THE ROLE OF SOCIAL CAPITAL AND ACCULTURATION IN HEALTHCARE ACCESS: THE CASE OF HISPANICS IN MISSOURI

A Dissertation

presented to

the Faculty of the Graduate School

at the University of Missouri-Columbia

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

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DECEMBER 2017

The undersigned, appointed by the dean of the Graduate School, have examined the dissertation entitled

THE ROLE OF SOCIAL CAPITAL AND ACCULTURATION IN HEALTHCARE ACCESS: THE CASE OF HISPANICS IN MISSOURI

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a candidate for the degree of doctor of philosophy of Rural Sociology,

and hereby certify that, in their opinion, it is worthy of acceptance.

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To Fabio, the love of my life (R.I.P.), who provided so much support for me to pursue this PhD

ACKNOWLEDGEMENTS

I would first like to give special thanks to Dr. Steve Jeanetta for giving me the opportunity to be part of the survey used in this study, for constantly trusting me with responsibilities that allowed me to grow as a field researcher, and for all his support and advice throughout my doctoral program as my research assistantship supervisor. In addition, I am honored to have been a student fellow at the Cambio Center, which allowed me to learn so much from other researchers who are working with challenging issues faced by Hispanics.

I am very grateful for the valuable critique I have received from my academic advisor, Dr. Sandy Rikoon, who continuously pushed me to become a better researcher. I would also like to thank the other members of my committee - Dr. Jere Gilles, Dr. Hua Qin, Dr. Corinne Valdivia - as well as other faculty in my department - Dr. Mary Grigsby, Dr. Mary Hendrickson, and Dr. David O'Brien - who provided me with feedback and have challenged me through their classes and out of class discussions, all of which have enrichened me to write this dissertation.

In addition, I want to acknowledge the emotional support I received from so many friends, family members, and colleagues, in particular three close friends Marcia Berger, Kristi Livingston, and Teresa Velazquez. Without their support I would not have been able to finish this dissertation in such a difficult moment in my life of losing my husband to cancer.

I further want to acknowledge the support and collegiality of my fellow graduate students with whom I learned to become a stronger team worker.

Finally, I would like to acknowledge the Missouri Foundation for Health, the Center for Health Policy at University of Missouri and University of Missouri Community Development Extension Program who funded the survey used in this dissertation.

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ABSTRACT

Hispanics are today the largest group with the lowest access to health care in the U.S. as measured by several studies that quantify rates of uninsured and percentages who lack a primary care physician (R. Andersen, Lewis, Giachello, Aday, & Chiu, 1981; R. M. Andersen, Giachello, & Aday, 1986; Balcazar, Grineski, & Collins, 2015; Fiscella, Franks, Doescher, & Saver, 2002; Gresenz, Rogowski, & Escarce, 2009; Livingston, 2009). In states like Missouri, where the Hispanic population growth is relatively recent, the issue is new (Haverluk & Trautman, 2008; Stepler & Brown, 2015). Although the percentage of Latinos in Missouri is still low - about 4% - what is noteworthy is the group's population growth of 311% for the period 1990 to 2016 (U.S. Census Bureau, 2014b, 2014a). A theoretical analysis that applies Gramsci's (2014[1948]) idea of cultural hegemony shows that structural barriers have been imposed over the years to restrict access to health care for Hispanics mainly through the intersection of federal healthcare and immigration legislation. A meta-analysis of 83 published studies further corroborate the structural barriers in place and identifies additional ones that apply to acculturation and social capital. Although acculturation has been measured by various studies that focus on Hispanics' access to health care, overall, these usually fail to clearly explain and justify how and why they chose certain ways to operationalize such variable. In addition, social capital is practically neglected in this literature. Although there are studies that measure and discuss the importance of having social networks to access medical resources, almost no study uses the term social capital and even fewer measure or discuss it by subtypes. Data from a survey study conducted in the state of Missouri in 2014 is used as the basis of logistic regression analysis. The study further corroborates

that there are structural barriers, but also finds that acculturation and social capital impact access for this population. In particular, I find that Hispanics in Missouri possess low levels of acculturation as it applies specifically to the American healthcare system. Two types of social capital are found to be significant but in opposite directions. Bonding social capital, which stems from strong relationships, is found to hinder access. This may be because many such tight networks may not be as connected to the Anglo portion of the American society that is better linked to resources. On the other hand, bridging social capital, which stems from weak relationships, is found to be an enabler of access. These results indicate that we need to go beyond just offering medical insurance to this group. In order for Hispanics to increase access to health care they need to be better acculturated to the American healthcare system, as well as need to be connected to the proper social networks that can enhance access.

CHAPTER 1: INTRODUCTION

A. Background

For the past half century access to health care for Hispanics in the US has been problematic and continues to be the case. Hispanics represent today the largest group (based on Census classifications) with the lowest access to health care in the country as measured by several studies that quantify rates of uninsured and percentages who lack a primary care physician (R. Andersen, Lewis, Giachello, Aday, & Chiu, 1981; R. M. Andersen, Giachello, & Aday, 1986; Balcazar, Grineski, & Collins, 2015; Fiscella, Franks, Doescher, & Saver, 2002; Gresenz, Rogowski, & Escarce, 2009; Livingston, 2009). This problem has long been recognized in states, like California and Texas, where Hispanics have been established for longer periods and represent larger portions of the population.. However, in others like Missouri, where the Hispanic population growth is relatively recent, the issue is new (Haverluk & Trautman, 2008; Stepler & Brown, 2015).

The state of Missouri, particularly the Kansas City area, received a flow of Hispanic immigrants in the late 19th and early 20th century. Most of these immigrants, coming primarily from Mexico, were hired for the construction of railroads and meatpacking facilities (Serda, 2011). It took over a century for another significant inflow of Hispanic immigrants to reach the state (Carr, Lichter, & Kefalas, 2012; Haverluk & Trautman, 2008; Passel, Cohn, & Lopez, 2011; Kandel & Parrado, 2005). Although the percentage of the Hispanic population in Missouri is still low - about 4% - compared to other states - such as neighboring Illinois with 16.7% - what is noteworthy is the group's population growth of almost 80% for the period from 2000 to 2010 (Cambio Center, 2011; U.S. Census Bureau, 2014b, 2014a). If we look at total growth in the Hispanic

population from 1990 to 2016, estimates show a 311% average increase for the state, while in some counties it has been over 1,000%. Missouri's current population is projected at 250,476 Latinos (Missouri Census, 2017). Not surprisingly, these trends have brought about concerns regarding integration of Hispanics in Missouri (Haverluk & Trautman, 2008). Access to health care is one component regarding such integration.

Although there has often been confusion regarding the term "Hispanic" among both Hispanics and non-Hispanics, one thing is clear from the Census description (see Appendix 1: Glossary), Hispanics are treated as an ethnic group, as opposed to a racial one. Both race and ethnicity are deemed as social constructs by various social science scholars in fields like sociology (Haney-Lopez, 1994; Mora, 2014; Rumbaut, 2011; Shiao, Bode, Beyer, & Selvig, 2012) or psychology (Smedley & Smedley, 2005). Confusion is thus expected, particularly when we consider the term Hispanic has been adopted by the Census relatively recently - in the late 20th century (Cohn, 2010).

The Hispanic population encompasses a heterogeneous group with a wide range of cultural backgrounds that mainly have just two things in common: the Spanish language and its colonial link to Spain located in the Iberian (previously referred to as Hispania during the Roman Empire) peninsula in Western Europe. But even with respect to language, there are Hispanics, like those of 2nd or 3rd generation immigrants, who do not speak fluent Spanish or speak no Spanish at all. There are also Hispanics whose main language is of an indigenous origin other than Spanish, such as some from Mexico and Guatemala who speak a Mayan dialect.

Nowadays, the term Hispanic is used interchangeably with the term Latino. Latino adds to the confusion because Hispanic is linked to the Spanish language,[1] but Latino can be anyone whose language derived from Latin (i.e. Spanish, Portuguese, Italian, French, Romanian) (Mora, 2014; Rumbaut, 2011). The confusion caused by the use of these terms is sometimes problematic because it impacts how healthcare policy recommendations are being made in the US (Schur et al., 1987; Weinick et al., 2004). For the purposes of this study, Hispanic is used interchangeably with Latino as it is already the norm in the US. The two terms in this case are used to refer to those who reside in the US and whose official language in the family's country of origin is Spanish, depending on who originally immigrated (Mora, 2014).

Moreover, it is important to note that immigrants and descendants from Mexico have historically comprised the largest portion of the Hispanic population in the US, and still do so today, about 64% (Stepler & Brown, 2015). Octavio Paz (1997), the renowned Mexican writer and Nobel Prize Laureate, thoroughly describes the complexity of the Mexican identity when it blends with the American culture. The juxtaposition of a country traditionally seen as a model to the world in economic development (i.e. the US) and its neighboring poor Mexico, certainly has brought about consequences in the lives of Hispanics residing in the US. Such contrast between the two countries has given rise to prejudice against Mexicans/Chicanos in the US. The famous female Mexican artist, Frida Kahlo, depicts this contrast in her 1932 painting *Autorretrato en la Frontera entre Mexico y Estados Unidos* [*Self Portrait in the Frontier between Mexico and the United States*] that

[1] Although Hispanic is linked to Spain and its colonies nowadays, historically the Roman Hispania belonged to the Iberian Peninsula which today includes current Spain, Portugal, Andorra, and the British Overseas Territory of Gibraltar (Bowerstock, Brown, & Grabar, 1999).

portrays the relationship between the two countries and its impact on Mexican identity as described by Paz (Figure 1.1).

Figure 1.1. 1932 Painting by Frida Kahlo titled *Autorretrato en la Frontera entre Mexico y Estados Unidos* [Self Portrait in the Frontier between Mexico and the United States]; oil on metal 12 ½'' x 13 ¾'' from the private collection of Mrs. and Mr. Manuel Revero

Many of Paz's descriptions can be extended to other Hispanic immigrants when we consider that most Americans see Hispanics as a homogeneous group who immigrated to escape poverty (Smedley & Smedley, 2005). This "single story," to borrow from Adichie (2009), has concurrently raised emotions of pride that has united Hispanics, as well as feelings of inferiority, fear and resentment that tend to disaggregate a group that recurrently struggles to find common ground. Take for instance the current increased state of fear created through the rise of anti-immigrant sentiments across the US. On the one hand, Latinos are uniting to protect themselves in their communities and to speak out against attacks brought about against them. On the other hand, some Latinos

do not want to be associated with the "illegal" identity created and, as a consequence may even act aggressively against unauthorized immigrants or other Latinos supporting them.[2]

The struggle of finding common ground within a heterogeneous group can in a sense relate to what blacks have gone through historically in this country. Du Bois (1940/2011) explains how descendants of African slaves were "united" in the socially constructed definition of being black. The primary thing used to "unite" this group was the color of their skin. The fact that slaves were brought from different parts of Africa, with different languages, culture and religion was completely ignored in such construction. In addition, intellectuals like Du Bois struggled to relate to uneducated blacks living in poor neighborhoods. Similar to blacks, Hispanics are now facing the challenge to act united when in fact there is much that fails to bond the group.

