestingly, in the case of New York State, immigrant women were not in the worst health condition. But female naturalized citizens were more likely to be in poor health status than immigrant women (25% for female naturalized citizens and 21% for immigrant women).

strongest and healthiest are able to migrate. Also, before immigrant women enter the United States, they must undergo a medical examination to rule out those with active infectious diseases. During the process of migration, they must be healthy enough to travel. Many immigrant women may also come from countries with lower rate of chronic disease. Furthermore, many immigrant women practice “health promoting behaviors” such as abstention from smoking and alcohol consumption. As a result, these scholars believe that immigrant women share the characteristics of “family stability, healthy birth outcomes, and good overall health,” which is called the “healthy migrant effect” (Kramer, Ivey & Ying, 1999; Muenning & Fahs, 2002).

Admittedly, a “healthy migrant effect” may apply to some groups of immigrant women, especially the highly educated and skilled cohort in Canada. However, based on the survey data, more immigrant women in the U.S. were in worse health condition than female citizens. Yet, in view of the fact that data on health status may be not reliable enough, and there are no data pertaining to the health status in the 1997 round of NSAF, I employ another important measure to study the health care access by immigrant women – health care access. It can be argued that immigrant women were in poor health mainly due to their limited access to health care. Especially since the enactment of welfare reform in 1996, most immigrant women have been excluded from public health care assistance, and some eligible immigrant women have withdrawn from many government-sponsored health care programs because of confusion and fear. According to some studies, immigrants’ use of public health care programs was below the level at which they were actually eligible for those programs (National Immigration Law Center,

[NILC], 1999). Thus poor health and inadequate access to health care currently pose harsh problems for immigrant women in the U.S.

The problem of insufficient health care access affects not only immigrant women, but society as a whole (National Council of State Legislature, [NCSL], 1997). For instance, an immigrant woman has to turn to emergency treatment when her illness becomes life-threatening, due to having delayed the treatment or having failed to take preventive treatment. In such circumstances, the cost paid out of the federal or state revenues is much higher than that of the early or preventive treatment. To the contrary, if they receive early treatment or preventive treatment, immigrant women will have better prospects for early employment and self-sufficiency, and they consequently will be less likely to end up as “public charges” of the society (National Council of State Legislature, [NCSL], 1997: 3). For this reason, studying immigrant women’s health care access in this thesis should have implications for public policy recommendations that could make a major difference between despair and hope for those women.

Because there are no specific questions on the usage of medical services in the NSAF survey, I will employ a different but important variable in the survey that can be used to study health care experiences of immigrant women – health insurance coverage. A high uninsurance rate is a serious problem for the immigrant population (The Urban Institute, May 7, 2002). The survey shows that the majority of immigrant women lacked health insurance coverage.<sup>10</sup> The uninsurance rates for immigrant women were almost triple those for female citizens in 1997 and 1999 at the national level. Comparison among three states indicates that immigrant women in California were less likely to be insured

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<sup>10</sup> See Tables 2.

than those in Florida or in New York.<sup>11</sup> However, immigrant women's uninsurance rates change dramatically depending on sociodemographic characteristics such as employment and marital status.

### **Related Literature**

Many immigrant women in the U.S. were in poor health in 1999, and encountered some difficulties in obtaining public health care assistance, specifically health insurance. However, general public assistance programs usually cover the groups of people such as children and the elderly, leaving out immigrant women (Zimmerman and Tumlin, 1999). Furthermore, relatively few studies have systematically examined the health care access by immigrant women in the United States. In trying to explore the factors that influence immigrant women's health care access, this study is mainly located at the intersection of three broad bodies of literature: that on public policy factors, on socioeconomic factors, and on demographic characteristics that are likely to influence immigrant women's health care access.

When we study health care of immigrant women, we inevitably encounter the political issue of internal welfare controls and external immigration controls. The Welfare Reform Act of 1996 can be regarded as an example of welfare controls, which has tremendously restrictive immigrants' access to many government-sponsored welfare and Medicaid programs. Welfare reform of 1996 has had a significant impact on immigrants' lives (Fix, Passel, 2002; The Urban Institute, 2002; Weil, 2000; Loprest, 1999; The

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<sup>11</sup> Immigrant women were in worse health than immigrant men in 1999. Interestingly, immigrant women were more likely to have insurance coverage than immigrant men in most cases. Only in the case of Florida in 1997, immigrant women (45 percent) were a little less likely to be insured than immigrant men (40 percent).

Urban Institute, 1999). As a part of the immigrant population, immigrant women, especially those post-enactment immigrant women, are hindered from receiving most public health care assistance. In this research, I will explore how welfare reform of 1996 has been associated with the health care access by immigrant women.

To study health care of immigrant women, I also examine changes in health policy brought by welfare reform. In the United States, the health care system is somewhat separate from welfare system (Weil and Finegold, 2002).<sup>12</sup> Since welfare reform in 1996, health policy for the immigrant population has witnessed significant changes.<sup>13</sup> Some studies have found that Medicaid enrollment among non-citizens did decrease after welfare reform, as intended by law, and noncitizens were much less likely than native-born citizens to receive Medicaid (Wang and Holahan, 2003). For this reason, compared to the U.S.-born citizens, I anticipate that immigrant women may face more obstacles when they pursue public health assistance.

While public policy is a potential external influence on the health care access by immigrant women, the sociodemographic characteristics of immigrant women are individual-level factors that are likely to have an impact on immigrant women's health care. Though the research examining well-being among women and patterning of illness is still in its infancy, several views have emerged concerning the association between them. Research demonstrates a strong relationship between socio-economic status (SES)

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<sup>12</sup> When Medicaid was enacted in 1965, it was only a supplementary program in the welfare programs. Later, several eligibility policies delinked Medicaid and welfare. First, the Family Support Act of 1988 required states to extend Medicaid coverage for 12 months to families that lost welfare eligibility. Second, states may use medically need programs to cover some people who had incomes above welfare eligibility standards. And finally, under Section 1115 of the Social Security Act, some states obtained waivers allowing them to expand Medicaid coverage to new populations and to determine eligibility on a different basis from the Medicaid statute (Weil and Finegold, 2002: 144-145).

<sup>13</sup> The PRWORA barred legal immigrants who enter the United States after August 22, 1996, from Medicaid.

and health status (Anderson, Blue, Holbrook & Ng, 1993). Traditional indicators of socioeconomic status such as education, occupation and income reflect people's health and well-being to such a high degree that some scholars conclude that SES is a "fundamental cause of disease" (Anderson, et al., 1993). In my study, I include employment and marital status in the category of sociodemographic factors.

Economic incentives also have been viewed by some analysts as the root cause of immigration. Immigrants make up one in seven U.S. workers, and one in five low-wage workers (Capps, Fix, Passel, Ost, and Perez-Lopez, 2003). Since so many immigrants work and so many hold the low-wage jobs, I use employment as one important economic factor that is likely to affect immigrant women's health. Literature on the relationship between employment and women's health status is rather complex. On the one hand, employment may have a positive effect on women's health status, as a result of increased income, social support, self-esteem, and more opportunities to access employer-sponsored health insurance. On the other hand, employment may bring negative consequences to women's health, due to stress associated with hard work and the burden of housework at home. Anderson, et al. (1993) have described how the daily lives of a group of Chinese immigrant women in Canada and their inferior position in the labor market have influenced their health management. "Without job security, many [Chinese immigrant women] were forced to conceal their chronic illness" (p.16-17). Nevertheless, in this study, I hypothesize that there is an overall positive influence of employment on immigrant women's health.

Besides employment status, I add marital status to the category of sociodemographic factors likely to explain the health care of immigrant women. The idea

that marital status may influence the health status of immigrant women comes from the following literature. Some long-term research suggests that marriage will bring advantage to women's health, which can be called "marriage protection" (Waldron *et al*, 1996). The logistic regression analysis of NSAF data indicates that marital status is strongly associated with women's access to health insurance nationally; most likely because married women are more likely to receive health insurance from their spouses (see Table 4). So I hypothesize that marital status is a factor that affects immigrant women's health insurance positively in this study.<sup>14</sup> The findings discussed in Chapter 5 support this hypothesis.

### **Organization of the Thesis**

The rest of this thesis will concentrate on exploring factors that influence health care access by immigrant women in the U.S. In the second chapter, I will provide a detailed strategy to conduct analysis. Included there will be discussion of my hypotheses, research method, objectives and limitations of this study. Chapter Three examines in more depth some potential factors that are likely to affect immigrant women's health care access. Based on the possible explanations for immigrant women's limited access to health insurance in Chapter Three, I will examine three cases of individual states in Chapter Four and demonstrate whether my hypotheses are supported or not in Chapter Five. Finally I will endeavor to generalize about the significance of the findings, draw some conclusions about the data, and suggest some policy implications.

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<sup>14</sup> It is arguable whether marriage will contribute to better health status or whether healthier adults will be more likely to choose marriage. But Waldron *et al*'s studies indicate that at least there exists some relationship between marital status and health status.

## **Chapter 2: Research Design**

This chapter introduces how I undertake the examination of health care of immigrant women. First, I will outline several hypotheses the research will seek to test. Next, I will explain the methods used to test these hypotheses and justify the choosing of three cases. Finally, I will present objectives and significance of this study. Since this study mainly relies on two rounds of one survey, there are inevitably some limitations, which I will also indicate in this chapter.

### **Hypotheses**

Based on the early discussion in the first chapter, I put forward several hypotheses. First, I expect that policy changes since Welfare Reform influence the health care access of immigrant women negatively. The Welfare Reform Act of 1996 barred many immigrants, especially those arriving after 1996, from receiving health care assistance (Wang and Holanhan, 2003). In addition, since welfare reform, even those eligible immigrants may have withdrawn from public health care programs, such as Medicaid; this phenomenon is called the “chilling effect” of welfare reform by many scholars (Weil and Finegold, 2002: 185). To test this hypothesis, I compare Medicaid coverage of immigrant women and American women, and anticipate that immigrant women are less likely to obtain Medicaid-sponsored health insurance than U.S.-born women. I also make a comparison between two rounds of surveys – National Survey of America’s Families

(1997 and 1999).<sup>15</sup> If welfare reform of 1996 has had a “chilling effect” on eligible immigrant women, those immigrant women in 1999 would be less likely to access public benefits than in 1997. Besides conducting data analysis, I test this hypothesis by comparing health policies in three selected states. Since each state has responded to welfare reform differently, immigrant women should be more likely to receive public health care benefits in those states that put forward a more generous health policy for the immigrant population after 1996.

Second, I anticipate that the status of being employed influences the health insurance coverage of immigrant women positively. In other words, I hypothesize that immigrant women’s higher uninsurance rates are closely associated with their higher unemployment rates, compared to American women, because of the dominant role that employers play in the health insurance system. According to the National Survey of America’s Families, health insurance was mainly paid by employers. Employers paid the health insurance for about two-thirds of U.S.-born citizens and two thirds of naturalized citizens in 1997. Although the foreign-born population was less likely to receive employer-sponsored health insurance than U.S.-born citizens (only 42 percent of non-citizens had health insurance paid by employers), the employer was unquestionably the major health insurance provider for the immigrant population.

Finally, I hypothesize that being married is positively associated with immigrant women’s health insurance status. In fact, the logistic regression analysis shows that marital status is such a powerful predictor of insurance coverage that, when controlling

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<sup>15</sup> The survey is a nationally representative survey of households with persons under age of 65 that includes data on 40 thousand women and 35 thousand men in 13 states. It is one of the few national surveys with a large number of immigrants that include economic, health and social status of immigrants. So it makes this analysis possible. Furthermore, the three states that I have chosen as case studies are among the 13 states.

for other factors, married women in the national population were almost three times as likely to have insurance as the unmarried. Married immigrant women are more likely to get employer-based health coverage, probably through their spouses.

To test the second and third hypotheses, I will use the 1999 national survey. The independent variables are the sociodemographic characteristics of employment status and marital status. The dependent variable is health insurance status. How the variables are operationalized is exhibited in Appendices I and II, which show the variable label and concept.

Overall, the three hypotheses are put forward because employers are the principle health insurance providers for both U.S.-born citizens and the foreign-born population, followed by government-sponsored health care programs, and because marital status is the single important factor that is likely to impact immigrant women's health insurance coverage. In addition, these hypotheses are based on the literature that argues that health care access may be different as a result of two key general factors: public policy and sociodemographic characteristics including employment and marital status (Brown, 1999; Anderson, et al., 1993; Waldron, et al, 1996).

### **Research Method**

I use both quantitative and qualitative methods in this thesis. A series of literatures have argued that both quantitative and qualitative methods need to be used in women's health research in order to address the complexities of women's health on a number of levels. "Quantitative data are often thought of as 'hard' and qualitative as 'real and deep' — thus, if you prefer 'hard' data you are for quantification and if you prefer

‘real,’ ‘deep’ data, you are for qualitative participant observation” (Oakley, 1993a: 209). Since in this study of immigrant women’s health, not only the question of “how,” but “why” is raised, I will begin to test these hypotheses by using the most recent two rounds of National Survey of America’s Families (1997 and 1999). I also supplement the data analysis with case studies and policy analysis.

NSAF is a reliable source to study health information of immigrant women. It includes a large sample of immigrants and is conducted in thirteen states. The surveys cover a broad range of public health concerns, such as individuals’ health circumstances, health insurance coverage, access to health care, and a variety of sociodemographic characteristics.<sup>16</sup> Conducting data analysis using these two rounds of survey provides me a portrait of health insurance coverage of immigrant women in the three states and some factors that may contribute to the disparity in insurance coverage.

Besides using those two rounds of national survey, I have employed the approach of comparative case studies. Case studies bring us convenience in studying a complex issue through the contextual analysis of a limited number of situations and events. This method has been widely used for many years across a variety of disciplines. Since each particular state in the U.S. has a specific set of welfare programs, some studies have studied welfare programs and immigrants at the regional level. For instance, Fix and Capps (2002) have applied the case study approach in examining the well-being of immigrants in New York and Los Angeles, which are the nation’s two largest cities (The Urban Institute, March 06, 2002; Capps, et al., 2002). Furthermore, comparative studies of welfare and immigrants have been made on a cross-national scale (Fix and Laglagaron,

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<sup>16</sup> There were 75,525 respondents in NSAF 1997 and 74,719 respondents in NSAF 1999. Immigrants comprised 6 percent of the sample in both years.