The lack of common ground is currently reflected in Hispanics' low political participation. Even though Hispanic political involvement has improved in recent years, mainly in states where their presence has been established for longer periods (not the case for Missouri), in general it is still low (Logan, Darrah, & Oh, 2012). According to Bourdieu (1984) "abstentionism is a condition for the functioning of the restricted political participation" (1984, p. 398). In this sense Hispanics are seen to lack competence, they are not socially recognized with the right to be properly represented. If part of the Hispanic population lacks access to healthcare services due to legal restrictions, then this is a manifestation of not having full recognition of the group's rights. The right to speak for their healthcare needs could be tied to fears of discrimination, particularly but not solely against unauthorized residents (Heyman,

[2] These notes are from my personal insights obtained from anecdotes I'm hearing from communities across Missouri as I'm working in another project involving Hispanics in the states.

Núñez, & Talavera, 2009; Ku & Matani, 2001). Nonetheless, it is important to note the majority of Hispanics today are lawfully residing in the US. On average, less than 20 percent are unauthorized (Krogstad & Passel, 2015). However, according to Ku and Matani (2001) the fear of becoming more involved in American society persists even among those lawfully residing for several generations. Thus, the impact of discrimination is not limited to those labeled as "illegal." As a result, laws have been established that limit access to healthcare for Hispanics, including the Affordable Care Act (ACA) that explicitly maintains restrictions based on immigration status. The lack of involvement tends to be more accentuated in states where Latinos are considered newcomers, like Missouri (Haverluk & Trautman, 2008).

In addition to the heterogeneity related to the country of origin, the issue of lawful residence must be raised. There are different categories attached to Hispanics when it comes to their status of lawful residency, which are complex and can be difficult to grasp when one is not familiarized with them (see Appendix 1: Glossary). The ACA relies on immigration status to determine who is eligible for Medicaid, Medicare, tax credits or insurance subsidies in the Marketplace (Table 2.1). In the ACA, the term "lawfully residing" excludes all unauthorized residents. Further, the law provides limitations on subsidies to those who are not American citizens but are still lawfull/y residing (USA.gov, 2015). Historically, unauthorized immigrants were ineligible for federally funded assistance. Additionally, welfare reform legislation passed in 1996 restricted access for lawfully present foreign nationals based on their immigration status, when they arrived in the US, and their length of residence (Office of the Assistant Secretary for Planning and Evaluation, 2012). Federal legislation discrimination is often strengthened

at the state level where anti-immigrant sentiments are strong. Consider for instance the fact that Missouri did not expand Medicaid when states were given the chance to do so by the ACA, a component of the legislation act that heavily impacts Latinos who predominantly belong to low income levels. So, legal discrimination against Hispanics has been increasing since 1996.

Evidence since the 1960s showing discrimination in healthcare access for Latinos suggest that this topic is an important aspect in the study of sustainable development. From my PhD coursework, it is clear to me that there is no consensus on how to define sustainability or sustainable development. My sense is that if the aim is to achieve some sort of balance between economic, environmental and social goals for a community, a state, a country or the world, the idea of sustainable development is utopian. Yet, this does not mean we shouldn't aim at getting as close as possible. Every step we take in that direction moves us at least a bit closer to the ideal goal, even if we are never able to reach it fully.

Eichler (1999) states that a starting point in the effort to conceptualize sustainability is to view it as a "form of social stratification" (p. 192). The biospheric system (Figure 1.2) she introduces is adopted here to situate the topic of this dissertation within her framework. Access to health care is part of social equity. Access to health care is also a major limitation faced by Hispanics in this country. Therefore, the topic serves as one example pinpointing how, even in a developed country with one of the highest GDP per capita, we find flaws with respect to how sustainable development appears in practice. When income per capita and access to basic human rights are not distributed evenly among its population, there is clearly much work to be done in development.

In Eichler's (1999) framework, the factors covered in this dissertation are just a small piece situated at the intersection of the social, cultural, governance and economic systems. This dissertation however, does not include environmental components that belong to the surrounding biosphere since those were not covered in the survey study.

Furthermore, universal access to health care is included as a key component of "Good Health and Well-Being," among the 17 sustainable development goals recently listed by the United Nations.[3] In discussing that goal, the UN states: "The aim is to achieve universal health coverage, and provide access to safe and affordable medicines and vaccines for all" (United Nations Development Programme, 2017). More specifically, the target goals state: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (United Nations Development Programme, 2017).

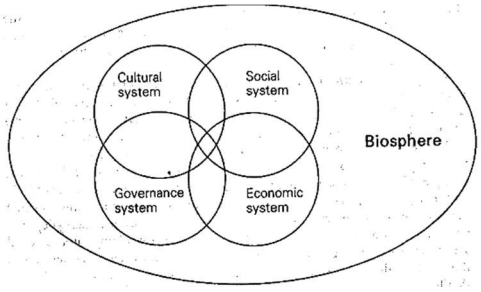

Figure 1.2. Eichler's (1999) biospheric system of sustainable development

[3] The 17 Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development was adopted by world leaders in September 2015 at a UN Summit and officially came into force on January 1, 2016 (United Nations, 2017).

Access to health care is defined as "the degree to which people are able to obtain appropriate care from the health care system in a timely manner" (Tienda & Mitchell, 2006, p. 411). The two most important indicators of access to health care in the US are having health insurance and having a primary care provider. Although non-Hispanic-whites represent today the largest group of uninsured for the total population (about 45% of total uninsured), when groups are broken into categories, Hispanics consistently show the highest rates of uninsured (29%) when compared to non-Hispanic-white (11%), blacks (19%), or Asian (15%) (DeNavas-Walt, Proctor, & Smith, 2013; Doty & Holmgren, 2006). The rate of uninsured is worrisome when we consider that having insurance is the first institutional requirement to access care in the US, as will be explained in Chapter 2.

When we examine disparities between countries and think about development overall, it has become somewhat natural for us to think of failures in health achievements as being a problem inherent to developing countries. However, uneven development is not just a reality between countries (Harvey, 2006), but one within countries, including those with developed economies like the US.

One example illustrating uneven access in the US is offered by (Stone, Boursaw, Bettez, Larzelere Marley, & Waitzkin, 2015). The authors prove that insurance coverage is distributed unevenly across counties in the continental US when they compare numbers and percentages of the population that are insured at the county level. Hence, the geographical disparities observed by Harvey (2006) should be applied not just to compare countries, but also regions within countries or states The study by Stone, Boursaw, Bettez, Larzxelere Marley, and Waitzkin(2015) clearly shows that lower access is

accentuated in counties with higher proportions of poverty and minorities. This dissertation explores causes behind the lack of access faced by the Hispanic population. Because Hispanics recurrently appear as the largest group with the lowest access to health care, they could also serve as a good example to help researchers and policy makers question broader idiosyncrasies about the American healthcare system. Having the best technology and the best medical doctors available does not ensure universal access to healthcare, but policies do make a big difference (Deaton, 2007, 2013a, 2013b).

In discussions on access, there is correspondingly a distinction I make with respect to how the term health-literacy is used. Since 2000, the US Department of Health and Human Services (2000 adopted the following definition for health literacy: "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."Although there have been controversies on how people define, understand, and apply this term, this is perhaps the most widely used description nowadays (Berkman, Davis, & McCormack, 2010; Baker, 2006). For the purposes of this study, the above definition will hold, but the portion referring to services needs to be understood as a subcategory. Due to the different types of skills and knowledge needed to navigate the complex US healthcare system, it is important to address literacy with respect to *accessing healthcare services* separate from the capacity to address one's own health.

The focus of this study is on Hispanics residing in the US, more specifically the state of Missouri. For this reason, the use of healthcare literacy refers to the degree of capacity people possess to access the *American* healthcare system. Capacity in this sense encompasses various impediments that are common to Hispanics today, such as fluency

in the English language, understanding how to go about obtaining insurance, learning about the importance of having insurance as well as a primary healthcare physician, understanding that their insurance may not cover all costs and that bills will be sent later by mail, and so on. In other words, there are specific skills and knowledge that an immigrant must acquire in order to start accessing healthcare services and even more so to master the system. Therefore, the notion used to refer to literacy with respect to accessing healthcare services should be labeled *healthcare literacy* and treated as a subset of health literacy as defined by the US Department of Health. Moreover, healthcare literacy is not a static concept since people can change their level of literacy through time as stated by Berkman et al. (2010). In this dissertation, the process of acquiring healthcare literacy is equivalent to becoming acculturated to the American healthcare system. It is important to keep this in mind as the reader advances through the chapters.

I adopt a general perspective from the fields of sociology and political economy in this dissertation. By applying this worldview, the purpose is to first attempt to get to the root of what is causing the observed healthcare crisis. This purpose allows me to provide a clear context in which my specific study on Hispanics' access to healthcare in Missouri fits. Limitations in access have grown in recent decades and today affect most Americans. Economic data is presented to illustrate the level of the current crisis and the degrees of inequality. Such inequalities are primarily the outcome of structural barriers (as labeled by sociology) or institutional barriers (as labeled by New Institutional Economics). If we account for the structural barriers and consider that Latinos are newcomers to this crisis, by enabling this population to acculturate to the system we

could help improve access. In the acculturation process, social capital - in particular bridging social capital - may serve an important role in gaining healthcare access literacy.

My analysis is critical of how the healthcare system has been structured, but not in the sense of aiming to recommend that we should immediately dismantle the whole system. Instead, the aim is to start a real conversation on the misalignment between what the facts are telling us today, from data dating back to the late 1970s, and what many Americans still seem to believe works best for them. There is a cultural hegemony – a term I adopt from Gramsci's (1948/2014) *Prison Notebooks* - acting behind the scenes that supports neoliberal policies in this country. From my perspective, the Cold War has left scars in the American society and those with power have taken advantage of this to continue to attack anything that can be slightly associated with the word socialism. The fall of communist economies also adds to the biases in place against anything associated with socialism. So, people are looking at what they consider socialist ideas through the lenses of these biases. Acknowledging such biases is therefore the first step in any attempt to bring about real changes to health care.

The sociologist's views direct us toward a more guaranteed universal healthcare system. However, in order for the system to be rerouted from its current neoliberal path dependency, it is not enough for sociologists to just criticize the system in place. It is also necessary to acknowledge that a cultural hegemony barrier still exists. We must get past the public's fears towards socialism in order to truly help people understand the criticisms brought about by sociologists. I am not however, advocating for a socialist system to replace the current one. Instead I believe the US should aim for a more social democratic system. This shift alone (although a huge shift indeed) could significantly

increase access for Hispanics due to their proportionately large presence among the poor who confront larger structural barriers.

Nonetheless, there are huge economic barriers when we consider the size of the healthcare economy. If we consider for instance a hypothetical situation of a radical change, we can envision the impact through huge job losses and social disruption. Swapping jobs from the current neoliberal system to a more social democratic one would require significant and complex coordination efforts that take time. Hence, there are no easy or fast routes to make the necessary transition. Recognizing these major barriers is therefore critical in order to move beyond criticizing the system and towards a realistic effort that aims at fairer policies for all. Moreover, comparisons of the economic costs of social democratic programs in healthcare that work better must be done in order to show the public that in fact it is the current policies that are costing more money, on top of the loss in quality and large number of people being excluded from access - 47,951,000 people (15.4% of total population) when measured by uninsured rates before the ACA went into effect (DeNavas-Walt et al., 2013).

The theorists I have studied in my PhD coursework have given me the tools necessary to understand the complexity of a socio-economic problem, like the issue of access to health care. The same theorists have not however, given me answers when it comes to recommendations on how to fix the problem. I believe this gap has to do with the fact that when you get to the root of a problem, we are inclined to offer radical solutions that aim at starting all over again. Many theorists covered in sociology, even when not providing recommendations, lead the reader to feel depressed about the issues analyzed and with no other alternative solution than a radical switch from a capitalist

model to a socialist one. Even modern political economists, like Piketty, who have been vocal and proven that neoliberalism is badly hurting societies around the world, fall into this tendency of recommending radical changes. I want to therefore stress that this dissertation simply offers a view of the problem. I do not intend to offer unrealistic specific recommendations because the level of complexity of this topic is too high. Hence a whole dissertation is needed to simply present the issue. In order to offer realistic and objective recommendations a whole new study, perhaps from a consultant's standpoint, will be needed.

I'm not necessarily arguing against sociologists' or Piketty's (2014) recommendations, but rather saying that radical changes cannot realistically happen overnight. There has to be a gradual approach, as well as more transparency to the public, to any big transition. I believe most sociologists fail to provide realistic proposals for a gradual transition.

Current sociological literature on health reform also fails to acknowledge the cultural hegemony governing civil society, which must be accounted for first in any practical steps recommended to be taken. Accounting for the existence of the cultural hegemony means that the intellectual dialect has to be translated into the public's language. As Gramsci (1948/2014) puts it: "the active man-in-the-mass has a practical activity, but has no clear theoretical consciousness of this practical activity" (p. 333). He goes further on this topic by stating: "one of the greatest weaknesses of immanentist philosophies in general consists precisely in the fact that they have not been able to create an ideological unity between the bottom and the top, between the simple and the intellectuals" (p. 329).

Only after we first consider the cultural hegemony present and put effort in transmitting the problem in a language that the public can understand and relate to in their personal lives, can we then begin to discuss more realistic strategies on how to go about making the changes needed. In other words, we must reroute the *invisible hand*, to borrow from Smith (1776/2003) but not in terms of the free market, that is controlling the cultural hegemony by educating the public properly. However, the purpose of this dissertation is focused on exposing the issue, a starting point to then hopefully be able to move to the next step of exploring what strategies would work best in the context of such a complex healthcare crisis. Although general recommendations are offered in the last chapter, as I said, it is beyond the scope of this research to make specific strategies.

It may seem counterproductive to bring up Adam Smith into this discussion because neoliberalism traces its roots back to his famous book *The Wealth of Nations.* As put in the introduction by Amartya Sen of a recently published version of Smith's other famous book, that is less known today, *The Theory of Moral Sentiments,* Smith (1759/2009) was extremely concerned with inequalities and morality, the two central issues in my sociological analysis of health care. In fact, the two books were meant to be a sequence. Over time though, economists have taken Smith's idea of self-interest entirely out of context and neoliberalism was born from that neglect rather than from Smith himself.

The current attention to the dangers of inequalities brought about by Piketty (2014), Lindert and Williamson (2016) and other scholars (Stanford Center on Poverty and Inequality, 2016) were already densely discussed by Adam Smith. Smith acknowledged that self-interest did not exist in isolation to other human emotions and

therefore it is a huge historical error (and also unfair to Smith) for scholars who came after him to have taken that notion, precisely in isolation. But why are Smith's moral concerns relevant to this particular discussion? The use of self-interest in isolation has been applied frequently in policy-making and is in fact causing the inequalities we observe, not just in health care, but in nearly all sectors. Again, ironically, Smith warned about greed and inequalities. He was a strong advocate for policies that would treat all people equally and, as Sen notes, believed that inequalities are "socially generated, rather than natural, disparities" (Smith,1759/2009).

Hence, the ideas that have been sold to the American society were not even part of the overall picture presented by the philosopher who is considered the father of neoliberalism today. Smith was arguing in favor of free markets but, for instance, he acknowledged the greed of companies when he discusses how their profit interests can dangerously take over the interests of society when he stated: "Their mercantile habits draw them in this manner, almost necessarily, though perhaps insensibly, to prefer upon all ordinary occasions the little transitory profit of the monopolist to the great permanent revenue of the sovereign" (Smith,1759/2009, p. 810).

Smith's views in this statement are in fact utopian; he is after all expecting profit-seeking companies, who were extracting from the English colonies, to think beyond their profits and consider the well-being of the people. However, what he is saying is not necessarily wrong; he is trying to make the case for these companies that they should look beyond their short-term profits if they want to survive in the long-term in any society. This same scenario could apply to insurance companies today. We could argue that if they want to survive in the long-term they must account for the well-being of

Americans to avoid social disruptions that in the end could destroy their existence. I find it hard to believe that once companies attain a high level or power in the market and politically, like is happening now, that they would be able to view past their short-term profit goals.

Thus, Smith was not arguing in favor of capitalism, but rather of free markets where there is perfect competition. Capitalism and free markets later came to be treated as substitutes in economics and politics, but conceptually they are not the same thing (Duménil & Levy, 2004). In a perfectly competitive market (which is utopian), a large number of competitors have equal market power, which is precisely what maintains the balance in the market. Mixing profit-seeking behavior with health care is in fact a utopian idea, or perhaps, more realistically speaking, a strategy of those who have gained direct access to power in the American political system. If we were to seriously pursue fairer - and in the case of the US, cheaper and less compex - access to health care, = we must disentangle profit-seeking goals from health care. We must also embark on this process in a gradual manner. Even so, it is important to recognize that the structural barriers that have emerged from neoliberal policies do not encompass the only barriers to access health care for Hispanics.

On top of the structural barriers imposed over the years that overwhelmingly affect Hispanics, this group also faces obstacles in understanding how the system works and possessing the proper social capital that could enhance their comprehension and/or access. The lack of acculturation to the American healthcare system is stronger among immigrants, but the problem persists across generations especially because worldviews on how a healthcare system should work are passed on by the parents. Furthermore, being

more acculturated to the system as well as possessing the right types of social capital to access resources can help overcome some of the structural barriers. The meta-study included in this dissertation illustrates how acculturation has been measured by various studies who focus on Hispanics' access to health care without clearly defining the term. The second problem observed in the literature with respect to acculturation is that most studies fail to clearly explain and justify why they chose certain ways to operationalize this variable. Since there is no clear consensus in the social sciences regarding the definition and operationalization of acculturation, it is, despite being deemed important, being treated superficially by researchers within the particular topic of Hispanics' access to health care.

In addition, social capital is mostly neglected in the literature focusing on Hispanics' access to health care. Although there are studies that measure and discuss the importance of having social networks in accessing medical resources, almost no studies use the term social capital and even fewer measure or discuss it by type. Because immigrants make a large portion of Hispanics, it is striking to not see social capital being used more extensively in this literature. Particularly because there is an extensive literature on social capital and health (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006; Macinko & Starfield, 2001; Murayama, Fujiwara, & Kawachi, 2012)., I was expecting such would have impregnated the literature I focused on here.

In sum, Latinos are faced with strong structural barriers that limit their access to health care. Structural barriers have been widely discussed and measured since the 1970s as the meta-study here shows. Also significant, is the lack of acculturation this group has with respect to the American healthcare system. In addition, we must understand better if

Latinos possess the proper types of social capital to access resources and/or aide in the process of acculturation. Acculturation, when measured must be defined and operationalized in clear terms. Moreover, it is important to measure social capital by type since the impact of each may vary across states where Latinos have been established for longer periods, as well as in the same location over time. In other words, more established populations may have better access to the proper types of social capital.

B. Major Contributions of the Dissertation

The first contribution of this dissertation is the identification of the main underlying causes behind the structural barriers Latinos face in accessing health care in the US. As mentioned, these barriers have increased through the years and impact most Americans, but Latinos have consistently been recognized as the most at risk population. Although many studies that focus on Hispanics' access to health care have analyzed the factors that measure these barriers, they tend to do so in a balkanized way. In other words, the focus is on the variables, not the underlying causes.

I apply a somewhat anthropological approach in the attempt to disentangle the cultural hegemony that has supported the neoliberal policies passed since the late 70s to recurrently cut safety nets through federal legislation. With respect to national policies, Latinos are impacted not just through healthcare legislation, but also by the intersection that exists between healthcare and immigration legislation. Cuts in access to health care, that mostly impact those of lower income levels, affect Hispanics largely because the group possesses a greater proportion of its population in these income brackets. Moreover, the group also possesses a large proportion of immigrants within its

population group, about 34% (Flores, Lopez, & Radford, 2017) hence also being largely affected by the intersection of healthcare and immigration legislation. Again, the studies identified in the literature explore, measure and discuss specific factors that point to federal legislation discrimination, but they fail to address the underlying causes behind these.

The healthcare crisis, in which Latinos represent the largest group negatively affected, can be summarized through facts that illustrate the US today as having the most expensive, most complex and most inefficient healthcare system in the developed world (Table 1.1) (Davis, Stremikis, Squires, & Schoen, 2014; Squires & Anderson, 2015). The US is also the country that leaves the most number of people uncovered in this group (Cohen, Martinez, & Zammitti, 2016; OECD, 2011). Among OECD countries, only Japan (1.5% for year 2011), Luxembourg (2.5% for year 2011) and the US (15.7% in 2013 before ACA; 8.6% in 2016 after ACA) have a population that is not covered by health insurance, with the US faring worst even after the enactment of the ACA that already improved health care coverage. When we account for the percentage of GDP spent on health care, the US spends on average about 17% of GDP, the next developed country in line is France with 11.6%, while the lowest is the UK with 8.8%. When we account for the per capita amount spent on health care, the US is also ranked first, $9,086, while the next in line is Switzerland, $6,325. In terms of tax money spent on health care (mainly Medicaid and Medicare), the US is ranked third =highest, $4,197, even though it is the only wealthy country with no universal access. Further, the amount spent on a per capita basis by the government on Medicaid and Medicare, does not include the $250 billion in subsidies that employers spend on employment sponsored insurance. Even

more striking is when we compare the percentage of the population covered by the government, 34% in the US, to the UK, where all residents are covered at one of the lowest rates of tax money spent on a per capita basis, $2,802. Thus, in the case of Hispanics, the lack of acculturation to such a complex system and low levels of social capital that possess the proper resources to access the system, accentuate the level of exclusion of this group due to the structural barriers that these general numbers portray, as is discussed in Chapter 2

The second contribution is with respect to acculturation. First, my theoretical analysis on the role of capital in Chapter 3 provides some background on the importance of being acculturated to a new type of healthcare system from an immigrant's perspective. In this sense, immigrants include not just those who have migrated themselves from another country, but also first and second generation individuals being born in the US. Worldviews are passed within the family from the parents and it takes several generations to fully change the worldview on health care. It is important to note that the emphasis here is not about which system is best or worse, that analysis is offered in Chapter 2. The issue here is that whatever model holds for the healthcare system, Hispanics need to acculturate to is in order to increase their chances of accessing services. Therefore, although the analysis in Chapter 2 points to the need to restructure the healthcare system and transitioning to a more social democratic one, the analysis on the need to acculturate is more immediate. In other words, in the short-term health care is still needed, so we can't wait for big changes to happen overnight. Thus, Hispanics face the need to acculturate to the system in place. In the long-term we must be looking at the healthcare system with more critical eyes and consider transforming it gradually.