2002). All of these literatures provide me a justification for doing case studies of immigrants and health care in three states.

In this study I have chosen three states as case studies: California, Florida, and New York. These three states have been used as the geographic focus of this study because a very large proportion of immigrants, about 49% of all immigrants, settle in these three states (Capps, Fix and Passel, 2002). Thus studying the health care access by immigrant women in the three cases is important to reveal the insurance coverage of immigrant women in the U.S. In addition, since these three states are located in the west, the south and the east respectively, and attract different groups of immigrants, examining these three states can demonstrate the health care access by immigrants from different origin countries. Discussion of the three geographic cases will follow a similar format. Each will begin with discussion of demographic characteristics of the state, followed by its public health policy, economy, and employment opportunities. By making a comparison of the incumbent governors' approaches to policy, economic development, and public policy in these three states, I aim to explain how disparities among these states might account for the difficulties that immigrant women encounter in obtaining health care.

### **Research Objective and Significance**

The main objective of this study is to inquire about the health care access by certain members of the immigrant population – immigrant women. Specifically, I wish to answer substantive questions about the health care access by immigrant women in the United States by comparing three representative states, examine the underlying factors

contributing to health care problems of immigrant women, and identify the implications of these findings for improving health care policy making with regard to immigrant women.

It is also my wish that this thesis will contribute to the growing body of work on welfare, health care, and immigration, by focusing on health care access by immigrant women. These women are chosen as the focus of the study because they have entered the United States in large numbers, their health status is rather poor, and the research is relatively meager. They face double barriers to accessing health care because of their immigrant status and gender. It is also my goal that people will regard my thesis not only as a discussion of health and immigration policies, but as a dialogue with those who require aid and attention. I expect that a benefit to me will be that I will be changed by my encounters with those people and their experiences. I also expect that the experiences of those in need will be changed through the efforts of more and more people who are willing to join this dialogue.

### **Limitations**

As mentioned above, I mainly rely on current national surveys and case studies to test the hypotheses I have formulated. However, there are always limitations to generalizing from such results. First, as already discussed, an important variable for this study – self-reported health status – may be biased and responses are not available for 1997. Nor does the survey provide detailed information regarding the means by which immigrant women obtain health care. Because of these difficulties, I have emphasized health insurance coverage instead. Second, although the survey provides data on health

insurance coverage and sources of health insurance providers, it does not cover access to various welfare and Medicaid programs. This excludes analysis of a lot of differences among different programs, which might play a very important role in explaining health care access by immigrant women. Even so, by using rough comparison of policies provided by the three states, I partially compensate for that problem. Third, the data on which this study is based may be biased. For instance, since some immigrants may be unwilling to report their informal working status, the actual employment rate may be higher than that in the survey. Also immigrant women's high unemployment rate may be due to the fact that they choose to stay at home caring for family members, rather than the barriers in seeking employment.

Furthermore, selection of these cases may limit the usefulness of the findings. These states are chosen because of their large share of the immigrant population. However, immigrant women's health care access may be different in those states in which fewer immigrants reside. It is quite possible that the hypotheses will be rejected when more cases are included.

Moreover, my study focuses on a survey conducted by one research institute – the Urban Institute. This will weaken external validity as well as reliability of the research result. Given the fact that each institute has its specific inclination on immigration study – more liberal or more conservative – reliance on the findings of one institute will result in a loss of many other viewpoints.

And finally, another possible limitation of the study is that of my selection bias. Given that I am a foreign student in the U.S., I may be more likely to select the data that favor the immigrant population. This means that my argument and findings may be based

on my preconception, which is that immigrant women live under inferior political, socioeconomic, and cultural conditions.

## **Chapter 3: Potential Factors**

Immigrant women may face a variety of barriers in seeking health insurance due to their immigrant status and sociodemographic characteristics. In the following part, I will discuss how researchers have identified associations between various factors, such as welfare reform, and socioeconomic status and health care access by immigrant women. One critical factor that is likely to influence immigrant women's access to health care is public policy, which has tied eligibility for health care assistance to immigrant status and time of entering the U.S.

### **Policy Factors**

#### *Background of Welfare Reform*

In 1996, President Clinton signed into law one of the most important welfare policies in the United States – the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). This act has caused significant changes for both individuals and the states. For individuals, under the rationale to reduce welfare dependency, the law substituted Temporary Assistance for Needy Families (TANF) for AFDC and other programs. Unlike the previous lifetime welfare assistance, TANF imposed a five-year limit on receipt of benefits (Tumlin & Zimmermann, October 20, 2003; Randy Capps et al., 2002).

Significant changes also took place at the regional level after welfare reform in 1996. The previous open-ended funding to states was ended, and instead a \$16.4 billion was granted to states and territories per year. Under the block-grant structure of TANF,

states enjoyed flexibility in implementing welfare programs and making funding decisions. Meanwhile, states and communities were given a variety of responsibilities. States should provide a wide array of services such as education and training to those unemployed, community service jobs. In addition, states should offer wage supplements to employers for several months and encourage them to hire welfare recipients. And finally, states should promote marriage, help single mothers, and reduce out-of-marriage childbearing (Tumlin and Zimmermann, October 20, 2003).

#### *Specific Restrictions for the Immigrant Population*

One important point of welfare reform in 1996 was its fundamental significance for the immigrant population. Welfare reform is not merely an act that brings changes to welfare programs, but it is a law that is closely related to immigrant provisions. Actually since the welfare reform act was enacted, a large amount of debate has concerned the law's immigrant provisions (Weil and Finegold, 2002). As Fix and Capps (August 31, 2002) indicate, welfare reform plays an important role in explaining well-being among immigrants, including health status and health care. This law is “an unprecedentedly tough legislative agenda that substantially restricted the legal and social rights of immigrants” (Fix and Zimmerman, 1998: 7).

Welfare reform has significantly limited immigrants' access to welfare benefits. Since 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has imposed a set of eligibility rules that exclude the immigrant population from receiving some public benefits.<sup>17</sup> After welfare reform, the law restricted legal

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<sup>17</sup> Restricting immigrants' access to welfare evolved through the mid-1990s. Proposals to limit non-citizens' access to SSI and other benefits originated during the Clinton administration. More restrictions

immigrants' access to TANF and related employment services. In addition, the law reduced legal immigrants' access to food stamps, Medicaid, the State Children's Health Insurance Program (SCHIP)<sup>18</sup>, and Supplement Security Income (SSI) (Zimmerman and Tumlin 1999; Fix and Capps, August 31, 2002). Furthermore, states may restrict eligibility of non-citizens for TANF and Medicaid, except for the obligation of the states to provide treatment of emergency medical conditions to undocumented aliens<sup>19</sup> (Weil and Finegold, 2002; Siddharthan & Alal Sundaram, 1993).

Another eligibility rule of PRWORA is related to the timing of immigrants' entry into the United States. Legal immigrants who arrived after welfare reform's enactment are eligible for fewer benefits than those who arrived before its enactment. Under this law, except for refugees, immigrants who enter the U.S. after August 22, 1996 are excluded from Medicaid, the Children's Health Insurance Program (CHIP), and food stamps (Zimmerman and Tumlin, 1999; Fix and Capps, August 31, 2002; Tumlin and Zimmerman, October 20, 2003; Sanchez de Dios, 2002).

In a word, after welfare reform, eligibility for the majority of social benefits was more closely related to citizenship status and the timing of entry into the U.S. by immigrants (before or after PRWORA's enactment). Immigrants are less likely to receive public benefits than citizens. And the post-enactment immigrants encounter more obstacles in accessing the welfare system than the pre-enactment immigrants.

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were written into the "Contract with America", the policy blueprint for the Republican Congress elected in 1994. And the final version of the restrictions was the welfare reform law on August 22, 1996 (Weil and Finegold, 2002: 180).

<sup>18</sup> SCHIP are the primary public programs that provide food assistance and health insurance to low-income families.

<sup>19</sup> Undocumented aliens are those persons who are in the United States illegally or those who are legally resident but undocumented. The latter group consists mostly of political refugees who are allowed to stay in the country while pursuing political asylum. They are undocumented because they do not possess a visitor's visa or a green card that establishes temporary or permanent residency in the United States (Siddharthan, 1993: 410).

### *Decentralization*

Two salient characteristics of welfare reform are worth mentioning – ‘decentralization’ and ‘separation.’ Since welfare reform of 1996, the immigrant provisions have been decentralized – from the federal to the state level. Thus, immigrants in different states, even immigrants arriving before or after 1996 in the same state, are likely to receive different health care assistance. According to the welfare reform act, states obtained the authority to treat legal immigrants and citizens differently, which was a power denied by the courts previously. In addition, states can exclude non-citizens entering after 1996 from TANF for their first five years, and they have powers to decide whether their non-citizens should have access to federal and state benefits, including TANF after that period.<sup>20</sup> For the undocumented immigrants, states need to pass a law if they wish to provide benefits. This acts as a harsh barrier for undocumented immigrants to seek public benefits (Tumlin and Zimmerman, October 20, 2003; Weil and Finegold, 2002).

As a result, there are differences in immigrants’ access to public benefits in different states, different health care access by pre-enactment immigrants versus post-enactment immigrants, and variation in eligibility of documented immigrant and undocumented immigrants even in the same state. I expect that the immigrants’ access to public assistance will be less likely to be restricted in the generous states than in the less generous states. In the case studies, I will examine the influence of different welfare and health care programs in three states on immigrant women’s health care.

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<sup>20</sup> Only Alabama chose to do so.

Another result of decentralization is different treatment for legal immigrants entering the United States before and after the enactment of PRWORA. In fact, most states are reluctant to provide public assistance to post-enactment immigrants. After the enactment of PRWORA, almost all states extended public benefits to pre-enactment immigrants, but they were less generous to the post-enactment immigrants.<sup>21</sup> This difference in treatment between pre-enactment and post-enactment immigrants results from fiscal incentives. Under current law, states and federal government share expenditures on TANF, Medicaid, and SCHIP for those pre-enactment immigrants. Yet, states cannot obtain federal grants to extend social benefits to post-enactment immigrants. This law has widened the difference in the usage of public benefits between pre-reform and post-reform immigrants (Weil and Finegold, 2002).<sup>22</sup>

### *Separation*

Another significant change brought by welfare reform is that it has continued to separate Medicaid eligibility from welfare, which can be called “separation.” When Medicaid was enacted in 1965, it was only a supplementary program in the welfare programs. Low-income families and their children obtained health insurance mainly through cash assistance if they were eligible for AFDC. In the 1980s, there was an increasing need for Medicaid coverage to be separated from the welfare state. Most people needed health care assistance, although they were ineligible for welfare programs. They could not receive welfare assistance, because most of them had jobs and stable income. Yet, as health care costs increased tremendously, many working people could

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<sup>21</sup> California is the only state that provides substitute benefits to post-enactment immigrants in the areas of health, cash assistance, and nutrition (Weil and Finegold, 2002, 183).

<sup>22</sup> The latter group stands for roughly one-third of all legal permanent resident aliens.

not afford health care and health insurance on their own. In addition, more and more people came to be in poor health status (Weil and Finegold, 2002). These two trends required the Medicaid program to develop separately from the welfare program to meet the increasing need for health care assistance. Meanwhile, policymakers found that Medicaid could work more efficiently when it was separated from welfare. Consequently, during the late 1980s, legislation enacted two new eligibility categories for Medicaid, a new provision of Medicaid law – Section 1902 (r) (2) , the Family Support Act of 1988, states’ medical needy programs, and the waivers some states obtained under Section 1115 of the Social Security Act (Weil and Finegold, 2002).

Welfare reform of 1996 still let Medicaid develop along a separate path. Though Medicaid remained relatively intact compared to welfare programs after 1996, a lot of provisions in the new welfare law brought changes to Medicaid eligibility. One provision of PRWORA eliminated Medicaid eligibility for many legal immigrants entering the U.S. after 1996. In the past 20 years, Medicaid and welfare have each worked independently to maximize the efficiency of their systems in serving American citizens. Ironically, they have always cooperated to minimize the eligibility of immigrants. Immigrants who lacked access to welfare after 1996 likely found that they were also excluded from Medicaid. One year after the passage of welfare reform, the State Children’s Health Insurance Program (SCHIP) was enacted, which provided health care benefits for children in immigrant families. But many immigrant adults still continue to be in poor health status or uninsured since welfare reform.

Different from welfare programs that obtain federal funding, Medicaid is mainly funded by states. There is almost no solid financing mechanism from the federal

government to provide health benefits. According to the Clinton administration's proposal in 1994, most of the funds for Medicaid were to come from cost savings (Torre, 2002). But because of the increasing prescription drug costs and the increasing large number of enrollees, it is hard to save on Medicaid costs. Thus, Clinton's promise of access to health care for millions of uninsured or underinsured seems impractical. With no federal funding, states and counties may be unable to enroll those uninsured people or families, regardless of whether they are immigrants. In contrast, states may be more generous in the welfare programs since they obtain federal grants. For this reason, when we study health care for the immigrant population, both Medicaid and welfare should be taken into account.

#### *Results of Welfare Reform*

As intended by the policymakers, welfare reform brought declining Medicaid caseloads. According to Weil and Finegold (2002), national Medicaid caseloads peaked in 1995, fell until 1998 and experienced a turnaround after 1998. It is possible that the strong economy increased incomes so that people were more likely to be able to afford health insurance by themselves, without relying on Medicaid. Also, the economic prosperity made more employer-sponsored health insurance available to the low-wageworkers. In addition, some people who were excluded from welfare after welfare reform might have left Medicaid as well, even though they were eligible, because the welfare revisions produced confusion over Medicaid eligibility. Furthermore, some states added new steps in applications for cash assistance, which brought inconvenience for applicants and made them unwilling to apply for assistance (Weil and Finegold, 2002).

These reasons apply to the declining caseloads among both citizens and immigrants. There are other specific reasons to explain the declining Medicaid and welfare enrollment for immigrants.

Actually, according to some scholars in the Urban Institute, the declining Medicaid caseloads since welfare reform were largely attributable to the falling Medicaid enrollment of immigrants, and the declining caseloads among immigrants were mainly due to the welfare restrictions (The Urban Institute, May 7, 2002). Welfare reform imposed much severer restrictions on the immigrant population than on citizens, and much harsher regulations on the post-enactment immigrants than the pre-enactment immigrants. Thus, these scholars argued that welfare reform was actually a paradox: the welfare system constructed laws such as welfare, food stamps, Medicaid and SSI to provide public assistance, but those people (namely, immigrants) who mostly needed the assistance actually could not get help (The Urban Institute, May 7, 2002). Since welfare reform, fewer immigrants are eligible for Medicaid.

The reason for declining caseloads among the immigrant population can also lie with the fact that the immigrants have confusions about their eligibility for welfare and Medicaid. The welfare restrictions of PRWORA are quite complicated. First, even among the immigrant population, there are different restrictions for “qualified” immigrants and “unqualified” immigrants.<sup>23</sup> Unqualified immigrants are ineligible for the majority of social benefits except a small portion of federal or state benefits, such as emergency Medicaid, immunizations, diagnosis, treatment of communicable diseases, and school lunch and breakfast programs. Second, there are variations in eligibilities between qualified immigrants and qualified naturalized citizens under PRWORA. The naturalized

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<sup>23</sup> The unqualified immigrants are those undocumented immigrants and some lawfully present immigrants.

citizens are eligible for all noncontributory programs called “means-tested federal benefits,” such as TANF, Supplement Security Income, Food Stamps, Medicaid, and SCHIP (Weil and Finegold, 2002). Public health care assistance for the immigrant population is restricted to emergency medical services under Medicaid, immunizations, and testing and treatment for symptoms of communicable diseases, such as tuberculosis, HIV/AIDS, and sexually transmitted diseases (Zimmerman and Tumlin, 1999). As a result, many immigrants who are eligible for Medicaid may withdraw from the program, and large numbers of immigrants do not seek needed health care (Schlosberg and Wiley, 1998), in part because they have confusions about eligibility.

Kretsedemas (2003) has examined access to services by Haitian immigrants in Miami, Florida. He found that since the implementation of the 1996 Welfare Reform Act, the caseloads have declined significantly. It is impossible that those post-enactment Haitians have suddenly become rich and unqualified for those services, because many Haitians are living in poverty and they do report a need for some basic services such as food assistance, housing and health care. Kretsedemas attributes the decline in caseloads to the confusion over eligibility guidelines.

Also, qualification within “mixed-eligibility” families plays a role. Kretsedemas demonstrates that qualified immigrants living in households with unqualified persons are less likely to access services than are other qualified immigrants. “Some people do qualify [for services] but since they have people in their household without proper documentation they are afraid to go to social services because they are afraid that the INS will come to get them. Many Haitian people – in their household – have one or two people who are undocumented. And those people may be qualified [to access services]

but since [other household members] don't have documentation they don't apply" (Kretsedemas, 2003: 320).

Welfare reform not only has produced direct restrictions on welfare eligibility for immigrants, but contributes a "chilling effect" that discourages the immigrant population from seeking public health care assistance. Compared to U.S. citizens, immigrants have a special set of worries and fears when they encounter Medicaid and welfare programs. They may be afraid that they are ineligible for the assistance, or they may fear that their legal status will be affected by receiving public assistance. Even for some eligible immigrants, their access to health care assistance is hindered by the fear that their immigrant status will be reported and they will finally be deported. Actually, only agencies that administer SSI, housing assistance under the U.S. Housing Act of 1937, or block grants under the TANF programs are required to report the immigrant status (Potocky-Tripodi, 2002). Immigrants do not need to worry about their citizenship when they apply for public health benefits. Yet, most immigrants are unaware of such policies.

Besides the "chilling effect" of welfare reform, most immigrants have another kind of fear that prevents them from seeking health care. The fear comes from the "public charge" provisions of PRWORA and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) (Potocky-Tripodi, 2002).<sup>24</sup> Many legal immigrants who are eligible for benefits are confused about the implication of receiving benefits.

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<sup>24</sup> Under these laws, aliens who wish to enter the U.S. for permanent residency must show that they are not likely to become a public charge. Otherwise, their request to enter the U.S. or application for changing immigration status will be delayed or denied (Families USA 1999). One factor in determining whether a person will become "public charge" is whether they have depended on some kind of public assistance for financial source in the past. According to INS guidelines, non-citizens who establish a pattern of systemic government use will be labeled a "public charge." A public charge determination by the INS can result in the refusal of an immigrant's citizenship application or the denial of an application to sponsor other immigrants. Public charge can also play a role in deliberations that result in the permanent removal of an immigrant from the nation (Kretsedemas 2003).

They believe that receiving public benefits may jeopardize their ability to obtain a green card or that when they become citizens, they have to repay their Medicaid benefits. Thus, the Urban Institute (May 7, 2002) argues that the low income of immigrants, welfare restrictions, and confusion over eligibility lead to economic hardships for the immigrant population. Again according to Kretsedemas (2003), most Haitian immigrants fear that using some public assistance will label them as a “public charge,” and they will consequently meet difficulties in naturalization or even be deported. In fact, most immigrants have misunderstood public charge rules. Immigrants may use any public health benefits, services, or programs, except long-term institutionalization, without being considered a “public charge” (Potocky-Tripodi, 2002). Use of the majority of public assistance programs officially is not supposed to have negative effects on the process of naturalization or applying for green card.

Among undocumented aliens, Siddharthan & Alalasundaram (1993) finds two factors to explain why many lack health insurance. First, consistent with the discussion above, undocumented aliens are unable to participate in government programs such as Medicaid because of ineligibility (except in the case of emergencies). Another reason is that undocumented aliens are usually concentrated in specific areas, which has made it difficult for the local government to provide sufficient health care assistance. I will call the latter the “concentration effect.” In the following part of this thesis, the “concentration effect” partly plays a role in explaining health care access by immigrant women in three selected cases. All three cases are selected due to the high concentration of the immigrant population. Among them, California has the largest number of immigrants, and the California government claims that welfare and Medicaid account for

the second largest portion of state budget. Even so, partly because it is the state with the high concentration of immigrants,<sup>25</sup> in California, immigrants are less likely to receive health insurance from Medicaid than immigrants in New York.

### *Arguments against Welfare Reform*

The Welfare Reform Act is partly based on the theory of “welfare magnet.” Anticipating that people will be attracted by places with generous welfare programs, policymakers intend to control the entry of immigrants by controlling immigrants’ access to welfare and Medicaid benefits. However, Capps, Fix, and Passel (2002) found two demographic trends that indicate the opposite. First, many immigrants move out of the most generous states into the least generous states. Second, the percentage of immigrants residing in the least generous states increased during the late 1990s. On the one hand, immigrants will not move to a place due solely to the generous welfare and Medicaid programs; on the other, immigrants will not leave a place just because the welfare and Medicaid programs are restrictive to them. The power of the so-called ‘welfare magnet,’ has been contested in much literature (Weil and Finegold, 2002). In this thesis, welfare reform appears to be negatively associated with immigrant women’s health care access. Furthermore welfare reform fails to meet its aim – that of controlling immigration by controlling public assistance.

The debate on welfare reform actually reflects the conflict between two values: the compassion to help those in need and the worry that charity will bring dependency. What policymakers are always seeking is a balance between these two values and an

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<sup>25</sup> In California, 26.2 % of the population was foreign-born in 2000, compared to 16.7 % in Florida and 20.4 % in New York (U.S. Census Bureau, retrieved on May 24, 2004).

appropriate ratio of those in the welfare system to those who do not depend on it. Suro provides a vivid metaphor: the welfare system is just like a cart with some people pulling it and some people inside it. The purpose of welfare reform is to reduce the number of people in the cart and to let more people pull the cart (The Urban Institute, May 7, 2002).

Some anti-immigrant policymakers fear that the influx of the immigrant population may cause the U.S. economy to deteriorate (Torre, 2002). They charge that illegal immigrants worsen the economic recession in the U.S. and that these pose a fiscal burden for the government. As many immigrants enter the labor market, they contend, they compete with American citizens for a limited number of positions, and consequently, the rate of unemployment remains high for U.S.-born citizens. But most immigrants work in the low-wage-sector, in which the majority of Americans are unwilling to work (The Urban Institute, May 7, 2002). Historically, workers from Mexico in the southwestern U.S. have worked in low-wage-sector jobs such as the agricultural industry (Torre, 2002). There is demand in the U.S. economy for such a group of low-skilled, low English proficient workers who will perform tasks and be paid with very low wages. They are actually ‘pulling the cart’ for the U.S. As President Bush (January 7, 2004) has said, “Our nation needs an immigration system that serves the American economy, and reflects the American Dream. ... some of the jobs being generated in American’s growing economy are jobs American citizens are not filling. ... Out of common sense and fairness, our laws should allow willing workers to enter our country and fill jobs that Americans have not filling. ... And I believe we can do so without jeopardizing the livelihood of American citizens” (President Bush, 2004).

Most anti-immigrant policymakers argue that immigrants deplete finite public resources, due to the assumption that government spends much more expenditures on immigrants than on native-born citizens. In fact, immigrants are the vulnerable group of people who are less likely to obtain public assistance than U.S.-born citizens. In the mid-1990s, the total expenditures<sup>26</sup> averaged roughly \$ 3,800 for the U.S.-born citizens and \$ 2,200 for the foreign-born (Simon, June 25, 1997). In addition, the saving resulting in excluding immigrants from public assistance is rather minor, only \$54 billion, according to the Congressional Budget Office's estimation (Weil and Finegold, 2002). Since immigrants receive less public assistance than U.S. citizens, and expenditures on immigrants account for a small proportion of the total government budgets, this anti-immigrant viewpoint lacks of support.

Those anti-immigrant policymakers are also worried that the mass population of immigrants will corrupt the "American Culture" (Torre, 2002). In his recent article, "*The Hispanic Challenge*," Samuel P. Huntington (2004) warns that Hispanic immigrants are dividing the U.S. into "two peoples, two cultures, and two languages" (p. 1). But have those immigrants made contributions, large or small, that have been assimilated into the American Culture? Has the American Culture been enhanced, in some degree, through the influx of a large number of immigrants? The immigrant population brings U.S. not only brains and labor, but a highly competitive atmosphere. A group of highly intelligent and diligent immigrants are "pulling the cart" for the U.S. Meanwhile, they push other U.S.-born citizens to "pull the cart." From this perspective, the aim for the PRWORA to reduce the culture of dependency is paradoxical.

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<sup>26</sup> The total expenditures per person include welfare expenditures, payments to the elderly, schooling costs, unemployment compensation, and Medicaid.

In addition to welfare law and public health care policy, immigrants face other policies and laws that will affect their access to health care: for instance, immigration policy. A series of anti-immigrant policies have been issued since the 1993 World Trade Center bombing, such as the 1996 Antiterrorism and Effective Death Penalty Act. This law restricted non-citizens' rights of residence and judicial appeal and the ability of undocumented immigrants to adjust to legal status (Weil and Finegold, 2002). A few weeks after the passage of PRWORA, Congress passed important immigration legislation, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). The IIRIRA further restricted the eligibility of immigrants for public benefits. For instance, the minimum income level to be eligible for public assistance is 125 percent of the poverty line; sponsors are required to support the immigrants until they have worked for 10 years or have become citizens; states are authorized to limit general cash assistance to aliens (Fix and Zimmerman, 1999; Gimpel and Edwards, 1999).

### **Sociodemographic Factors**

In addition to public policies, socioeconomic status is a strong factor that is likely to influence health care access. People in lower socioeconomic status are more likely to work in jobs that do not offer health insurance or to be unable to afford their share of the health insurance offered (Ross, 2000). Socioeconomic status is such an important factor in predicting the health care access that it even has more predictive power than racial/ethnic minority status or immigrant status (Anderson, et al., 1993). I will focus on employment status, one element of socioeconomic status, as the key to understanding health care access by immigrant women in the case studies.

Additionally, there have been many studies on the utilization of health care for ethnic and racial minorities.<sup>27</sup> These studies have shown that ethnic and racial minorities are less likely to access public health services than their counterparts (U.S. Department of Health and Human Services, 1998). Racial and ethnic minorities are more likely than whites to live in areas with low level of medical services and with an inadequate number of physicians (U.S. Department of Health and Human Services, 1998). Also, compared to other racial or ethnic groups, Hispanics are least likely to have a usual source of care. One's status as an ethnic or racial minority is a potentially important factor, but in this study, I mainly focus on the policy and sociodemographic factors of employment status and marital status that are likely to affect immigrant women's health care access.

To sum up, the multiple disparities in health status and health care access are due to a combination of public policy, sociodemographic characteristics, and other factors. In the next chapter, I will examine how these forces are associated with the health care activities of immigrant women in three states where immigrants are highly concentrated.

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<sup>27</sup> It is important to note that though racial and ethnic minorities in general are in worse health status, there are some disparities within minority groups. For example, "Hispanic" and "Asian" each include a variety of subgroups (Guendelman 1998; Takada, Ford, and Lloyd 1998).