Table 1.1. Healthcare Spending: Country Comparisons

Country	Healthcare Spending as % of GDP (2013)	Total Healthcare Spending Per Capita (2013)	Total Tax Money Spent Per Capita (2013)	Total Out of Pocket Spent Per Capita (2013)	Percentage not Covered by Insurance (2011)
United States	17.1% (1st)	$9,086 (1st)	$4,197 (3rd)	$1,074 (2nd)	15.7%
France	11.6% (2nd)	$4,361	$3,247	$277	
Sweden	11.5% (3rd)	$5,153	$4,126	$726	
Germany	11.2%	$4,920	$3,677	$649	
Netherlands	11.1%	$5,131	$4,495 (2nd)	$270	
Switzerland	11.1%	$6,325 (2nd)	$4,178	$1,630 (1st)	
Denmark	11.1%	$4,847	$3,841	$625	
New Zealand	11.0%	$3,855	$2,656	$420	
Canada	10.7%	$4,569	$3,074	$623	
Japan	10.2%	$3,713	$2,695	$503	1.5%
Norway	9.4%	$6,170 (3rd)	$4,981 (1st)	$855 (3rd)	
Australia	9.4%	$4,115	$2,614	$771	
United Kingdom	8.8%	$3,364	$2,802	$321	
OECD Median		**$3,661**	**$2,598**	**$625**	

Sources: (OECD, 2011; Squires & Anderson, 2015)

The meta-study in Chapter 4 recognizes that acculturation has in fact been measured by other studies as an important factor in Latinos accessing medical care. Nonetheless, researchers have not done a good job defining this term, particularly when considering that there is no clear consensus on its definition. In addition, the way acculturation has been operationalized is also inconsistent and unclear. This paper does not argue for a consensual definition of acculturation, but rather that researchers need to clearly define it in their studies. They also should clearly articulate why they chose certain ways to operationalize acculturation as a variable. In the statistical analysis applied in Chapter 5, using a survey study we conducted in the state of Missouri, I prove that acculturation is indeed an important factor to consider for this group in accessing health care. I rely on Berry's (Berry, 1980;Berry, 2003, 2005; Berry, Trimble, & Olmedo, 1986) bi-dimensional definition of acculturation and apply a scale adapted from this definition and tested among Hispanics.

The third contribution of this dissertation applies to social capital. Although some studies measure social capital, the term barely appears in the literature that focuses on

Hispanics' access to healthcare. The lack of use of this concept is interesting when we consider that the literature on social capital in the social sciences is extensive, particularly in sociology (Bourdieu, 2011; J. S. Coleman, 1988; J. L. Flora, 1998; M. Granovetter, 1985; Lin, 2001; O'Brien, Phillips, & Patsiorkovsky, 2005; Portes, 1998), political science (Helliwell & Putnam, 1995; Putnam, 1993, 1995) and economics (Fukuyama, 1999; Woolcock, 1998, 2001). Furthermore, there are no studies that measure the impact of the three main types of social capital – bonding, bridging, and linking - separately from each other in order to compare them. The meta-study applied in Chapter 4 identifies such gap. Further, the statistical analysis using data from the survey study collected in Missouri, finds that there are differences among the types of social capital. More specifically, in the state of Missouri, with a relatively recent growth spurt in the Latino population, bridging social capital (made up of weak ties) is proven to enhance access. Bonding social (made up of strong ties) is proven to hinder access, while linking social capital (made of vertical ties) is not found to impact access. These findings point to two main conclusions. First, as the general literature on social capital suggests, it is important to measure social capital by type since their impact may vary by local context and over time. Second, bridging social capital is found to be an important tool that could be used as a means to enhance acculturation and access to health care in policy at the federal, state or more local levels.

C. Organization of the Dissertation

The dissertation is organized in four main chapters in addition to this introduction and the last chapter on conclusions and recommendations. **Chapter 2** analyzes access to

health care in the US from the lenses of sociology and political economy. The main purpose of Chapter 2 is to situate the study. In other words, the chapter provides the context in which Hispanics are found today to correspond to the largest group possessing the lowest access to health care. There is a healthcare crisis, and Hispanics inevitably are part of that crisis. The crisis is the result of structural issues that have been accumulating over decades. The theoretical perspective adopted in Chapter 2 ties the healthcare system with other current crises happening in American society that stem from neoliberalism (i.e. rise in incarceration rates, education, climate change and so on). A critical perspective on neoliberalism is therefore adopted. Gramsci's (1948/2014) concept of cultural hegemony from his *Prison Notebooks* is borrowed in this analysis to portray what supports the recurrent passing of neoliberal legislation that has a significant impact on the healthcare crisis we observe today. Economic data is presented to show that, when compared to other countries, the US has the most neoliberal system relying the most on the private sector, and, in fact, the most inefficient, expensive and unfair healthcare system in the developed world.

Chapter 3 discusses the role capital plays in access to health care for Hispanics. The focus is on two main types of capital: cultural capital, as it applies to the US healthcare system, and social capital, as it applies to networks that are connected to the proper healthcare resources needed to access medical services. The chapter argues that in order to bypass some of the structural barriers imposed primarily through immigration and healthcare policies, Hispanic immigrants must acculturate to the complex healthcare system in place today. Through this approach, it is examined how certain codes, as posed by Bourdieu (1984, 2011), that apply specifically to the American healthcare system must

be learned and adopted by those who grew up with a different worldview of health care. The different worldviews apply not just to Hispanics who themselves immigrated, but also to those of second or third generation immigrants that acquire them, at least partly, from their families (Balcazar et al., 2015).

Bourdieu's theoretical framework is the starting point of the analysis in the 3rd chapter. Although Bourdieu (1993, 2011) did not discuss health care as part of his cultural capital argument, his ideas are transferable. Cultural capital and social capital are analyzed from the perspective of Hispanics having the proper stocks and capabilities to navigate the healthcare system. In the case of social capital, Bourdieu's definition is limited, so the chapter relies on research done by other scholars in the social sciences. There is already a general consensus among researchers that social capital should be measured by its different types separately (Woolcock, 2001). Three types of social capital: bonding, bridging and linking are part of the discussion in this chapter.

Chapter 4 presents a meta-analysis of the literature on Hispanics' access to health care. There is extensive literature dating back to the 1960s that measures and analyzes the barriers confronted by Latinos to access healthcare in the US. From this literature, it is clear that Hispanics stand out as the largest group having the lowest access to health care in the country, not just presently, but for decades. The meta-study supports what the critics of neoliberalism pose, that structural barriers have been enacted through the years as the US adopted more capitalist policies and moved farther away from a social democratic healthcare system. With the exception of those at the very top in income and wealth levels, this chapter also illustrates that Hispanics are not the sole losers in this system.

Although the main obstacles for Hispanics are still structural in nature and primarily stemming from the intersection of healthcare and immigration legislation, the meta-analysis also identifies studies that measure or explore the impact of acculturation and social capital. The American healthcare system is not just complex for immigrants, but even Americans who have been established here for several generations struggle with its intricacies. Hence, there is a unique value in analyzing this system from the perspective of barriers faced by newcomers (i.e. immigrants in this case). Such analysis helps raise the level of awareness with respect to the idiosyncrasies of such a system and force us to question things that Americans have become accustomed to and passive about changing. The main findings in the meta-analysis complement the discussion in the previous two chapters and as result help construct the main hypotheses that are tested in the final chapter.

Chapter 5 applies logistic regression analysis to data from a 2014-2015 survey study conducted in Missouri among Latinos in five communities where the Hispanic population is comparatively large. I test two main variables the impact of acculturation and social capital, on access to health care for this group. As mentioned, both of these factors have been measured in other studies, but there are some flaws in the literature with respect to them. The results from the logistic regression prove that acculturation is in fact a significant factor when it comes to access. Results also show that separating social capital by its type is critical when it comes to immigrants.

In particular, it is bridging social capital that matters for Latinos in Missouri, while bonding is proven to have a negative effect and linking no effect. I must stress the fact that these conclusions about social capital should not be generalized to Hispanic

populations in other locations. Context seems to have an important role here, meaning it is critical to have local studies that measure social capital in order to make proper recommendations for specific locations. These findings also imply that even in the most complex healthcare system, access can be improved for immigrants if we focus on helping them to acculturate to the system via bridging social capital, which can be created through policies or local programs (i.e. the *promotoras de salud*).

CHAPTER 2: AN ANALYSIS OF ACCESS TO HEALTH CARE THROUGH THE LENSES OF SOCIOLOGY

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane"
Dr. Martin Luther King Jr.

There are many factors that influence the health of individuals. Access to health care is one of them. To illustrate the importance of healthcare access I will start with an example. Diabetes in some cases can be prevented by what types of food a person eats. To a certain point, having access to health care can also impact what people eat (i.e. through recommendations made by a primary-care physician in an annual check-up) and as a result help prevent diabetes. In general though, having a healthy lifestyle is not really addressed through medical care today. Nonetheless, when someone has already attained the disease, access can make a big difference. A good example, published recently in the New York Times, is Sergio Ortega, a lawful resident of California (Tavernise & Gebeloff, 2016). Sergio had been suffering with diabetes for a long time, but at first, he did not know it because he couldn't afford a doctor, nor did he have insurance to cover for those costs. He quit his job of demolishing buildings after suffering from extreme fatigue and started selling fruits from a street cart. When the Affordable Care Act (ACA) came into effect (in 2014), California expanded Medicaid.[4] Sergio qualified after the expansion and enrolled in Medicaid. By the time he finally made it to the doctor, the nerves in his left leg had already been damaged by the disease and the leg was amputated. His diabetes is now under control and he received a robotic leg to replace the one

[4] The expansion involved increasing the poverty level so that more people at lower income levels, who couldn't afford insurance, could get public insurance. The decision by state was voluntary though, and not all states expanded Medicaid. Missouri for example chose not to expand.

amputated thanks to his public insurance. Sergio's example basically shows how insurance plays an important role in access to healthcare and can make a significant difference in a person's life. In other words, Sergio's diabetes and his lack of insurance impacted his health, followed by a change in his human capital, therefore having profound effects on his personal life.