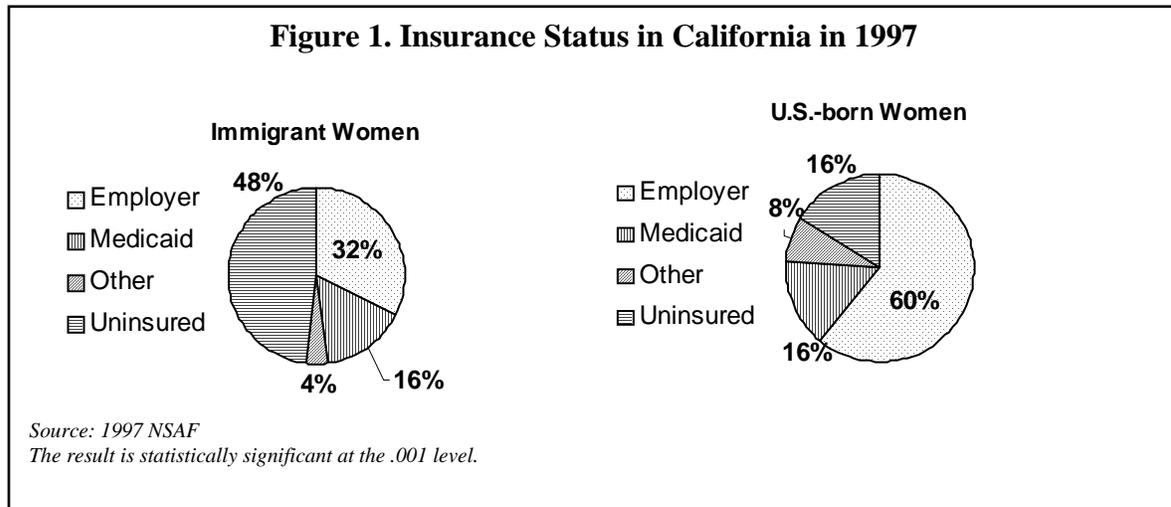
## **Chapter 4: Case Studies**

Based on the discussion in the previous chapter, in this chapter I examine and compare health care access and factors associated with them in three states. The primary goal of this thesis is to identify the factors that account for the variations in the health care access by immigrant women in the U.S. For doing this, I will use three in-depth cases studies in California, Florida and New York. These cases are chosen because a large number of immigrants reside there, and consequently they have an impact on the federal public policy targeting the immigrant population. I will also employ the National Survey of America's Families (NSAF completed in 1997 and 1999), in order to study the health care access by immigrant women in these cases.

### **Case One: California**

Immigrant women in California were a vulnerable group of population with “fair or poor” health according to NSAF (see Table 1). About one in three immigrant women in 1999 was in “fair or poor” health (31% of immigrant women). Compared to female citizens, immigrant women in California were more likely to report that their health was “fair or poor”. Research indicates that health status is closely related to health insurance coverage. Individuals with insurance typically have significantly better health outcomes than the uninsured (National Women's Law Center, retrieved April 20, 2004). Thus, having access to health insurance is extremely important for immigrant women to live a healthy life. Based on the data from NSAF (see Figure 1), 48 percent of immigrant

women in California in 1997 were uninsured, almost triple the rate for female citizens. In the following part, I will explore some factors contributing to the limited health care coverage for immigrant women in California.



### **Demographics**

California has been one of the six primary destinations for legal immigrants to the U.S. for the past three decades. In 2002, one in four foreign-born non-citizens – 27.4 percent of nation’s total foreign-born population – resided in California, which means that California alone attracted as many immigrants as Florida, New York and Texas combined. Though recently, the immigrant population has grown slightly slower than other states such as South Carolina, California was still the home of the largest number of immigrants in 2002. In addition, California had a higher concentration of foreign-born persons than Florida and New York in 2000: about 26.2 % of the state’s population was foreign-born (U.S. Census Bureau, retrieved May 24, 2004). Two cities in California – Los Angeles (38.4%) and San Francisco (34%) – are the areas with the highest percentage of foreign-born residents. An enormous number of immigrants residing in California indicate that health policymakers meet a relatively larger challenge in order to

satisfy the health care needs of this group of people (Capps, Fix & Passel, November 26, 2002; U.S. Census Bureau, retrieved April 20, 2004).

Another characteristic of the population in California is its high racial and ethnic diversity. In 1999, one in three people was Hispanic, one in ten people was from Asia, and one in fourteen people was African American (Homepage of California, retrieved April 20, 2004). One of the possible results of high racial and ethnic diversity is racial tension in California. In *Racial Fault Lines*, Tomas Almaguer (1994) argues that California history is a series of racial divisions in which white privilege has prevailed. Patricia Zavella (2001) also argues that California has become a place of racial tension and social conflict. The passage of Proposition 187 reflects the contentious character of the presence of immigrants in California.<sup>28</sup>

### ***Health Policy for Immigrants***

California, with the largest number of immigrants and high racial and ethnic diversity, has historically had racial and ethnic conflict. In the mid-1990s, California witnessed a severe economic recession, which resulted in a decreasing number of job opportunities. Many Californians saw the immigrants as responsible for taking away their jobs, lowering wages, and posing a fiscal burden on the local government. As a result, anti-immigrant sentiments became prevalent and consequently were represented in the passage of Proposition 187 in 1994 (Fix and Zimmerman, 1999; Desipio & Garza, 1998).

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<sup>28</sup> Another example of anti-immigrant sentiment and the intention to impede illegal immigration was the passage of the 1986 Immigration Reform and Control Act (IRCA). Of course, considering the importance of the immigrants to California agricultural industry, policymakers have allowed for a period of transition. Special Agriculture Worker Program provided opportunities for farm workers to apply for U.S. citizenship. The Replenishment Agricultural Worker Program (RAW) allows new immigrant workers to enter the United States between 1990 and 1993, and after working three consecutive seasons, they too would qualify for permanent resident status. The H-2A program allows seasonal workers to be brought in to work temporarily when farmers cannot meet their labor needs (Zavella, 2001).

Proposition 187 denied basic health benefits to illegal immigrants and called for the exclusion of their children from the public schools. While seemingly targeted against the undocumented immigrants in California, Proposition 187 de facto had a negative impact on all the immigrant population in California, and even in the whole nation. The passage of Proposition 187 in part contributed to the passage of welfare reform act in 1996 (PRWORA) (Desipio & Garza, 1998).

In addition to the anti-immigrant proposition, California's governors since 1990 have adopted a relatively moderate expansion of budget for health care programs. From 1991 to 1999, California was under the control of a Republican governor, Pete Wilson. In 1999, Democrat Gray Davis replaced Wilson as the governor of California, but people who expected a sweeping expansion of public health care programs were disappointed, since he was a conservative democrat.<sup>29</sup> As he declared, his top three spending priorities were "education, education, and education" (Lutzky and Zuckerman, 2000: 2). Education accounted for 50 percent of state general public expenditures in 2000. In contrast to his generosity on education programs, Davis was unwilling to make dramatic changes in health policy, because they might bring budgetary problems. Since 1998, however, California has moderately expanded eligibility for its public health insurance (Lutzky and Zuckerman, 2002).

In spite of the anti-immigrant tenor of Proposition 187 and despite the conservative health policy approach adopted by California's governors, the Medi-Cal health program in California has been one of the most generous programs for the immigrant population in the country since 1996, in terms of its broad eligibility criteria.

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<sup>29</sup> The current Governor is Mr. Arnold Schwarzenegger who was sworn in as the 38th Governor of California on November 17, 2003.

The 1996 welfare reform law (the Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) barred many legal immigrants from receiving some public benefits, especially those immigrants who entered the U.S. after August 22, 1996, who were to be excluded for their first five years in the U.S. Yet, states could make a decision on whether or not to provide state-funded TANF and Medicaid to immigrants who had entered the country after that date. California is the state with the largest number of immigrants, most of whom lack health insurance. In consideration of these facts, California has responded to welfare reform by using state funds to continue the Medi-Cal assistance to those post-enactment immigrants (Tumlin & Zimmermann, October 20, 2003; National Immigration Law Center, 2002; Zimmermann & Tumlin, 1999).<sup>30</sup>

Health policy can play a significant role in explaining the health care access by immigrant women. Any shift in health policy will likely affect immigrant women's access to public health care programs, which are the second largest insurance resources for them. In this study I hypothesize that changes in health policy associated with welfare reform will have a negative impact on the health care access by immigrant women. The enactment of Proposition 187 was a dramatic effort to drive out undocumented immigrants by cutting them off from medical and other public services and depriving their children of the right to education. Although this law was enacted before welfare reform, it influenced immigrant women's health care access as negatively as welfare reform act did. Not surprisingly, influenced by such anti-immigrant public policy, the uninsurance rate among immigrant women was much higher than that of the female U.S.-born citizens, which lends support to my first hypothesis (see Table 2). Yet welfare

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<sup>30</sup> Documented immigrants in California arriving after 1996 are still eligible for Medi-Cal. For those undocumented immigrants, who are eligible for emergency services under Med-Cal, non-emergency and state-funded programs have been reduced.

reform did not bring dramatic changes to the Medi-Cal program in California – post-enactment immigrants continued to qualify for public health care assistance. This can partially explain why immigrant women in California were almost as likely to receive health care assistance from Medi-Cal as female U.S.-born citizens, as reflected in the 1999’s survey. This pattern again supports the first hypothesis (see Table 2). I also anticipate that immigrant women in 1997 survey would be more likely to receive Medicaid than those in 1999 survey, because welfare reform has restricted immigrants’ eligibility for most public benefits. The NSAF surveys indicate that Medi-Cal coverage for immigrant women did decline by 6 percentage points from 1997 to 1999, which is also consistent with this hypothesis (see Table 2).

### ***Economy and Employment***

In addition to the policy factors, immigrant women’s access to health insurance is likely to be influenced by their employment status, since employers are the major insurance providers. In California, 48 percent of non-citizen immigrant women were uninsured in 1997, while only 16 percent of American women lacked insurance, according to the NSAF data (see Table 2). Immigrant women’s high uninsured rate is largely associated with their tremendously low rate of employment, and the extremely low rate of health insurance provided by the employers. The immigrant population is mainly employed by the agricultural industry, which is a significant economic sector in California. In order to understand the health insurance coverage of immigrant women in California, I will explore the development of the agricultural industry and the employment opportunities for immigrant women in the following part.

Agriculture in California has brought massive revenue to the state government, and it has been the largest employer for the Californians. California's annual agriculture receipts from agriculture were more than \$23 billion in 2003, which was more than Hollywood motion picture industry revenues (Zavella, 2001). Meanwhile, since California became a state in 1849, agriculture's labor market has depended exclusively on immigrants, many of whom are from Latin America, specifically Mexico (Martin, 2001). California's vigorous economic development has to a large degree depended on its Hispanic immigrant laborers. Without this immigrant labor force, California's agriculture would quite likely to be unable to maintain the current level of production. In the early 1980s, California farmers shifted to producing specialized high-value fruit and vegetables, and this shift resulted in an increased demand for farm laborers. In response to this demand, many people migrated from Mexico to California. Meanwhile, during the 1980s, Mexico experienced economic crisis, which also pushed many Mexicans to migrate to the United States, even if it meant risking apprehension by the Border Patrol. During this time period, more immigrant women came to California accompanying their male family members. As a result, by the mid-1990s, California had become the state with the largest immigrant population. Some scholars even describe rural California as a "Latinized" area – immigrant farm workers have become the majority population and have even changed the character and culture of the rural life in these communities (Zavella, 2001). Recently there has been a slowing of economic growth, partly due to the events of September 11, 2001 and to California's energy crisis. As a result, California policymakers have adopted a "cost avoidance" strategy for Health and Human Services and encouraged controls on public health costs (Lutzky & Zuckerman, 2000). Though there have been no budget cuts

to public health care programs, this restrictive strategy may have a negative impact on immigrant women's access to health insurance.

Although immigrant women are a large portion of California's population and play an important role in California's economy, they are also a vulnerable group. The NSAF data reveal that immigrant women in California had a lower rate of insurance coverage by their employers, compared to female U.S.-born citizens (see Table 2). In California, farm-work is usually the only job they can obtain, because it does not require application forms or references, and consequently it becomes an easy-entry occupation for many immigrant women. Without an alternative way to earn money in the U.S., immigrant women have to accept the field work and the low wages offered. It is reported that four of five farm workers are immigrants; in addition, two thirds of assembly workers are immigrants, and one in two household domestic workers is an immigrant (Latino Issues Forum, retrieved April 22, 2004). Most immigrant women are in the low-wage economic sector, in which the employers usually do not provide health insurance.<sup>31</sup>

According to my second hypothesis, the status of being employed will influence immigrant women's insurance coverage positively. As mentioned above, in California, immigrant women were less likely to be employed, or to have insurance coverage, than American women, which is consistent with the second hypothesis. Furthermore, employed immigrant women in California were more likely than U.S.-born women to participate in the low-wage agricultural industry, which usually does not provide health insurance to employees.

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<sup>31</sup> In spite of the fact that farm workers in California must be covered by unemployment insurance (UI) and workers compensation (WC) insurance, according to the labor laws, they do not question their rights to health insurance.

### ***Conclusion***

In order to understand the health care access by immigrant women, this case study focuses primarily on immigrants' demographic characteristics, health policy that targets immigrants, and the agricultural industry in California. California has the greatest number of immigrants in the U.S., although in 2000, the percentage of immigrants coming to California began to decrease for the first time in 30 years. This indicates that health policymakers face a challenge to meet the health care requirements of the immigrant population. Meanwhile, California has a highly diverse group of immigrants who come from more than ten countries, but primarily they are from Mexico. Due to the high racial and ethnic diversity, there is racial and ethnic conflict in California, which was aggravated in the aftermath of September 11, 2001.

On the one hand, the racial and ethnic tensions have in part resulted in the passage of a series of anti-immigrant public policies in California, such as Proposition 187. California's governors since 1991 have adopted only a moderate expansion of budget on health care programs. On the other hand, California is known for its generosity in providing health care for those immigrants entering the U.S. after 1996. After welfare reform, California chose to provide state-funded medical services to post-enactment immigrants, which meant that documented immigrants in California arriving after 1996 were still eligible for Medi-Cal. Yet, the anti-immigrant Proposition 187 and the "chilling effect" of welfare reform appear to have discouraged immigrant women from seeking health care benefits.

Immigrant women's lack of health insurance coverage is also closely related to their socioeconomic status, in which employment status is an important factor. Most immigrant women work in the agricultural industry, which usually offers inadequate or

no health care benefits. Since employer-sponsored health insurance is the main source of health care in the U.S., immigrant women have less access to health care and insurance than U.S.-born women with better employment opportunities. In addition, immigrant women are more likely to concentrate in blue-collar jobs, which require low skills and offer low wages. The low financial status (and high poverty level) among immigrant women makes them less likely to have the resources to purchase health care coverage out of pocket.