In Sergio's example, we observe how access to health care is one factor that impacts health outcomes and as a consequence can damage human capital, which in turn affects livelihoods. In regions where Latinos are well established as part of the state's population, researchers have estimated that those without health insurance, the most common measure of healthcare access, receive about half as much medical care as those insured. Uninsured Hispanics are also less likely to have a regular physician, have a prescription filled, receive preventive care, and tend to wait longer between and during visits (Solis, Marks, Garcia, & Shelton, 1990; Valdez, Giachello, Rodriguez-Trias, Gomez, & De la Rocha, 1993; Vitullo & Taylor, 2002). Further, Latinos without health insurance are less healthy and tend to require more intensive care than those who are insured. Preventable diseases, like asthma and diabetes, are common among Latinos without insurance. Ironically, the cost of improving access for these Latinos is estimated to be less than the cost of treating them at more advanced stages in diseases commonly faced by this group (Valdez et al., 1993). Studies done on Hispanics' access to health care clearly illustrate the social and economic importance of insurance in gaining access in this country.

In this dissertation, access to health care is treated as a basic human right. As will be shown later in the meta-analysis, inequalities observed in healthcare access are often

measured by demographic variables. Such variables usually include socioeconomic status, race, ethnicity, and others. However, the discussion in this chapter will argue that if we look at the outcomes of such inequalities through the lenses of sociology, the underlying cause is actually the same. The focus here is on the US healthcare system. When looking at the specific American case, it is important to distinguish it from healthcare systems elsewhere. Different ideologies govern different healthcare systems across countries. By shaping policies, various worldviews in turn produce diverse outcomes around the globe.

The primary purpose of this chapter is to present the general context in which Hispanics today confront barriers to access healthcare services in the US. The chapter will first portray the current state of the US healthcare system. A significant amount of studies show the growing number of negative consequences from policies enacted since the late 1970s. Health care in the US is currently in crisis, but the crisis is ongoing; it began the moment society started *feeling* the negative consequences of legislations that restrict access for a growing portion of its population. Hispanics represent the largest group suffering from these restrictions nationally. In order to understand how such policies came about, with lack of access becoming more problematic for those at all income levels, it becomes critical to analyze the ideology driving these policies. The neoliberal culture that governs the American healthcare system is covered in the second part of this chapter. The last section discusses the main structural barriers in access to healthcare for Hispanics. Such institutional barriers observed now are the result of both immigration and healthcare legislation that were enacted through a neoliberal mentality as well as prejudice against Latinos.

A. The Current State of the US Healthcare System

Before debating on the inequalities observed in healthcare access, the role neoliberal policies have had in the rise of socio-economic inequality overall in the last 30 years must first be addressed. The increase in inequality however, is not unique to the US; it is happening in all developed economies (OECD, 2015a, 2017a, 2017b; Piketty, 2014), with the US having experienced the most pronounced rise (Lindert & Williamson, 2016; Piketty, 2014). According to a report published by the Stanford Center on Poverty and Inequality (2016), when compared to 10 of the wealthiest countries in the world, the US ranks worst in every category used to measure poverty and inequality. Even when compared to a broader set of countries that include less wealthy countries, the US still ranks low, 18th among 21 countries. The same report also finds there are significant institutional barriers (structural barriers) blocking mobility from various angles, including extreme residential segregation, large barriers to economic inclusion, extreme health disparities, low prime-age employment and extreme income and wealth inequality. Further, the US ranks last in safety nets offered to its population. If we look at wealth alone, the top 0.1% of households in 1978 owned about 7% of wealth and by 2012 this share rose to 22%.

Several studies have documented this rise in inequality (Dumenil & Levy, 2004; Duménil & Levy, 2011; Edsall, 1984; Piketty, 2014; Piketty & Saez, 2003, 2006; Solt & Ritakallio, 2008; Stanford Center on Poverty and Inequality, 2016). How these researchers estimate the level of inequality (i.e. through income, wealth, capital) varies, but all of them agree on one thing; the overall rise in inequality that occurred since the

late 1970s has been historically significant and could have been prevented at no cost to the overall real GDP growth through fairer policies. Piketty's (2014) findings report that the top 10% of the American population held about 45-50% of the national income in 1910s-1920s, which dropped to 30-35% by the end of the 1940s. Inequality was stabilized for a while between 1950 and 1970. Beginning in the late 70s however, Piketty observes a rapid rise in inequality and by 2000 the US returned to the top 10% earning between 45-50% of national income (p. 23).

According to scholars who have measured inequality rise since the 1970s, there was a clear shift in policies which has proven to benefit those in the upper income and wealth brackets at the expense of those in the lower ones. The result of this shift brought systemic policy alterations that have become very complex, what Piketty (2014) calls institutional changes and sociologists would refer to as structural changes. Consider the 1960s when various pieces of legislation were passed to benefit the poor and the working class including: Medicaid, Medicare, Food Stamp Program, Supplemental Security Income, Job Corps, Head Start, and so on. In less than a decade, these programs began to be dismantled in particular by the Ronald Reagan administration. In the 80s, there was basically an overall swap, tax cuts for the top 10% were put in place in exchange of big cuts in safety net programs for the poor and the working class (Edsall, 1984). The public argument for the shift has been recurrently that by cutting taxes to the top earners, these would invest in businesses that would offer new jobs for those at the bottom. The neoliberal argument goes that through these new jobs, safety nets are unnecessary since they will be attained through the private sector. By using historical economic data, Piketty (2014) shows that this economic idea is an illusion when interest rates (i.e. rates

of return on financial capital) are higher than economic growth (i.e. real GDP per capita). Hence investments to create jobs do not happen as expected because returns are higher by simply investing in financial markets.

According to (Lindert & Williamson, 2016), income inequality has been an ongoing American reality since colonial times. Even so, historically the US experienced two great waves in which the rise in inequality worsened significantly. The first wave occurred in the period between 1774 and 1860 and the second from 1970s to today. Between 1910 and 1970, the US went through what the authors call "the Great Leveling" (p. 10). Piketty (2014) points out that the sharp reduction in inequality observed between 1914 and 1945 was primarily due to the disruptions caused by the two big wars and the Great Depression. Since the late 1970s the country shifted towards cutting income taxes for upper income households and decreasing domestic programs. As Harvey (2006) puts it, from here on, policies in the US become "an accumulation strategy" (p. 82). The costs of this shift include crises, slow growth and social disruption (Dumenil & Levy, 2004), which we are already seeing in various sectors of the economy, including health care.

Lindert and Williamson (2016) do not attribute historical inequalities to just policies, but they do mention the most recent great wave of rise in inequality can be reversed through policies that favor those at the bottom, particularly policies in education, financial regulation and inheritance taxation. They also point that such reversal can be done concurrently with promoting overall economic growth. In other words, if the primary goal in economics is to increase real GDP for the country, these researchers argue that this can be accomplished concurrently with policies that focus on a more even distribution of income. Hence, a shift in how these policies are currently being

implemented could reverse the trend that began in the late 70s and the country could still achieve growth with the advantage of decreasing the risk of social unrest. Among the changes needed are policies in health care that further impact human capital.

As pointed out, the shift in ideology impacting policies in the US did not just affect income and wealth, but also safety nets, including those in health care. Of course, when it comes to human capital, policies that provide safety nets and those that directly target income and wealth are interconnected. There is a large body of evidence that shows a rise in healthcare access inequalities since the late 70s, as depicted in the meta-analysis in Chapter Four. Sergio's example given above illustrates how inequalities in access to health care can impact human capital, which in turn affects income and wealth. As a result, we end up with a vicious cycle between lack of access and constraints in human capital. Nevertheless, ethically speaking the problem becomes a basic human rights issue.

According to The Economist, the two most profitable industries in the US economy today are health care and technology. One of the best return on investments from companies in these two sectors comes from lobbying, $514,224,628 was spent on healthcare lobbying in 2016 (OpenSecrets.org, 2016). The amount spent on lobbying for all sectors in the last decade has increased by a third and has reached a total of $3 billion for the year 2016. During the same period that amount spent on lobbying grew, profits for companies investing in lobbying did too. Consequently, most sectors in the economy, including health care, are experiencing high levels of concentration. Justifications to the public for these mergers are based on efficiency. An estimated $150 billion were cut in costs for companies who merged. However, most of the gains were not passed on to

consumers, but rather to shareholders, which explains part of the income/wealth inequality mentioned above (The Economist, 2016a).

Research and recent reports indicate that the bottom line problem with access to the US healthcare system comes down to profits. Healthcare companies are acting like companies in any other sector; their ultimate goal is to make profits. Shareholders who own these companies expect profits to increase over time to assure they bring value to their investments. Simply put, expecting a small number of large profit-seeking companies to assume the responsibility of offering fair healthcare access to the nation's population is unrealistic. Particularly when we isolate the sick and those of lower income households, it is incompatible to put together the end goals of making money and offering fair healthcare access. Profit-seeking companies' primary goal is not to care for the sick, but again, to expand profits for their shareholders. There is perhaps a misalignment of interests between what the government expects from the private sector and what shareholders expect from their investments. Hence, it is immoral for a society to allow for the healthcare sector to continue to expand profits for shareholders at the expense of people's health. Pairing these two issues, making money and providing fair health care seems counterproductive, but that is exactly what has been done in the American case. More on the ideology backing this profit-seeking model is discussed in the next section.

In the healthcare sector, consolidation has indeed brought some efficiencies, but it has also increased market power that in turn led to both increases in prices and an overall decrease in the quality of services (Gaynor, 2011; Trish & Herring, 2015). The price increases are seen in all of the three main service providers for this sector: hospitals,

insurance companies and pharmaceutical companies. Furthermore, the efficiency justification has proven to be problematic. Not only are consumers not getting the benefits, but most of the gains from cost cutting seem to be attained mainly right after a merger happens. Over time, these gains level off and many companies return to pre-merger levels (Harrison, 2011). If such gains are only observed temporarily, it follows that companies will seek further consolidation after the gain in efficiencies is gone, thus strengthening the vicious cycle of market concentration. Further, as companies grow, they are seen as *too big to fail,* meaning their failure can bring huge job losses in the economy as well as shortages of services. Thus, when large companies support a large portion of jobs it can cause a hold-up situation for the government.

In the healthcare sector, the big wave of consolidation began with hospitals in the 1990s, which slowed down around 2002 and then returned in recent years (Gaynor, 2011). As hospitals consolidated, insurance companies followed, since they are the ones negotiating prices with hospitals and now needed to increase their bargaining power in the market. So, a cycle that began in the 1990s keeps getting stronger. The end result has been that as hospitals increased prices and cut on quality of services, insurance companies passed those costs on to consumers. The increased costs to consumers are observed through the fact that employers have passed these to their employees through lower wages (i.e. no wage increases, or smaller increases, particularly when adjusted to inflation) or simply reduced benefits (i.e. higher premiums, less coverage, and in some cases loss of coverage)[5] (Gaynor, 2011).

[5] More recent reports show that although the cost of employment-based insurance is still increasing (at higher rates than wages and inflation), the growth rate seems to be diminishing at least for the short-term since 2015 (The Henry J. Kaiser Family Foundation and Health Research & Educational Trust, 2016; The Kaiser Family Foundation and Health Research & Educational Trust, 2017).