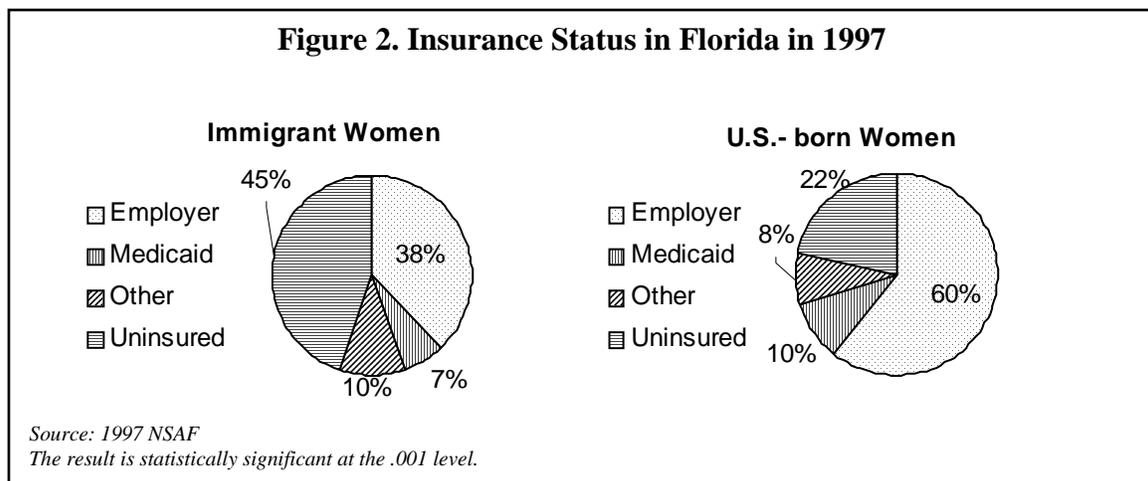
### **Case Two: Florida**

Overall, immigrant women were more likely to report being in fair or poor health than female citizens in Florida (see Table 1). Among all immigrant women, more than one in five or 20%, perceived their health as being fair or poor, compared with 13% of female U.S.-born citizens.<sup>32</sup> In contrast to immigrant women in California, immigrant women in Florida were in better health according to their own perception of general health and well-being. Since some scholars have questioned whether or not the perception of fair or poor health is related to the actual health status among immigrant women (Kramer, Ivey & Ying, 1999; Muenning & Fahs, 2002), as I have explained in the previous chapter, I employ health insurance coverage to study health care access by immigrant women.

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<sup>32</sup> Yet, the pattern between immigrant women and immigrant men in Florida is slightly different for that in California. Both group of people in Florida were similarly likely to be in fair or poor health (20% of immigrant women compared 21% of immigrant men), while in California, immigrant women were more likely to be in poor health than immigrant men (31% of immigrant women compared to 12% of immigrant men).

In Florida, immigrant women were more likely to be uninsured than female citizens (see Figure 2). Compared to female non-citizens in California, Floridian immigrant women were more likely to have insurance coverage through employers, which can partly explain why Floridian immigrant women were healthier than Californian immigrant women. Lack of health insurance may increase the risk of poor health among immigrant women. Without health insurance, they may delay needed care and preventive care, and finally lose time to cure diseases. With limited access to health insurance, immigrant women may have poor control of chronic conditions, and inadequately monitor physical development.



**Demographic**

Florida has the third-largest immigrant population in the U.S. (after California and New York). Almost one in eleven immigrants in the U.S. lives in Florida, and one of every eight residents in Florida is a foreign-born non-citizen. The majority of immigrants and refugees come from Central and South America and the Caribbean basin, similar to the case of California. Yet in contrast to the fact that most immigrants in California come

from Mexico, in Florida Cuba plays a major role in this settlement pattern, and it accounted for almost one-quarter (24%) of the foreign-born population in the state in 2000 (U.S. Census Bureau, retrieved April 20). Florida is a geographically convenient place for immigrants and refugees from Cuba; for instance, the city of Miami is only 200 miles north of the country of Cuba. Thus many Cubans who oppose Fidel Castro and his government, founded in 1959, have fled to Florida. A large group of immigrants from the Caribbean have made Miami a city with a very strong Cuban culture (Kretsedemas, 2003). Besides Cuban immigrants, many Haitians who fled the oppression of Haiti's Duvalier regime arrived in South Florida in the early 1980s (Kretsedemas, 2003). Though political forces play a role in promoting Haitians' migration, most Haitian immigrants and refugees have been defined as economic migrants rather than political refugees by the U.S. Immigration and Naturalization Service (INS). Compared to many Cuban immigrants, who are mainly categorized as political refugees, most Haitian immigrants are less likely to receive government assistance (Kretsedemas, 2003). Such a large number of foreign-born non-citizens residing in Florida have posed a tremendous burden on the health care system of local governments.

Similar to California, Florida has one of the most racially and ethnically diverse populations in the country. According to Yemane & Hill (2002), the black and Hispanic populations make up 16.6 % and 16.7 % of the Florida population respectively. Not surprisingly, the racial and ethnic diversity is reflected in anti-immigrant sentiment among both policymakers and the public opinion. Democratic Governor Lawton Chiles first "blew the ugly wind" of anti-immigration with his lawsuit against the federal government for its failure to "protect the borders" (*Counterattack*, March/April 1996: 3).

This action was followed by a proposal by a Florida congressman to deny U.S. citizenship to illegal aliens' children born in this country (*Counterattack*, March/April 1996). In addition, two groups in Florida – the Save Our State Committee and FLA-187 – have pressed for passage of anti-immigrant regulation like Proposition 187 in California (*Counterattack*, March/April 1996). Public opinion and media stereotypes of immigrants also reflect anti-immigrant sentiment. According to a *Sun-Sentinel* poll, 81 percent of respondents in Florida thought that the U.S. government should place more restrictions on immigration (U.S. Census Bureau, retrieved April 20, 2004). The mass media have portrayed immigrants from Cuba as “the dregs of Cuban society, ... anti-socials, homosexuals, drug addicts, and gamblers”, and carriers of the AIDS virus (Kretsedemas, 2003: 315). Parallel to these negative images of immigrants, policymakers also have set up public health policy disadvantageous to the immigrant population.

### ***Health Policy***

Florida is less generous in health care assistance to the immigrant population than California, and in this sense, Florida's policies, compared to California's, are more consistent with the anti-immigrant sentiment among the general population. Before welfare reform, immigrants were offered public assistance similar to that given to U.S.-born and naturalized citizens. In 1996, the welfare reform act and another immigration law enacted that year barred many immigrants from a variety of public benefits such as Medicaid, food stamps, and the Supplemental Security Income program (SSI). It also withdrew federal funding for states' Medicaid programs to exclude non-citizens who entered the U.S. on or after August 22, 1996. In the absence of federal funding to help

post-enactment immigrants, some states, such as California and New York, have made efforts to restore health care for immigrants at the states' expense. Florida has not been as generous to its immigrant population. For instance, Florida recently imposed a ceiling on the number of immigrant children in its SCHIP program, placing many children in immigrant families who apply for public benefits on a waiting list (Ku and Blaney, 2000). Also, according to the NSAF data, immigrant women in Florida were least likely of those in the three states to receive insurance coverage from Medicaid (7% in Florida, 16% in California and 20% in New York). This is consistent with the policy approach taken by Florida.

From 1991 to 1998, Florida was governed by Lawton Chiles (1930-1998) of the Democratic Party, and Republican Jeb Bush became governor in 1998; for both governors, health related policy has occupied an important place in their agenda, although differences exist (Yemane & Hill, 2002). Chiles was known as a health care advocate throughout his political career. He led a campaign to create the National Commission for Prevention of Infant Mortality in the late 1980s, appealed for health care reform before it became the national agenda, and focused on health care coverage for the uninsured population. In 1992, he created the Florida Healthy Start program to provide prenatal and infant care to poor mothers, and he made efforts to set up regional health care alliances throughout the state in 1994. Although he actively tried to expand the health-care program, he encountered difficulties passing his proposal in the state legislature, because Florida's legislature was controlled by the more conservative Republican Party. In addition, the recession in the early 1990s seriously hindered economic development in Florida, especially tourism. As a result, during Chiles' term, there was no salient

expansion of public health care assistance for the uninsured population. Compared to Governor Chiles, the current Governor Jeb Bush has been more conservative on health care policy (Homepage of Florida, retrieved on April 20, 2004). One example is a change in the Florida Health Security program. Under the Chiles administration, that program aimed to sponsor health insurance premiums for the entire low-income uninsured population; however, under Bush this program has been narrowed to target vulnerable groups such as low-income children, persons with disabilities, and the elderly. To summarize, health care programs in Florida since 1991 have moderately expanded, but they are less generous than those in California (Yemane & Hill, 2002).

In Chapter 2, I hypothesize that public policy changes brought by welfare reform will have a negative impact on immigrant women's insurance coverage. After welfare reform, Florida chose to restrict post-enactment immigrants from receiving most public assistance, such as Medicaid and food stamps. In the case of Florida, immigrant women were less likely to receive Medicaid than American women, and immigrant women's insurance rate in the 1999 survey was lower than that in the 1997 survey, which is consistent with this hypothesis (see Table 2). Many legal immigrant women who entered the U.S. on or after August 22, 1996, lacked health insurance, partly due to their limited access to state-sponsored Medicaid program.

### ***Economy and Employment***

Another factor associated with immigrant women's high uninsurance rate is their employment status, which is tied to the nature of the economy in Florida. The 1997 and 1999 National Survey of America's Families show that the employment rate was

significantly lower for immigrant women than for U.S.-born women in Florida in both years. Though the employment rate for immigrant women slightly rose from 1997 to 1999, immigrant women were less likely to be employed, compared to U.S.-born women and immigrant men. Consequently, immigrant women in Florida were least likely to obtain employer-sponsored health insurance. The low rate of employment of immigrant women mainly explains the low insurance rate for them.

In addition, even those immigrant women who are employed may not receive health coverage from employers. The economy of Florida, especially Miami, is heavily dependent on the state's tourism industry. Because Spanish is widely used in Miami, the city is a major attraction for Spanish-speaking tourists from South America and Central America. According to Weekly Reader Corp. (1993), Spanish-speaking tourists spend about \$2 billion a year in Florida's tourism industry. The flourishing tourism industry has contributed to economic development in Miami, Florida. Yet, the entrepreneurs in these sectors typically do not provide employees health insurance coverage. Nearly 65.2 percent of uninsured employed Floridians aged 18 to 64 reported that their employers did not offer health insurance (Yemane & Hill, 2002).

Furthermore, more female immigrant workers may become uninsured when employers face a weak economy, because employers may be unable to afford employee health care coverage. Especially in the aftermath of September 11, 2001, Florida's vital tourism industry began to deteriorate, economic development slowed down, and the state budget reached a crisis level. Due to these economic difficulties, immigrant women in Florida experienced a lower employment rate and higher uninsured rate, which is consistent with my second hypothesis.

### ***Conclusion***

This case study examines health insurance available to immigrant women in Florida, by exploring the demographic characteristics of the state, health policy adopted by the governors, and the core economic sector in Florida. Florida had the third largest immigrant population in the country behind California and New York in 2000. This large number of immigrants has acted as a stress on the state budget and has led to a relatively restrictive government health care program. Similar to California, there are racial and ethnic tensions due to a highly diverse foreign-born population. Xenophobes in Florida tried to deprive the citizenship rights of U.S.-born children of illegal immigrant parents and wanted to pass a California-style anti-immigrant Proposition 187.

Under such an anti-immigrant atmosphere, combined with a state legislature controlled by conservative Republicans, and a Republican governor since 1998, the current health policy has restricted the eligibility of the immigrants who entered the U.S. after 1996. The data show that fewer immigrant women received Medicaid from 1997 to 1999, which supports the first hypothesis that policy changes brought by welfare reform impacts immigrant women's insurance coverage negatively.

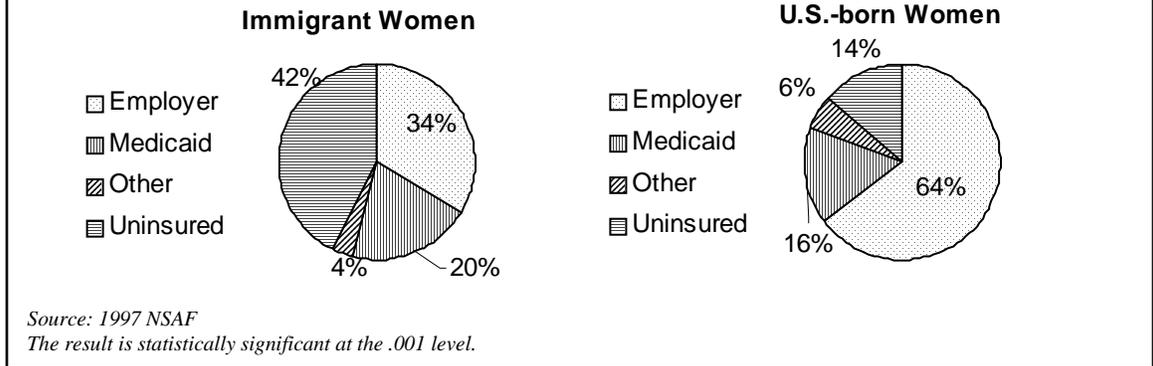
Tourism is the largest industry in Florida, and it has employed many female immigrant workers. Yet, like the agricultural industry in California, employers in tourism usually provide inadequate or no health insurance for the employees. Furthermore, immigrant women were the least likely to be employed. The combination of limited access to employment and employer-sponsored health care plays the chief role in

explaining the high uninsurance rate among immigrant women, since employers are the main sources of health insurance.

### **Case Three: New York**

In New York State, immigrant women were also more likely to be in fair or poor health than either female citizens or immigrant men, similar to in California (see Table 1). Yet immigrant women in New York were more likely to report being in good health than Californian immigrant women. According to my previous argument, health status largely depends on their access to health insurance coverage and their experiences with the health care system. In New York, immigrant women were two times less likely to receive employer-sponsored health insurance, and three times less likely to be insured, than female citizens (see Figure 3); this partly explains the disparity in health status between immigrant women and female citizens. However, the relatively higher insurance coverage of immigrant women in New York than in California may in part explain their apparent better health. Health insurance is the key that makes health care services more accessible to a population that has less optimal health status and has poorer access to health care, such as immigrant women. This case study provides some essential demographic and socioeconomic information about immigrant women residing in New York State, and it addresses the impacts of welfare and health care policy on the health care access by immigrant women.