A similar scenario can be observed with pharmaceuticals. The cost of drugs has not only increased overall, but production of certain drugs that do not bring high profits have been cut over time, bringing shortages for doctors and hospitals as well as increased prices for old drugs that have already long recovered their R&D investments (Fink, 2016; Pollack, 2015; The Economist, 2016b). In addition, Gaynor (2011) points out that substitution of doctors for nurses occurs when prices are kept for certain services at hospitals, therefore compromising quality. The cost of drugs and compromises in quality of medical services affect those at all income levels, but have the highest impact on individuals and families in lower income brackets. The one exception seems to be among those at the very top. The New York Times recently published an article that shows how very wealthy households are receiving preferential treatment through this system. A new kind of business in healthcare has emerged, one that charges a high monthly premium for households in order for them to get immediate access to the best doctors and hospitals in the country (Schwartz, 2017).

The US Government Accountability Office (2014) recently reported to Congress a summary of findings that portray consolidation trends in the private health insurance sector. They divide private markets in three groups to measure this (Note: Medicare Advantage is not included as part of the private health insurance sector): individual market, small group market and large group market. Concentration observed in all three groups across states from these findings is not just obvious, but worrisome. In 2013, enrollment was concentrated among three companies in most states; the three largest insurers had at least 80% of the total market share (i.e. in the three groups) in at least 37 states. In addition, in more than half of the states, one insurer had more than half the

market and in five states the largest insurer held 90% of the market share. Blue Cross and Blue Shield was identified as the largest insurer in 44 states for the individual market, in 38 states for the small group market, and in 40 states in the large group market for the period between 2010 and 2013. Dafny (2015) finds that in Medicare Advantage, government-financed private plans that serve about 22 million beneficiaries, there was also consolidation from 2011 to 2015 in the combined market shares of the top four companies (Kaiser, Coventry, Aetna and Humana). She estimates that about 37% of Medicare beneficiaries live in counties that are highly-concentrated in the Medicare Advantage market.

There is by now overwhelming evidence that market concentration of hospitals, pharmaceutical companies and insurance companies increases prices and cuts on quality as well as the number of products and services for consumers (Capps, David, & Carlton, 2010; Clifford & Moynihan, 2017; Dafny, 2009; Dafny, Duggan, & Ramanarayanan, 2012; Dafny, 2010, 2015; Dranove, Gron, & Mazzeo, 2003; Fink, 2016; Gaynor, 2011; Gaynor, Ho, & Town, 2015; Gaynor & Town, 2011; Gaynor & Vogt, 2000; Harrison, 2011; Pollack, 2015; The Economist, 2016b; Trish & Herring, 2015, 2015). One recent study done by Trish and Herring (2015) though, does find that in the current market situation after two decades of heavy consolidation in hospital and insurance markets, results can sometimes be mixed. According to the authors, premiums are higher when you have a high concentration of insurers as compared to employers and also when you have a high concentration of hospitals as compared to insurers. However, when there is a high concentration of both insurers and hospitals, premiums are lower due to insurers being able to counterbalance the hospitals' bargaining power. If we look at this study in

isolation, the recommendation would be to allow for both hospitals and insurers to consolidate so that we keep premiums low. The problem with this conclusion is that this scenario ignores vertical integration, which is still not happening at an accelerated rate (Gaynor, 2011).

As the US Government Accountability Office's (2014) report shows, large insurance companies operate in local markets, and as such, their behavior with how they're charging employers varies by market. However, when we look at what's happening nationally, over time, a small number of firms are gaining national control of the markets. In his thorough review of several studies done regarding market consolidation, Gaynor (2011) illustrates two decades of massive consolidation happening at the national level with consumers picking up the bill. When the ACA was implemented, Medicaid expansion and subsidies offered by the government to obtain private insurance included demand from a new group previously left out of these markets. Essentially, the ACA accelerated a trend that had started in the 90s. As Dafny (2015) points out, consolidation trends existed before the ACA was added to the equation. In other words, we cannot look at the effects of the ACA when it comes to low number of insurance options, higher premiums and higher deductibles happening in many states in isolation from what was already happening (Pear, 2015, 2016a, 2016b).

In market concentration, Gaynor (2011) points out that the wave of mergers in health care has been mainly in horizontal integration and less so in vertical integration. We can therefore predict that the closer we get to monopolies in the hospital and insurance markets, vertical integration is going increase. The rationale behind mergers is to increase efficiencies. So when, for example, hospitals merge in large numbers as well as insurers,

both sides will end up finding themselves at some point with not much more to gain in bargaining power through horizontal integration, as Trish and Herring's (2015) study shows. The next step is for insurers to merge with hospitals in order to achieve efficiencies from both sides, or as economists would put it, to cut on transaction costs (Coase, 1937). Trish and Herring's (2015) data actually show that less than 3% of the markets in which employers purchase fully-insured coverage are not concentrated today and about 50% are highly concentrated, meaning we're nearing the point where horizontal integration will be saturated for insurers. As mentioned, vertical integration is already happening between insurers and hospitals, but not yet at accelerated levels (Gaynor, 2011).

The Herfindahl-Hischman Index (HHI) is what the Federal Trade Commission and Department of Justice use to determine levels of market concentration.[6] In 1987, the national mean HHI for hospital markets was 2,340 and by 2006 the HHI was 3,440. Already by 1992, the HHI for hospitals (=2,440) was just below the cut-off point for being considered as highly-concentrated. As Town et al. (2006) highlight, the increase in concentration was primarily due to the strong wave in mergers and acquisitions that hospitals went through during this period. Leemore Dafny has been one of the leading researchers measuring the impact of mergers and acquisitions in the insurance markets (Dafny, 2009, 2010, 2015; Dafny et al., 2012;). Her studies find the HHI numbers for

[6] The HHI goes from 0 to 10,000. The higher the number, the closer a market is to a monopoly, where 0=perfect competition and 10,000= 1 firm in the market. In general, the US Department of Justice considers less than 1,500 to be a competitive marketplace, 1,500-2,500 to be moderately concentrated, and above 2,500 to be highly concentrated. Anytime a merger and acquisition case raises the HHI by at least 200 points, they may be blocked based on anti-trust concerns.

insurance markets to also be worrisome. In 1998, the national mean HHI for large employer insurance markets was 2,984 and by 2009 the HHI went up to 4,126.

In the US, about 56% of the non-elderly population receives health insurance coverage through employment, 8% through non-group, 22% through Medicaid and about 4% other type of public insurance (i.e. military or Veterans Association). By the end of 2015, the number of uninsured non-elderly was 28.5 million, a decrease of about 13 million since 2013. Medicare covers about 55.5 million people today. Between 1995 and 2007, about 16% of the non-elderly population was uninsured. This percentage increased during the recession and then remained at about 17% until the ACA was enacted in 2014. In 2013 about 41 million people remained uninsured, a number that does not include those without continuous coverage.

After the ACA enactment, the rate of uninsured dropped to about 10.5%, or about 28.5 million people in 2015. The major impact from the ACA in reducing the number of uninsured came from Medicaid expansion; 32 states (Missouri excluded) including D.C. expanded Medicaid through the ACA. The total amount spent on Medicaid was about $572 billion for year 2016, of which 63% was paid by the federal government and 37% by states. Medicare expenditures paid by the federal government were about $597 billion. These numbers illustrate what lies at stake when we are talking about potential access measured through insurance coverage (The Henry J. Kaiser Family Foundation, 2013, 2015a, 2015b, 2015d, 2016a, 2016b, 2017).

However, when discussing the healthcare sector today, we are not just addressing who gets access and who doesn't; the sector covers a large amount of jobs in the American economy, about 9% of total jobs (The Henry J. Kaiser Family Foundation,

2015c). The healthcare industry overall is worth about $3 trillion (Blumenthal, 2014; OECD, 2015b). So, we have on the one hand, shareholders interested in making money, on the other, individuals needing the services, and then also those who are employed by the sector. Moreover these three factors don't include the indirect economic effects of healthcare jobs, the further gains/investments from returns, and the losses/gains in human capital by inequalities in access. It is important to keep these three aspects in mind when we go to the next section that criticizes the role of neoliberalism in the current state of the healthcare system. The present situation in which jobs, profits and health intermingle makes it difficult to transition to a fairer system without also abruptly disrupting the economy.

For the purposes of this dissertation, the current crisis of the American healthcare system is relevant in the sense that, among the people who are suffering from inequalities in access, the Hispanic population is the largest group today affected by such disparities as measured by several studies that quantify rates of uninsured and percentages who lack a primary care physician (Andersen et al., 1981; Andersen et al., 1986; Balcazar et al., 2015; Fiscella et al., 2002; Gresenz et al., 2009; Livingston, 2009). Three main characteristics (further discussed in Chapter 3 and 4) of the Hispanic population seem to be causing this outcome. The first characteristic is socio-economic in nature: in a system that relies primarily on employment-based insurance, Hispanics overwhelmingly occupy low paid jobs that do not offer insurance. The second issue relates to the fact that because the public does not properly comprehend the real reasons behind the high service costs, policies continue to restrict access to public insurance primarily targeting lower income and immigrant groups, among which the Hispanic group is also the largest. The third

characteristic is socio-cultural in nature and can perhaps also be extended to other immigrant groups. Overall, Hispanics have not yet acculturated enough to the healthcare system.

In a way then, the Latino population serves to expose some major symptoms of a dysfunctional system. Again, the problem is that because the public does not have a proper grasp on the real causes of the crisis, politicians continue to use the wrong tools to address the real issue: the fact that a neoliberal system is not just improper, but is in fact detrimental in dictating healthcare policies. The next section analyses the culture that dominates in American society that seems to allow for this vicious cycle to continue.

B. The Underlying Culture of the American Healthcare System

"The philosophers have only interpreted the world, in various ways. The point, however, is to change it."
Karl Marx (in "Eleven Theses on Feuerbach")

This section borrows from Gramsci's theoretical framework on the concept of hegemony (Gramsci,1948/2014). According to him, hegemony relies on "intellectual unity" (p.333) and "moral unity" (p. 181) both of which transport society on a "universal plane" (p. 181). The intellectual unity in the American case would be "economism" (p. 161). The term hegemony appears in several forms throughout his essays such as, "social hegemony" (p. 12, p. 53), "moral and political hegemony" (p. 58), "political hegemony" (p. 59), "hegemony is ethical-political" (p. 161), "political and cultural hegemony of the ruling class" (p. 208, p. 258), and so on. Henceforth, cultural hegemony fits perfectly in the analysis of what drives the healthcare system behind the scenes in the US. The real invisible hand (to borrow from Adam Smith) in American society today can be described in Gramsci's (1984/2014) words as:

> "the philosophy which has become a cultural movement, a religion, a faith, any that has produced a form of practical activity or will in which the philosophy is contained as an implicit theoretical premiss. One might say ideology here, but on condition of the word is being used in its highest sense of a conception of the world that is implicitly manifest in art, in law, in economic activity and in all manifestations of individual and collective life" (p. 328).