**Figure 3. Insurance Status in New York in 1997**



**Demographics**

New York has a long history of immigration and has always been a gateway for immigrants. By 1999, it is estimated that 8 million immigrants resided in New York, which makes New York the state with the second largest immigrant population, following California. And in 2000, 20.4 % of the New York’s residents were foreign-born, which made it a state with a high level of immigrant concentration, second only to California (U.S. Census Bureau, Retrieved on May 24, 2004). The data also show that New York had a larger immigrant population than Florida (Muening and Fahs, 2002). Because of its significant role in the history of migration in the U.S., and its tradition of accommodating many immigrants, New York is likely to set up friendlier public policy for the foreign-born population than California.

New York is also known for its high level of racial and ethnic diversity. Different from California, where the majority of immigrants come from Mexico, and different from Florida, where immigrant flows are represented by Latin American immigrants, New York possibly has the most diverse immigrant population. It is estimated that people of over 185 nationalities reside in New York State. In Queens – the most diverse county in

the United States – more than 150 nations were represented (Homepage of New York, retrieved April 20, 2004).<sup>33</sup> As White, E. B. (1999) wrote, “The collision and the intermingling of these millions of foreign-born people representing so many races and creeds make New York a permanent exhibit of the phenomenon of one World” (*Here Is New York*). The high level of racial and ethnic diversity has resulted in some conflicts. Newly-arrived immigrants often have to fight to have their customs accepted. For instance, Indians had to battle for the right to wear their turbans while driving taxis. In addition, New York has witnessed a worsening of conflict between native New Yorkers and Arabs and other immigrants, especially after September 11, 2001 (Souccar 2001).

While New York has historically been a destination for immigrants, since 1996, the state’s policymakers have faced new challenges to deal with immigrant issues due to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, welfare reform act) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA).

### ***Health Policy***

The state of New York has traditionally been generous in public support of health and social services. New York has the largest Medicaid program in the country, which is the principal single item in the state budget with total expenditures of \$24 billion. 3.3 million New Yorkers were enrolled in the Medicaid program in 1995. Health care provides more than 13% of all employment opportunities, which makes it the third largest economic sector in New York City (Muennig and Fahs, 2002; Holahan, Evans, Liu,

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<sup>33</sup> In 1995, the largest single country where immigrants in New York come from is the Dominican Republic, with 395,000 or 12 percent of all foreign-born. The next largest are: China (229,000 or 7 percent), Jamaica (195,000 or 6 percent), and the countries of the former Soviet Union (182,000 or 5 percent).

Sulvetta, Haslanger and Cantor, March, 1998). The NSAF data show that immigrant women in New York were more likely to have Medicaid-sponsored health insurance than American women, which is consistent with the characteristics of public policy in New York, but distinctly different from the situation in California and Florida.

Since welfare reform, immigrants' eligibility has not changed much in New York. The welfare reform act made immigrant status and time of entry the principle criteria for eligibility for public benefits. The new law restricted recent immigrants' eligibility for most federal government sponsored benefits, such as Temporary Assistance for Needy Families (TANF), Medicaid, Supplemental Security Income (SSI), and food stamps. The welfare reform law also decentralized the welfare system – shifted the federal government's decision-making and fiscal responsibility to the state and local governments for providing public benefits to the immigrant population (Fix and Capps, 2002). In response to these changes, New York State adopted a more liberal and progressive way to provide health care to the immigrant population than did Florida. After the enactment of welfare reform, similar to California, New York continued to provide health care out of the state revenues for post-enactment immigrants, while Florida was unwilling to continue to pay for health care for the federally ineligible immigrants.<sup>34</sup>

According to my first hypothesis, immigrant women should be less likely to receive Medicaid than American women since the enactment of welfare reform. Yet in the state of New York, immigrant women were more likely to obtain government-sponsored health insurance than the U.S.-born women (see Figure 3). This seeming

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<sup>34</sup> In general, federal Medicaid program provides emergency care to all immigrants, prenatal care to all pregnant women regardless of their status or entry time, and health care for children of illegal immigrants (*Migration World Magazine*, September 2000 v28 i5).

inconsistency with this hypothesis is mainly due to the generosity of health policy in New York.

The state-funded welfare program in New York that targets post-enactment immigrants is called the Safety Net Assistance (SNA) program. Under this program post-enactment immigrants with children can still receive benefits and access to training and educational services, although assistance has been somewhat restricted. Unlike TANF, the SNA program has no formal assessment procedures to determine whether participants are job-ready or if they need additional training or other services before they enter the workforce. In addition, SNA was designed to provide vouchers to recipients for food, housing, and other basic necessities (Tumlin and Zimmermann, October 20, 2003).<sup>35</sup>

Another health care program closely associated with the health care access by immigrant women in New York is the Prenatal Care Assistance Program (PCAP), initiated in the mid-1980s. It originally was intended to address the infant mortality problem and eventually succeeded in providing prenatal health care to all Medicaid-eligible women. New York is more generous in providing prenatal care to undocumented pregnant immigrant women than Florida. The data indicate that in New York, only 3% of undocumented women had little or no prenatal care, while 30% of undocumented pregnant women had no prenatal care in Florida (The American College of Obstetricians and Gynecologists, retrieved April 20, 2004). This is mainly because Florida withdrew Medicaid eligibility for federally ineligible pregnant women after the passage of welfare reform act.<sup>36</sup>

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<sup>35</sup> Only rent vouchers, with account for most of the monthly grant, are being issued, with the remaining funds given to SNA recipients in cash.

<sup>36</sup> Florida is the only state that chose to do so.

With a long history of immigration and the highest racial and ethnic diversity, health care policy in New York is rather generous to immigrants. Though the Republican governor, George Pataki, who has served since 1994, has proposed reducing health care spending and reforming welfare, most of his proposals have not been adopted. This is partly because the lower house of the State Assembly is heavily Democratic (96 Democrats versus 54 Republicans), and more likely to represent the economically vulnerable population, such as immigrant women (Holahan, Evans, Liu, Sulvetta, Haslanger and Cantor, March, 1998).

In a word, health policy and health care programs in New York were generous to the immigrant women, consistent with the data that immigrant women had broader Medicaid coverage than U.S.-born women in New York. Yet, immigrant women still had a tremendously higher uninsurance rate, and the low rate of employer-sponsored insurance coverage provides an explanation.

### ***Economy and Employment***

Immigrants have been a vital component of New York's workforce. According to the 2000 Census, about half of the state's workers were immigrants. Although immigrant workers actively participated in the labor market, they were more likely to receive low wages. It is estimated that 35 percent of immigrant workers received an hourly wage under \$10, while only 19 percent of U.S.-born workers earned less than \$10 (Parrott and Vimo 2003: 4). New York has the largest disparity of incomes among the 50 states, partly due to the disparity of wages between immigrant workers and the U.S.-born workers. Immigrants usually work in the low-wage occupations. In New York City, the largest

employer of the foreign-born population is the restaurant industry (eating and drinking places), which provides about 125,000 positions for immigrant workers. Not surprisingly, owners of the restaurants usually provide low wages, around \$8.55 per hour. Other industries that hire large numbers of immigrants also provide relatively low wages, such as health services, apparel manufacturing, grocery stores, and private households (Parrott and Vimo 2003: 7). Consequently, female immigrant workers in those low-wages occupation are less likely to receive employer-sponsored health insurance. Meanwhile, immigrant women are possibly unable to purchase health insurance out of pocket due to their limited financial means. The NSAF data showing that immigrant women were in lower financial status and less likely to be insured than female U.S.-born citizens are consistent with this perspective.

Immigrant women tend to be of a lower socioeconomic status than female U.S.-born citizens in New York. Yet, compared to Mexican immigrants in California and Cuban refugees in Florida, New York's immigrant women tend to have a higher socioeconomic status. In New York, only two-thirds of immigrant women were below poverty line, while three in four immigrant women in California and nine in ten immigrant women in Florida were below the poverty line in 1997 (see Table 3). Passel and Clark (1998) argue that the percentage of naturalized immigrants is greater in New York than that for the country as a whole, mainly because New York's immigrants tend to have a greater prosperity that allows them to naturalize; this interpretation is consistent with the NSAF data. All of these facts may partly explain why the uninsured rates among immigrant women in New York were the lowest among the three cases in both 1997 and 1999.

### ***Conclusion***

In order to examine the factors that are likely to influence insurance coverage among immigrant women, this case study examines demographic characteristics, health policy, and employment patterns of female foreign-born non-citizens in New York. New York has traditionally been the principle entryway to the U.S. for immigrants, though California has replaced New York as the main destination in recent years. With 3.4 million foreign-born non-citizens, New York had a significantly larger foreign-born population than Florida (with 2.2 Million). Compared to the other two cases, New York has the more diverse immigrant population, which includes more than one hundred nationalities, among which no single one dominates. The data show that in 1995 the immigrants from the Caribbean made up 27 percent of New York's 3.4 million immigrants, European immigrants represented 25 percent of the foreign-born population, and South and East Asians accounted for 20 percent of the immigrant population in New York (Passel and Clark, 1998).

With the tradition of immigration, and the highest racial and ethnic diversity in the country, New York has adopted a rather munificent health care strategy toward the immigrant population. The state's Medicaid program is the largest in the country. After the passage of PRWORA (ie., the welfare reform act), New York continued to provide limited public benefits to federally ineligible immigrants. Two programs that are closely related to the health care of immigrant women are the Safety Net Assistance (SNA) program and the Prenatal Care Assistance Program (PCAP). These generous government-

sponsored health care programs partly explain why immigrant women in New York were more likely to receive health insurance from Medicaid.

In such a generous state as New York, nevertheless, immigrant women were still less likely to receive health insurance than the U.S.-born women in New York. One of the explanations may lie with their occupation patterns and the wages. Immigrant women are mainly employed by the restaurant industry, which usually provides low wages and inadequate or no health insurance. Not surprisingly, immigrant women were two times less likely to receive employer-sponsored insurance and three times less likely to be insured than American women (see Table 2).

## **Chapter 5: Testing of Hypotheses**

In Chapter 4, I have examined how specific health policies and the socioeconomic status of immigrant women contribute to explaining health care access in three states. In this chapter, I demonstrate to what extent my hypotheses have been supported, and I discuss some additional factors that may affect health insurance coverage for immigrant women.

### ***Policy Factors***

Public policy is a powerful predictor in explaining the health care access by immigrant women. Any shifts in health policy and public health care programs will impact immigrant women's access to health care assistance, because public health care programs are the second largest category of insurance provider. Since welfare reform has placed immigrant status and time of entry as principle criteria in determining eligibility for Medicaid, I hypothesize that the changes in public policies brought by welfare reform influence immigrant women's health insurance coverage negatively. Thus, immigrant women should be less likely to access Medicaid than female U.S.-born citizens after 1996.

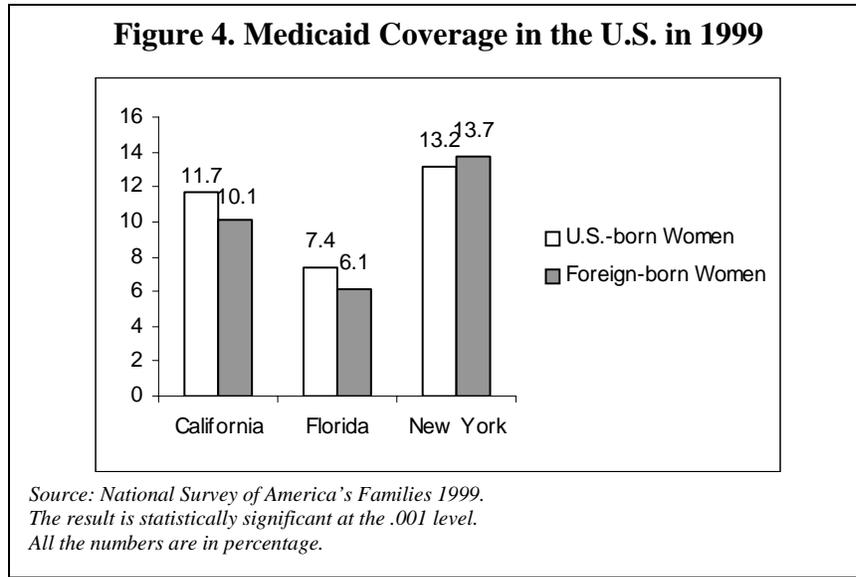


Figure 4 demonstrates the rates at which immigrant women and American women obtained Medicaid-sponsored health insurance in three states in 1999. In the cases of California and Florida, immigrant women were less likely to receive Medicaid than female U.S.-born citizens, consistent with this hypothesis. Yet, in New York, a slightly higher proportion of immigrant women received Medicaid compared to female citizens, which seems to contradict this hypothesis. As mentioned in the case study of New York, a long history of immigration and a highly racial and ethnic diverse immigrant population probably attribute to the generous health care programs in New York: the Medicaid program in New York is the largest among the country. This generous government-sponsored health care program partly explains why immigrant women in New York were more likely to receive health insurance from Medicaid than U.S.-born women in 1999.

The states have responded to welfare reform in different ways. The current health policy in Florida has restricted the eligibility of the post-enactment immigrants. Although both California and New York generously offered public health care assistance to the

post-enactment immigrants, there was a slight difference between these two states. To immigrant women, California with the anti-immigrant Proposition 187 is less generous than New York with the Safety Net Assistance (SNA) program and the Prenatal Care Assistance Program (PCAP). Figure 4 shows that Florida's immigrant women were less likely to receive Medicaid-sponsored health insurance than California's immigrant women, followed by those immigrant women in New York, consistent with the disparities in public policies in three states.

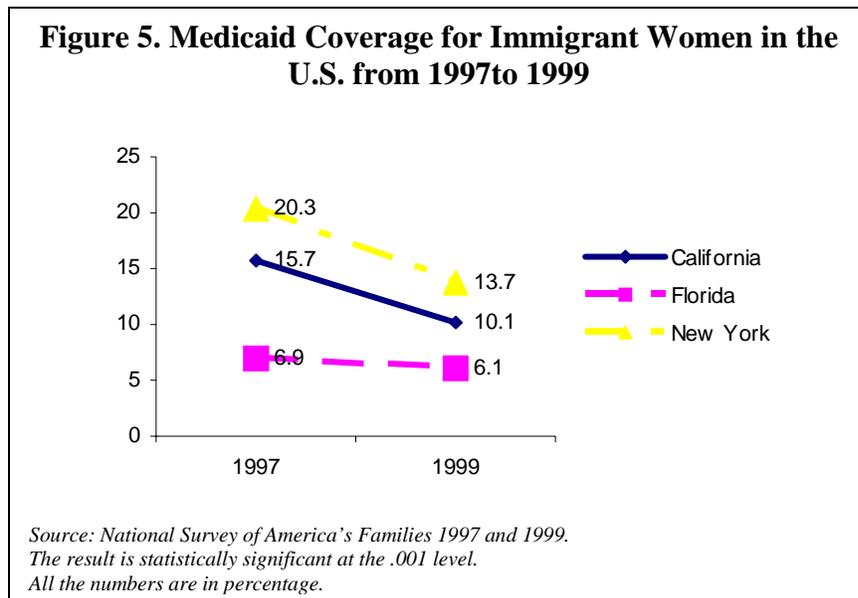


Figure 5 reveals the changes in Medicaid coverage for immigrant women in three states from 1997 to 1999.<sup>37</sup> Considering that Florida has become less generous to provide public health care assistance to the immigrants since 1996, the decline in caseloads of immigrant women for Medicaid programs in Florida is consistent with the first

<sup>37</sup> Since welfare reform act was passed on August 22, 1996, and the welfare reform laws might take a period of time to influence immigrant women's usage of Medicaid, I treat the respondents in 1997's survey as the pre-enactment persons. Thus the comparison between two rounds of survey should in some degree reveals the impact of welfare reform on immigrant women's usage of Medicaid.

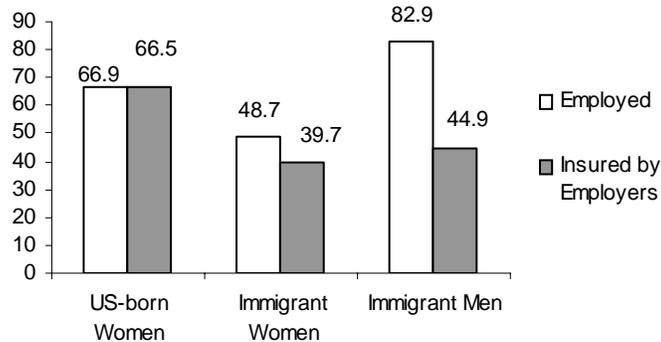
hypothesis, that welfare reform influences immigrant women's health insurance negatively. Yet, the decline in rates of immigrant women who received Medicaid (or Medi-Cal) in California and New York seems inconsistent with the first hypothesis, given that California and New York have continued to provide generous Medicaid programs to the post-enactment immigrants. I argue that the changes in the rates for immigrant women to seek Medicaid in three states are probably due to the "chilling effect" of welfare reform. After welfare reform, the complex regulation of the public benefits for immigrants may have a "chilling effect" on immigrant women's use of Medi-Cal or Medicaid benefits for which they remain eligible in California and New York. According to the argument made by Weil and Finegold (2002) and Potocky-Tripodi (2002), some immigrants may cease applying for public benefits for which they are actually eligible due to the confusion about the welfare reform act and fear of being labeled as a "public charge." It is quite possible that immigrant women are unaware of their retained eligibility for Medi-Cal coverage, or they have fear that the use of public health care assistances will render them a "public charge" under immigration laws and consequently affect their ability to naturalize. Also, they may think that they have to repay the Medi-Cal benefits when they obtain permanent residence. Furthermore, those undocumented immigrant women may fear that their illegal immigrant status will be discovered in the application for Medi-Cal benefits, and reported to the Immigration and Naturalization Service, and that this would consequently lead to deportation. The "chilling effect" of welfare reform, the confusion about eligibility that resulted from welfare reform, and fear of becoming a "public charge" seem to have contributed to the decline in caseloads of immigrant women participating in the public health care programs in California and New

York, although they were still qualified for the Medi-Cal or Medicaid programs. In addition to the “chilling effect” of welfare reform, California's Proposition 187, which is labeled as an anti-immigrant measure and attempted to bar undocumented immigrants from receiving a wide array of public services, may also lead immigrant women to believe they are ineligible and lead to the decline in caseloads.

***Factor of Employment Status***

My second hypothesis is that having employment affects immigrant women's health insurance coverage positively. As I have demonstrated, employers are the major health insurance providers. Thus the jobs held by the respondents have implications for the form of their insurance coverage. On the one hand, the unemployed will be less likely to receive employer-sponsored health insurance, and on the other hand, the unemployed will be less likely to purchase health insurance out of pocket. According to Figure 6, immigrant women were significantly less likely to be employed compared to U.S.-born women. The data also demonstrate that only 40 percent of immigrant women have employer-sponsored health insurance (1997), significantly below U.S.-born women (67 percent), which is consistent with this hypothesis.

**Figure 6. Employment and Employer-sponsored Insurance in the U.S. in 1997**



*Source: National Survey of America's Families 1997.  
The result is statistically significant at the .001 level.  
All the numbers are in percentage.*

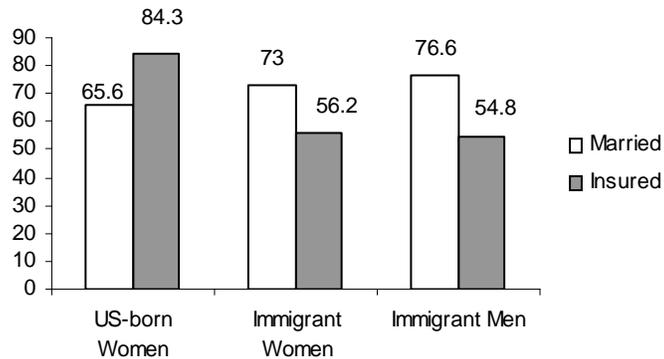
A further examination of the survey data indicates that the relationship between insurance coverage and employment status is not as self-evident as it appears. Immigrant men had a tremendously higher employment rate than immigrant women, while they shared almost equal insurance coverage with immigrant women. The major industries that employ those immigrants can partly explain this pattern. The case studies demonstrate that even those employed immigrants are more likely to be in the low-wage industries which usually do not provide health insurance for the employees. Immigrants are mainly employed by the agricultural industry in California, the tourism industry in Florida and the restaurant industry in New York. All of these industries provide low-wages and inadequate or no insurance to the immigrant population. As a result, immigrants' insurance rate was very low, although they actively participate in the labor market.

### ***Factor of Marital Status***

I have hypothesized that being married impacts immigrant women's insurance coverage positively. A snapshot of logistic regression analysis reveals that married immigrant women, controlling for the other variables, were about two-and-a-half times more likely to be insured than unmarried immigrant women (see Table 4). In all three cases, marriage is a single important factor that is likely to influence health insurance coverage positively. This is partly because married immigrant women will be more likely to get health insurance from their spouses' employers than unmarried immigrant women.

However, Figure 7 shows that immigrant women were more likely to report being married than American women, but were less likely to be insured, which does not support the third hypothesis. Marital status plays a complicated role in exploring health insurance coverage for immigrant women. Marriage may bring some "protective effect;" for instance, married immigrant women may be more likely to obtain employer-sponsored health insurance from their spouses. Yet, considering that immigrant men had relatively low employer-sponsored insurance coverage, I argue that this "protective effect" of marriage becomes minor for immigrant women. In a word, support for my third hypothesis is ambiguous in the current study.

**Figure 7. Marriage and Employer-sponsored Insurance in the U.S. in 1997**



Source: National Survey of America's Families 1997.  
The result is statistically significant at the .001 level.  
All the numbers are in percentage.

### ***Other Factors***

Racial and ethnic minority status also sheds some light on access to health insurance for immigrant women. America is known as an immigrant country. American people have always labeled their country as a haven for those escaping persecution and those seeking their fortunes. Yet, racial and ethnic discrimination still plays an important role in the immigration issue. Thus race and ethnicity are important in examining physical well-being of immigrant women, as observed by Estable (1986), “race, class and language intersect as significant factors to determine the specific quality of any immigrant women’s life” (p.1). As the case studies demonstrate, public policy in the recent history of the United States has been accompanied by an anti-immigrant sentiment and racial and ethnic discrimination. Another example is the differential treatment for Haitian and Cuban immigrants. For instance, illegal immigrants from Haiti are generally repatriated, but under the 1966 Cuban Readjustment Act, all Cubans who reach the U.S. are allowed to remain. Cuban refugees, most of whom are white, are granted citizenship, while black Haitians are sent back (Ogletree 2004). In his recent article, *The Hispanic*

*Challenge*, Samuel P. Huntington (2004) argues that the influx of the Hispanic immigrants in a large number is likely to “divide the United States into two peoples, two cultures and two languages” (p. 1). Whether the Hispanic immigrants have invaded, assaulted, or dissolved an American “creed” is open to more argument in the future. At least, Huntington’s anti-immigration position stresses the fact that racial issues are still important in immigration control. Thus, it is quite likely that racial and ethnic minorities, such as Hispanic immigrant women, will experience more difficulties in seeking health care assistance. More studies are needed to explore the health and well-being of immigrant women from the standpoint of race and ethnicity in the future.

Finally, cultural factors may also play roles in explaining disparities in health insurance and health care access by immigrant women. As noted by Chen *et al* (1996), self-reports of health status and access to health care may be influenced by a different culture or tradition. In another approach, several recent cross-cultural studies have provided evidence of the importance of culture and tradition to women’s well-being. For instance, Arber and Lahelma (1993a) compared women in England and Finland and found considerable differences regarding women’s economic status and employment type due to different cultures. As a result, they conclude that different customs among immigrant women are crucial for both financial and physical well-being. Given that culture and customs of immigrant women may be different from that of the place where they settle down, I argue that immigrant women may have a different definition of illness and believe in different treatment. For this reason, they may not perceive some illness in the Western medical world as illness and therefore ignore it. Also they may turn to folk treatment rather than receive public health care assistance. Many immigrant women are

actually eligible for public health care assistance, but because they have confusion about the eligibility, fear that their immigrant status will be reported, or have financial concerns, they may be unwilling to purchase health insurance or seek medical care. As a result, immigrant women often create their own methods of getting health care. Some immigrant women may combine two medical treatments – western medicine and folk remedies. Some immigrant women may avoid the American medical system entirely and rely on folk healers (*Migration World Magazine*, September 2000; Kramer, Ivey, and Ying 1999; Belluck May 9, 1996). That immigrant women come from cultures and customs which differ from those of the places where they settle down may influence their choices to access public health assistance.

To sum up, my hypotheses have been supported. Those immigrant women were less likely to obtain Medicaid than American women in Florida after welfare reform. Although immigrant women in California and New York were equally or more likely to obtain public health care assistance than U.S.-born women, this is because health care programs in those two states have not changed dramatically since welfare reform. Making a comparison between two rounds of surveys demonstrates the “chilling effect” of welfare reform. Comparing immigrant women in three states indicates that immigrant women in the more generous states were more likely to receive public health care assistance, which again supports the first hypothesis. Examining employment status sheds lights on how immigrant women gain access to health insurance in the U.S. Statuses of being employed and being married positively influence immigrant women’s health insurance coverage. Yet, considering that immigrant men had a higher employment rate and almost the same insurance rate as immigrant women, the association between

employment status and insurance coverage is not as straightforward as hypothesized. In addition to public policy and employment status factors, marital status did not bring as much “protective effect” to immigrant women as hypothesized. Although immigrant women were more likely to be married than American women, they still had higher uninsurance rate.

## Chapter 6: Conclusion

In this chapter, I summarize the findings of this study and demonstrate that some widespread public attitudes are inadequate to explain the health care access by immigrant women in the U.S. NSAF 1999 data reveals that female foreign-born non-citizens were more likely to report being in “fair or poor” health in the U.S. than American women. Although immigrant women’s self-reported health and well-being varied slightly in three selected states, immigrant women were generally in poorer health than both female U.S.-born citizens and immigrant men. Health insurance coverage is vital to provide timely and appropriate health care, and thus significant for immigrant women’s health status. This study looks at how public policy, employment status, marital status and other factors influence health insurance coverage for the immigrant women.

Since welfare reform, immigrants, especially post-enactment immigrants, have been barred from most public health care benefits. Because welfare reform has placed immigrant status and time of entry as principle criteria in determining eligibility for Medicaid, immigrant women have been less likely to access Medicaid than female citizens since 1996 in such less generous states as Florida. Although both California and New York chose to continue post-enactment immigrant women’s eligibility to Medicaid, the usage of Medicaid in these two states has also declined more than use by female U.S. citizens. This pattern is consistent with the interpretation that welfare reform is likely to have a “chilling effect” on immigrant women’s access to Medicaid.

The welfare reform act restricted the immigrants’ access to federally funded medical care programs, partly based on the concern that the immigrant population would

deplete public resources and social services. The public policy based on this assumption should be reexamined. Actually, from the survey data, we can see that immigrants and native citizens, in general, receive federally-funded health assistance at almost the same rates (see Table 2). In addition, although some immigrant women are less healthy than citizens, they are more likely to use folk healers, who do not compete with social services for native citizens. Furthermore, the only public services that undocumented immigrants can receive are emergency medical care, prenatal care, and K-12 education (Flores, 1984; Fix, et al., 1994). Under these circumstances, how can such a vulnerable group of people sharing a relatively low proportion of public benefits be a threat to U.S.-born citizens?

One of the important variables of socioeconomic status is the respondents' occupational profile. The data show that immigrant women were much less likely to be employed than female citizens, or immigrant men. The reason for limited insurance coverage among immigrant women may lie with immigrant women's low rate of employment, since employers are the major health insurance providers.