Hence, in this dissertation the American healthcare system is viewed as being run by an underlying culture, "a web of collective influences that shape people's lives" (Eckersley, 2001, p. 55), which is guided by a basic ideology, "an interlocking set of ideas and doctrines that form the distinctive perspective of a social group" (Waitzkin, 1978, p. 270). Thus, culture becomes a system of knowledge, values and practices in specific societies that guide their structure (Hays, 1994). Goffman (1959) describes how we become performers within a social structure without really being conscious about it, it governs our behavior; we follow institutionalized scripts that are based on the "collective representation" we have internalized (p. 27). I will be using the terms culture, ideology and worldviews interchangeably since they all apply to my central argument in this chapter (Mezirow, 1991).

In Gramsci's (1948/2014) "hegemonic apparatus" (p. 228) two major levels exist: "civil society" and "political society" (or "the State") (p. 12). Gramsci's analysis positions these two groups as being governed (i.e. manipulated) by a dominant group that has gained "spontaneous consent" from the "great masses of the population" over time through its prestige acquired from its "position and function in the world of production" (p. 12). If we analyze the sociopolitical and economic shift that happened in the late 70s in the US, the situation fits into what Gramsci calls a "passive revolution" (p. 105) where the interests of the dominant group are strategically inserted in the national agenda to "become the arbiter of the Nation" (p. 105). Domination is therefore not necessarily acquired through the use of coercive force, but rather through cultural hegemony of the

dominant group over society. Gramsci explains that in this passive revolution, the leadership of the dominant group is exercised before winning governmental power.

Sociologists, political economists and geographers refer to the transition occurring in the late 70s as the rise of neoliberalism in which American politics shifted to the right (Duménil & Levy, 2004; Harvey, 2006; McMichael, 2012; Peet & Hartwick, 2009). Duménil and Levy (2004) argue that this process was actually planned to restore power for the upper class. Furthermore, although neoliberalism remains abstract, the changes that took place since the late 70s are not just ideological, but have materialized as structural ones. Under the neoliberal worldview, the free market is depicted to society as being run by an *invisible hand*, but as Chandler (1977) mentions there is actually a *visible hand*, the one of corporations that operate with a primary goal, that of increasing profits for their shareholders. In this sense, profit-seeking behavior gains what Gramsci (1948/2014) refers to as "legal privilege" (p.255). Under such a model, the state is simply acting in line with the interests of a ruling elite. According to Harvey (2006), a major strategic step taken by the right-wing in this process has been aligning Christian values with free market ideology. What is important to note here is that although the Republican Party became the major party that carries the neoliberal mission, right-wing ideology impregnated the Democratic Party as well. For instance, during Bill Clinton's presidency, several neoliberal policies, such as the signing of Free Trade Agreements, took place (Harvey, 2006).

Under neoliberalism, there is a persistent belief that the individual has complete power over his/her life's outcomes. By placing the individual as the full and sole responsible force behind her successes and failures, neoliberal ideology ignores structural

barriers. Gramsci (1948/2014) would say that people are purposively led to believe that such structural barriers do not exist by the ruling class acting behind the scenes. Duménil and Lévy (2004) indicate that during this period "financial hegemony" (p.3) was attained by the wealthiest portion of society. As Du Bois (1940/2011) argues, in such a system, those in power conveniently will continue to fight towards keeping Hispanics trapped in the lower paid jobs, as well as restricting their safety nets, such as healthcare access.

So how does the neoliberal cultural hegemony impact the healthcare system in the US? Based on Gramsci (1948/2014), we should consider how cultural hegemony has shaped health care and consequently allowed for the strengthening of inequalities in access over the last few decades. Cultural hegemony is essentially the ideology shaping policies that impact access. Because inequalities are not just due to healthcare legislation, but also to exogenous factors that may or may not be linked to policy, we cannot be certain that different paths taken in policy would necessarily have eliminated inequalities for good. However, as the scholars mentioned above point out, part of the inequalities observed today could in fact have been prevented through fairer policies. In health care, policy impact on Hispanics primarily stems from healthcare and immigration laws that have continuously blocked access for them over time. Unequal access especially has negative impacts on the health of individuals who belong to groups that tend to have less political power and/or understanding of the healthcare policies that impact their lives. Therefore, we can see how neoliberal ideology has allowed for those with influence on the political system to shape the American health care system and inform policies in ways that benefit them most.

The American healthcare system is primarily governed by a capitalist ideology. The public is sold the idea that the unfettered market is the best means to provide for goods and services at the best possible prices in the most efficient manner. In a country like the US, where neoliberalism has come to shape most policies overall, health care is just one sector governed by *economism*. As argued by Eckersley (2001), *economism* is not concerned with morality, which lies at the center of this chapter's argument, but rather emphasizes efficiency and productivity in order to increase profits. Ethically speaking, healthcare policies are meant to improve the health of the population over time. As Gramsci (1948/2014) states, an ethical State "refers to the autonomous, educative and moral activity of the secular State" (p. 262). So, first, there is an underlying conflict of interest behind the ideology shaping healthcare policies and what society expects in outcomes from these policies.

The misalignment between outcome (i.e. unequal access to health care) and society's expectation (i.e. fair access to health care) is a result of the fact that the political and cultural hegemony ruling over civil society is based on the interests of the ruling class (i.e. expanding their capital growth through healthcare companies). So, on the one hand there are the voters who overall have supported the passing of neoliberal laws that created the currently observed exacerbation in inequalities. On the other hand, there are the people who run and study the system, who are also in line with this ideology (i.e. not questioning). "The practical man-in-the-mass has a practical activity, but has no clear theoretical consciousness of this practical activity, which nonetheless involves understanding the world in so far as it transforms it. His theoretical consciousness can indeed be historically in opposition to his activity" (Gramsci, 1948/2014, p. 333). In other

words, the issue with the current state of the healthcare system is not just that it is being run by profit-seeking interests, but it is also not being questioned by doctors, nurses, researchers, or even patients in most cases. This phenomenon is further discussed in the meta-analysis in Chapter 4.

Unlike the days when Marx criticized capitalism, the elite class today is driven by the idea of stock values having a never-ending growth in value as opposed to increased production. As Piketty (2014) illustrates, when the rate of return of stocks is higher than the growth rate of the overall economy (i.e. real GDP/capita growth rate), inequalities are going to worsen for as long as financial returns are allowed to expand, primarily through low income and wealth taxes. If the main mission of the government is to create a good climate for business and if this also applies to businesses in health care, then capital accumulation takes over society without much consideration as to what happens to employment or social well-being (Harvey, 2006). As social safety nets are reduced to a minimum under neoliberalism, society is not only led to believe that there is no need for the government to support them, but also that through the private sector they can be offered in a more efficient and cost-effective manner.

Consider the numbers of Medicare Advantage offered earlier, an example of a public-private partnership, the preferred form of governance under neoliberalism. As Harvey (2006) states, these kinds of partnerships proliferate in a way that the government assumes most of the risks (i.e. pays for insurance and is blamed for those left behind) while the private sector takes the profits. Moreover, as these companies continue to get bigger and gain more market power, their influence on writing legislation through lobbying also grows. Under the neoliberal model, the primary goal of the healthcare

system is switched from providing fair access to "enhancing capital accumulation" (Harvey, 2006, p.27).

Harvey (2006) refers to this modern form of accumulation as "accumulation by dispossession" (p. 43), meaning that as one group continues to accumulate capital, another group continues to lose rights. He also notes that when it comes to human rights, universalism is difficult to achieve under a neoliberal state, because the downfalls of different rights appear in separate silos. In other words, there is no unifying factor among the different crises observed in different sectors (i.e. crisis in education seen separate from health care, and finance, and so on). Such balkanized crises block civil society from being able to perceive that neoliberalism is the unifying feature behind the loss of these rights. In other words, the current crisis in healthcare observed in the US is not necessarily perceived by society as being part of the crises also going on with racism, education, food insecurity, financial sector and so on. The segregation is not just in politics, but also in the academic literature, even within specific sectors and fields of studies. The meta-analysis in Chapter 4 for instance, illustrates how access to health care for Hispanics is being studied by separate variables. There's not much questioning or investigation of what is the underlying cause for these variables to be blocking access. However, if we were to look at access to health care in the US today through the lenses of sociology, we can see that the underlying cause of inequalities in healthcare is the same as the underlying cause in the crises happening in other sectors. One way to be critical of this system is by comparing it to other countries that have done it differently (i.e. guided by other ideologies).

When comparing developed countries, Raphael (2006) finds that those with more neoliberal health policies – the US, the UK, Ireland and Canada – are actually performing worse in terms of prices and health outcomes than those with more social democratic ones – Germany, Italy, Spain. To be fair, none of the developed countries have cheap healthcare systems and there are various exogenous factors (i.e. not related to policy) impacting the costs of healthcare across them, such as the fact that more people are living longer and therefore expanding the pool of elder people requiring more quantity of and more prolonged health care. Furthermore, the US healthcare system, considered the most privatized among developed countries, has actually become the most complex, most inefficient and most expensive one in the OECD pool of wealthy countries (Davis et al., 2014).

These facts illustrate that even the primary justification used by neoliberals is deceptive. In other words, other systems depending more on social democratic models and less on capitalist ones, are not just fairer, but ironically cheaper and more efficient. The negative outcomes seen in the US are contradictory to what neoliberalism predicts in theory (or at least sells to the public), that the market produces the most efficient outcomes at the lowest possible prices. Why does, the US, considered to have the system most controlled by the private sector competing in a market system, actually have the least efficient and most expensive system? This is a central question to my argument.

There are three main problems with allowing neoliberal ideology to shape the healthcare system. First, even in the hypothetical situation that the market were to operate completely free, utopian market analyses tend to ignore inequalities because they usually focus on average outcomes (Deaton, 2013a; Duménil & Lévy, 2004; Piketty & Saez,

2003). So when policies focus on average outcomes by relying on market-premised ideology, those policies can actually strengthen inequalities as is now evident in the American healthcare system (Davis et al., 2014).

Second, I am not sure the blame should be put on the profit-seeking-behavior per se, but rather instead on the society allowing this ideology to govern healthcare policies. If we rely on Gramsci's (1948/2014) framework, it is the cultural hegemony sustained by the dominant class that is allowing this to happen from behind the scenes. Thirdly, a competitive free market is not the same as capital accumulation (Duménil & Lévy, 2004). In the ideal world of economists, a fully competitive market comprises of a large number of sellers and buyers. However, no company that is owned by shareholders, and therefore seeking to expand profits indefinitely, wants to be in a *highly competitive market.* If the goal of a company is to make money and continue expanding to make more money, it means that companies are constantly seeking to gain power in the market. As a result, their ongoing strategy is to eliminate as many competitors as possible. Once you pair profit-seeking goal with that of having access to political power, it should be expected for companies with such access to use it to strengthen their market power even further.

Therefore, the moment the American government formed private-public partnerships, for example in the insurance sector, it also opened the door for those companies to gain access to market power. In addition, the moment the government allows for lobbying, it opens doors for all companies in the healthcare sector - including not just insurance companies, but also pharmaceutical companies and hospitals - to buy their access to political power and use that to further expand their market power. Capital accumulation, the primary goal under neoliberalism, then leads to oligopoly and

preferably (for the companies gaining market share) at some point to monopoly. The idea of a competitive market is therefore utopian (Harvey, 2006). In Gramsci's (1948/2014) words, "*laissez-faire* too is a form of State regulation" (p. 160). Harvey (2006) calls it "predatory capitalism" (p. 115), one that is guided by the *visible hand* presented by Chandler (1977). In a neoliberal healthcare system, the private sector attains institutional support. Such support is used to dictate the way capital accumulation guides policies in a society that in exchange continues to cut rights for the masses.