Would the immigrant women's insurance rate rise if they had more opportunities to join the labor market? In view of the fact that immigrant men have a tremendously higher employment rate and relatively low insurance coverage, employment status has limited power to explain insurance coverage for immigrants. In a word, even if immigrants actively participate in the labor market, they are likely to lack employer-sponsored insurance. It is quite possible that they perform jobs for which employers do not offer health insurance. Furthermore, since they are ineligible for welfare and receive a relatively low wage, they cannot afford health insurance by themselves. Just as, according to Soru (The Urban Institute, May 7, 2002), work and poverty can coexist, I

argue that work and lack of health insurance can ‘coexist,’ as seen in the case of immigrant men. The concept underlying PRWORA is to move from welfare to work: let work insure people, rather than let government-sponsored programs insure people. But most immigrants still lack health insurance even when they are employed. Lacking health insurance cannot be blamed on immigrants’ reluctance to work. Clearly, promoting work and pushing immigrant people from welfare to work in welfare reform is not enough. More efforts should be made to encourage employer-sponsored health insurance coverage for uninsured people in the future.

One of the premises on which the welfare reform act is based on is that immigrants with their high birth rate will soon deplete American jobs. In fact, the main reason for job losses cannot be attributed to immigrants. As we can see in the case of California, it is changes in some industries that have brought job losses. These changes are not the product of cycles of expansions and recession but reflect more serious structural changes in the California economy. After decades of economic prosperity in California, costs of doing business have risen, especially as a result of dealing with industrial waste, water shortages, workers compensation, inflated rents, increasing insurance rates, and rising litigation costs. The needed reform of the economic structure will inevitably bring some negative effects such as job losses. Beyond this, because most of the immigrant population works in the low-wage-sector, they are doing jobs which many Americans are unwilling to do (Bush, January 7, 2004). Historically, Mexico-origin workers in the Southwest have worked in low-wage-sector jobs such as in agriculture (Torre, 2002). Apparently, some whites are unwilling to compete with those Latinos.

Among demographic characteristics, I include marital status as an important factor. The logistic regression data show that, married immigrant women were almost two-and-a-half times more likely to be insured than the unmarried immigrant women, when controlling for other factors such as education, employment and race. Yet, to immigrant women the marital factor is a complicated factor. On the one hand, marriage may bring some “protective effect,” such as employer-sponsored health insurance coverage from their spouses. On the other, married immigrant women will be less likely to be employed, in order to care for male spouses and children staying at home. Consequently, the positive effect of marriage intended by policymakers is minor, for they have proposed to promote marriage during the welfare reform, based on the premise of the “protective effect” of marriage.

To sum up, the characteristics above-mentioned provide a picture of immigrant women. In contrast to both immigrant men and other women, immigrant women were a vulnerable group of people, with a high risk of being in poor health, and with limited access to health insurance. Public policies and sociodemographic characteristics of immigrant women contribute to the explanation of low health insurance coverage among the immigrant women. In addition, coming from cultures and customs different from that of the places where they settle down, immigrant women may combine two treatments – western medicine and folk healer, which may influence their medical care experiences.

## TABLES

**Table 1. People in “Fair or Poor” Health in 1999**

	Citizen	Naturalized Citizens	Non-citizens
<b>The U.S.</b>			
Female	12.4	16.6	23.3
Male	10.1	12.6	18.6
<b>California</b>			
Female	12.4	20.1	31.2
Male	11.4	20.9	21.5
<b>Florida</b>			
Female	13.1	18.1	20.0
Male	12.5	9.8	20.6
<b>New York</b>			
Female	13.0	25.1	21.1
Male	10.0	16.9	11.2

*Source:* National Survey of America’s Families, 1999.

The result is statistically significant at the .001 level.

All the numbers are in percentage. For instance, 12.4 means 12.4 percent of female citizens were in “fair or poor” health in 1999.

**Table 2. Health Insurance Coverage**

The U.S. 1997		U.S.-born	Naturalized	Foreign-born
Female	Employer	66.5	63.4	39.7
	Medicaid	10.8	9.1	11.1
	Other	7.0	7.1	5.4
	Uninsured	15.7	20.3	43.8
Male	Employer	71.6	65.1	44.9
	Medicaid	3.8	3.9	4.5
	Other	8.7	8.4	5.5
	Uninsured	15.9	22.6	45.2
California 1997				
Female	Employer	60.7	56.8	32.3
	Medicaid	15.5	11.1	15.7
	Other	7.7	9.9	4.0
	Uninsured	16.1	22.2	48.0
Male	Employer	67.5	55.4	35.8
	Medicaid	6.7	4.3	5.9
	Other	9.0	7.9	4.3
	Uninsured	16.8	32.4	54.0
Florida 1997				
Female	Employer	60.5	58.5	37.9
	Medicaid	9.9	6.6	6.9
	Other	7.8	8.5	10.3
	Uninsured	21.8	26.4	44.8
Male	Employer	64.5	58.7	45.0
	Medicaid	2.0	3.7	2.3
	Other	10.9	13.8	12.4
	Uninsured	22.6	23.9	40.3
New York 1997				
Female	Employer	64.8	68.3	33.5
	Medicaid	15.7	13.1	20.3
	Other	5.9	4.1	3.6
	Uninsured	13.6	14.5	42.6
Male	Employer	72.0	62.0	35.7
	Medicaid	5.9	5.8	8.2
	Other	6.8	8.3	6.6
	Uninsured	15.3	24.0	49.5
The U.S. 1999				
Female	Employer	72.6	72.1	43.8
	Medicaid	8.3	7.3	8.8
	Other	6.2	5.8	4.8
	Uninsured	12.8	14.8	42.7
Male	Employer	76.3	72.9	48.4

	Medicaid	3.5	3.1	3.8
	Other	7.7	7.3	4.1
	Uninsured	12.5	16.7	43.6
California 1999				
Female	Employer	67.7	72.8	37.2
	Medicaid	11.7	5.4	10.1
	Other	7.5	7.1	5.4
	Uninsured	13.1	14.7	47.3
Male	Employer	71.3	67.0	43.8
	Medicaid	5.0	2.8	3.7
	Other	9.1	11.2	3.4
	Uninsured	14.7	19.1	49.1
Florida 1999				
Female	Employer	66.2	65.7	43.0
	Medicaid	7.4	4.8	6.1
	Other	8.3	7.2	5.2
	Uninsured	18.1	22.3	45.7
Male	Employer	69.7	69.5	42.4
	Medicaid	2.5	.6	4.7
	Other	11.5	9.1	5.3
	Uninsured	16.3	20.7	47.6
New York 1999				
Female	Employer	71.1	68.2	40.0
	Medicaid	13.2	13.7	13.7
	Other	5.5	3.3	3.0
	Uninsured	10.2	14.7	43.4
Male	Employer	76.2	69.1	45.9
	Medicaid	5.1	6.7	5.6
	Other	5.0	6.7	2.0
	Uninsured	13.7	17.4	46.4

Source: National Survey of America's Families, 1997 and 1999.

The result is statistically significant at the .001 level.

All the numbers are in percentage. For instance, 60.7 means 60.7 percent of the female U.S.-born citizens had employer-sponsored health insurance in 1997.

**Table 3. Sample Characteristics in 1997 and 1999**

	1997			1999		
	Native	Naturalized	Immigrant	Native	Naturalized	Immigrant
<b>Marriage (Married)</b>						
California						
Female	59.4	70.3	73.5	59.3	71.0	67.5
Male	72.0	80.9	76.2	67.9	78.6	70.6
Florida						
Female	62.9	74.8	70.8	62.9	72.9	70.4
Male	*81.0	*86.8	*81.9	74.9	84.8	77.1
New York						
Female	*62.7	*66.0	*59.9	*59.7	*59.7	*58.1
Male	*75.9	*82.9	*72.0	*72.6	*87.1	*67.3
<b>Employed</b>						
California						
Female	62.5	66.0	41.8	65.0	70.5	45.3
Male	*80.5	*79.1	*81.0	83.3	83.7	87.5
Florida						
Female	*67.4	*67.0	*58.6	68.5	70.5	60.0
Male	*81.3	*77.1	*82.2	82.1	85.4	86.5
New York						
Female	63.3	62.8	49.0	65.9	70.6	55.6
Male	82.1	81.0	79.1	84.2	79.2	83.7
<b>Below Poverty Line</b>						
California						
Female	35.4	47.6	92	30.3	31.0	78.6
Male	22.9	40.0	78.0	20.0	21.9	62.3
Florida						
Female	40.7	50.0	75.0	35.4	52.2	82.6
Male	24.3	29.6	45.8	14.0	21.6	42.9
New York						
Female	36.1	22.7	60.6	30.9	26.9	52.6
Male	24.6	31.0	60.6	18.2	31.9	55.6
<b>Hispanic</b>						
California						
Female	24.5	41.4	81.9	20.6	43.8	81.4
Male	23.1	45.3	79.1	18.1	48.8	80.4
Florida						
Female	9.0	53.8	63.8	8.1	52.4	61.7
Male	9.2	59.6	69.0	6.8	54.3	66.5
New York						
Female	12.8	29.7	47.8	10.9	31.3	45.6
Male	9.4	24.8	42.9	7.9	30.3	41.3

Uninsured						
California						
Female	16.1	22.2	48.0	13.1	14.7	47.3
Male	16.8	32.4	54.0	14.7	19.1	49.1
Florida						
Female	21.8	26.4	44.8	18.1	22.3	45.7
Male	22.6	23.9	40.3	16.3	20.7	47.6
New York						
Female	13.6	14.5	42.6	10.2	14.7	43.3
Male	15.3	24.0	49.5	13.7	17.4	46.4

Source: National Survey of America's Families, 1997 and 1999.

1. The result is statistically significant at the .05 level, except those labeled \*, which are not statistically significant.

2. All the numbers are in percentage. For instance, 55.4 means 55.4 percent of female citizens were younger than 39 in 1997.

3. Mean age = 39.41, and median age = 38 for all the data. Thus I recode the age into a dummy variable (0 = young = age from 15 to 38, 1 = old = age from 39 to 85).

4. Marital status is a relatively complicated variable. To ease the analysis, I've recoded it as following: 1 = Married, spouse in or not in household, and 0 = Other marital status.

5. I have recoded educational level variable (low educational level = 0 = below high school diploma, high educational level = equal to or above high school diploma).

6. I have recoded the variable – earnings below the poverty line – as following: 0 = earnings below poverty line, 1 = earnings equal to and above poverty line.

**Table 4. Logistic Regression:  
Factors to Health Insurance Coverage for Immigrant Women in 1999**

	Beta	Standard Error	OR	p
<b>Women</b>				
Marriage	1.084	.069	2.957	< .001
Employment	.295	.102	1.343	< .01
Poverty	1.428	.072	4.171	< .001
Race	-.722	.104	.486	< .001
<b>Immigrant Women</b>				
Marriage	.848	.333	2.335	< .05
Employment	.993	.391	2.699	< .05
Poverty	1.010	.403	2.745	< .05
Race	-1.243	.366	.289	< .01

*Source:* National Survey of America's Families, 1999.  
OR refers to Odds Ratio.

## APPENDICES

### I. 1997 National Survey of America's Families Adult Pair File (75,525 cases)

#### A. Independent Variables:

<b>Variable Name</b>	<b>Concept of the Variable</b>
UIMMSTAT	Immigration status
SEX	Gender
SITE	State of residence
UMARSTAT	Marital Status
IEMPNOW	Employed or Unemployed Now
IABVPV	Earnings below or above Poverty Line
UBETH	Hispanic/Non-Hispanic

#### B. Dependent Variable:

<b>Variable Name</b>	<b>Concept of the Variable</b>
UHINS4	Health Insurance Coverage

## II. 1999 National Survey of America's Families Adult Pair File (74,719 cases)

### A. Independent Variables:

<b>Variable Name</b>	<b>Concept of the Variable</b>
UIMMSTAT	Immigration status
SEX	Gender
SITE	State of residence
UMARSTAT	Marital Status
IEMPNOW	Employed or Unemployed Now
IABVPV	Earnings below or above Poverty Line
UBETH	Hispanic/Non-Hispanic

### B. Dependent Variable:

<b>Variable Name</b>	<b>Concept of the Variable</b>
UHINS4	Health Insurance Coverage
UCNGHL	Health Status

### III. Recode Table

	<b>Old</b>	<b>New</b>
<b>Immigrant Status</b>		
	1-2 (Native and Naturalized Citizens)	0
	3 (Foreign-born Non-citizens)	1
<b>Insurance Coverage</b>		
	4 (Uninsured)	0
	1-3 (Insured)	1
<b>Gender</b>		
	M (Male)	0
	F (Female)	1
<b>Marital Status</b>		
	3-8 (Not Married)	0
	1-2 (Married)	1
<b>Employment</b>		
	2 (Unemployed)	0
	1 (Employed)	1
<b>Financial Status</b>		
	1 (< Poverty Line)	0
	2 ( $\geq$ Poverty Line)	1
<b>Race</b>		
	N (Non-Hispanic)	0
	H (Hispanic)	1

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# Curriculum Vitae

Ju Wang

[juw@vt.edu](mailto:juw@vt.edu)

## Education

- Master of Arts, Political Science, July 2004, Virginia Polytechnic Institute and State University (Virginia Tech), Blacksburg, VA, U.S.
- Bachelor of Arts, Humanities and Social Sciences, Summer 2002, Nanjing University of Aeronautics and Astronautics (NUAA), Nanjing, China

## Positions Held

### *Teaching*

Teaching Assistant, Department of Political Science, Virginia Tech, Blacksburg, VA, Fall 2002 – Spring 2004

- Assisted in courses: U.S. Government and Politics, Contemporary Political Theories, International Law and Comparative Politics
- Administered class, evaluated students, made up quiz questions, graded papers, held office hours

### *Working*

Program Support Technician, Department of Political Science, Virginia Tech, Summer 2003

### *Extracurricular Activities*

Editor and Journalist, Broadcast Station at Nanjing University of Aeronautics and Astronautics, China, from September 1999 to May 2001

- Interviewed directors of departments and administration
- Arranged photo shoots
- Wrote editorials on Public and International Affairs
- Wrote articles on campus topics weekly

Volunteer, in the 6<sup>th</sup> World Chinese Entrepreneurs Convention, Nanjing, China, September, 2001

- Served as Interpreter
- Designed and distributed flyers

## Research Interests

- Welfare
- Health Care
- Comparative Politics (Chinese Politics)