A good example of the lack of pure competition may be familiar to many patients: the lack of transparency of cost in most hospital services. An insured patient leaves the hospital without the slightest idea of what she owes. We may say, why care if she is insured. But the truth is, a portion of the bill (and growingly so) goes to the patient through deductibles and co-payments/co-insurance. In economics, this portion of the bill attached to the patient is used as an incentive for her to act "responsibly" and not overuse medical care. If a large portion of patients in the system lacks such incentive, economists predict that the non-responsible use of medical care will drive up costs over time. Although this idea is not entirely without merit, behind the incentive notion also lies the previously mentioned idea that neoliberalism centralizes all responsibilities in the individual. The argument assumes that patients are the ones driving up the costs of healthcare services because insurances are paying for their bill. While this may be partly true, as the studies discussed earlier illustrate, increased market power resulting from increased market concentration is actually the major cause in the rise of prices, not individuals. Even the most responsible patient is not given the chance to fully act responsibly in a system that lacks transparency. Further, bills usually take months to

reach the patient, sometimes over a year, and are usually sent in various separate statements causing confusion and anxiety to patients, as well as making it difficult to plan and financially prepare for what they will owe. The lack of transparency is due to the fact that today insurance companies negotiate with hospitals the cost of different procedures and, even for the same insurance company, the costs for the same procedures may vary depending on the plan each patient gets. For Hispanic immigrants coming from countries where a patient's bill is given at the time of service, this situation is beyond common sense understanding.

One way to compare discrepancies is to compare prices for the same procedure in different hospitals, for example, a knee replacement. The price paid by private medical insurances vary significantly, from $3,400 to $55,800. Price discrepancy can occur in the same city. A knee replacement in Kansas City, Missouri, can cost between $8,900 and $31,500 in 19 different hospitals. Most of the data comparing prices relies on data from Medicare spending, which, although it still varies by location, does not represent the full range of variability in prices. As insurers have constantly increased deductibles and premiums over the years, prices continue to vary widely by location. Locations that may actually show as low spenders through Medicare data, cannot be classified as low cost locations when data from prices paid by individuals and insurances are also considered. For example, Grand Junction, Colorado, shows as the 3rd lowest spending location among 306 places for Medicare. When private insurance costs are included, Grand Junction is ranked the 42nd highest spending. Researchers are showing that price transparency has practically been ignored in healthcare policy-making (Cooper, Craig, Gaynor, & Van Reenen, 2015; Quealy & Sanger-Katz, 2015).

Another way to analyze the results of leaving it to the market is prescription medicine. Policy makers assume that prices will be balanced by the market where pharmaceuticals are situated on one side of the equation (i.e. the supply) and health insurances on the other (i.e. the demand). According to The Economist (2016b) medicine costs have overall been increasing over recent years. In some cases, insurance companies have been able to counterbalance and protect from increases. However, on average the price increases have once again been passed on to consumers through higher prescription deductibles. Moreover, the article in The Economist poses that prices charged for some prescriptions, like the now well-known extreme cases of the *EpiPen*[7] and *Daraprim*[8], are not based on market premises, but rather oligopolies or monopolies, where only one or a few large pharmaceutical companies control the market for certain medications. The control in these markets can become abusive when we consider access to basic medication. "The American Society of Health-System Pharmacists currently lists inadequate supplies of more than 150 drugs and therapeutics, for reasons ranging from manufacturing problems to federal safety crackdowns to drug makers abandoning low-profit products" (The Economist, 2016b). Shortages include antibiotics, painkillers, cancer treatments and anesthetics which are not considered cutting edge medicines and that some pharmaceutical companies simply are producing less of because of low profits. Many of these are produced by just one manufacturer, which means they completely control the market and when they cut on production, shortages are immediately passed on

[7] EpiPen is an allergy injection that patients carry with them and can save their lives if they are suddenly hit by an allergy attack. Last year it suddenly experienced a sharp increase, from $57 in 2007 to $500 in 2016, a 400% increase. This case caused a political outcry in the US (Woodyard & Layton, 2016). In addition, this did not happen in other countries, such as Britain where the cost is $69 (Paton & Kresge, 2016).
[8] Daraprim is a common drug that has been in the market for over 60 years used in hospitals for treating life-threatening parasitic infection. When Turing Pharmaceuticals purchased it, the drug went from $13.50 to $750 overnight bringing the annual costs of patients to hundreds of thousands of dollars (Pollack, 2015).

to hospitals, which means patients sometimes lack access to a common pain killer when hospitalized.

Although I think it is immoral for companies to make profits from people's health, I do not believe that is precisely the underlying problem here. The real problem lies in the unsubstantiated belief by the American society that profit-seeking behavior can solve the healthcare needs of its population. The power struggles we see in the US are not unique; they also exist in other OECD countries. Then why are we not seeing the same types of policies in the social democratic countries? This goes back to the underlying culture or ideology present in different societies. The dominant group apparently has been more successful in the US than in other countries by selling this idea of free markets to mask the end purpose of capital accumulation. Over time an ideology planted in a society creates a path dependency (North, 1990). The American healthcare system exemplifies how, once path dependency is established, it is difficult to re-route deeply rooted mistakes. Another term to describe the American healthcare system's path dependency is Gramsci's (1948/2014) idea of "mechanical determinism" that acts as a "tremendous force of moral resistance, of cohesion and of patient and obstinate perseverance" (p. 336), which "produces a condition of moral and political passivity" (p. 333).

None of these issues are new. Waitzkin (1978) discussed the problems we see today back in the late seventies, including, inequalities in health outcomes, lack of access to health care for the poor, control of the market by large insurance companies, monopolistic tendencies, and so on. As Waitzkin (1978) notes, the problems are solved through "patching" (p. 273), which essentially allows society to keep functioning in a

social system that is often the source of the problem. McMichael (2012) states that in the neoliberalist development model we tend to keep treating the symptoms, as opposed to dealing with the real problem. I discuss these ideas further in relation to the American case in Chapter 4's meta-analysis.

If we were to truly address healthcare inequalities, we must first acknowledge that profit maximization is not compatible with the goal of achieving fair access to health care for the overall population. It is unrealistic to expect the two to happen in conjunction with each other, but more so, it is unethical to pair them. The cycle of power and market concentration happening in health care is worrisome because it impacts basic human rights. Waitzkin (1978) explains how the same status structures that appear in other sectors governed by neoliberalism are also present in the healthcare system. As the private sector gains control of the system, it drains public resources and health workers' time, on behalf of their profits and to the detriment of patients. In other words, the structural conditions that have been established predefine the tasks that maintain the system and as a result the structure of privilege persists (Habermas, 1970). This system has correspondingly become highly bureaucratic. Weber (1958) warns us that "once it is fully established, bureaucracy is among those social structures which are the hardest to destroy" (p. 228). Once again, such a pattern connects to path dependency mentioned earlier.

As the theory predicts, the American healthcare system has in fact grown to a colossal size. The US has by far the highest spending on health care in the world in total amount ($3.0 trillion), in per capita ($9,523 for 2014), as well as in percentage of GDP (17.5% for 2014; the next countries spending more as percentage of GDP start at around

11%) (CMS, 2014; OECD, 2015b). Costs in health care have been growing every year as well as annual expenditures from the federal government spent directly on health care (Topoleski, 2013). The size of the US healthcare system today is larger than France or Britain's economy. When compared to national GDPs it is equivalent to the 5th largest economy in the world (Blumenthal, 2014).

It took decades for democrats to pass a fairer healthcare bill that was finally achieved through the passing of the ACA in 2010. Republicans have been working hard to repeal this law since then but have not received the support they expected from their constituencies. Apparently, some people, including many who were initially against the ACA, are starting to see the benefits. The healthcare crisis will continue regardless of Obamacare being repealed or not. If the law is repealed through an even stronger neoliberal law, inequalities will simply worsen continuing on the current path dependency situation of further market concentration through horizontal integration, which I expect would then transition to vertical integration. If Obamacare is kept, there is still plenty needed to change in this legislation that would make it less capitalist and more social democratic. As demonstrated by the data and comparisons presented in this chapter, we urgently need to move towards a more social democratic system. For Hispanics, this simply means they will have to acculturate to the current neoliberal system if the goal is to increase the group's access in the short run.

Gramsci (1948/2014) warns us that crisis is inevitable when the "ruling class has lost its consensus" (p. 275). The only way to continue with the current neoliberal policies would eventually be through the use of coercive force. Discontentment is rising as prices and inequalities continue to do so as well. The bigger challenge of course is to educate

the population about how these problems unite in a similar underlying cause. Piketty (2014) also warns about democracy being jeopardized when inequalities are not taken seriously. The analysis in this section lead to the conclusion that structural inequalities in access to health care exist in the US today because of the neoliberal policies that have been put in place over time. As mentioned earlier, Latinos represent the group suffering the most from these policies due to the fact that they have a higher proportion of their population in vulnerable socio-economic situations.

C. Structural Barriers in Health Care for Hispanics

In the case of Hispanics, structural barriers have been put in place to block access to health care primarily through federal healthcare and immigration legislation. There is an intersection between these two when it comes to refugees and immigrants' access to health care in the US and not just for Latinos. This intersection impacts the Hispanic population the most because of the large number of immigrants that have come mostly from Mexico and Central America; about 34% of the Latino population is foreign born, which corresponds to about 6% of the total population (being Hispanic and foreign-born) (Flores et al., 2017). With respect to immigration, the issue of Hispanics' heterogeneity based on country of origin and how Latin American countries have been treated differently by US immigration law is critical to understand. In terms of structural barriers imposed directly through healthcare legislation, the previous discussion on how neoliberal policies have increased inequalities is the central point. These are not the only forms of legislation that have brought about inequalities in healthcare access that largely

impact Latinos, but they are the two that have had the most direct impact and are the focus of this discussion.[9]

To analyze the issue of access with respect to citizenship and immigration status, the two concepts of potential and actual access must be understood. In the field of medicine and public health, access to health care is defined as "the degree to which people are able to obtain appropriate care from the healthcare system in a timely manner" (Escarce & Kapur, 2006, p. 411). Potential access and realized access are further differentiated. Potential access "refers to the presence or absence of financial and non-financial barriers to obtaining appropriate and timely care," while realized access "refers to the quantity of health care actually received" (Escarce & Kapur, 2006, p. 412). As it will be depicted in the meta-analysis chapter, potential access is primarily dependent on having insurance in the US. Actual access, is measured mainly through realized visits to a doctor, usually a primary care physician or a specialist.[10]

The first institutional requirement to access healthcare services is to have insurance. Therefore, legislation that impacts insurance coverage matters in determining who has potential access. Immigration legislation blocks many Hispanic immigrants (and also other immigrants) from having insurance, primarily (but not solely) those of lower income levels (Table 2.1). Hispanic citizens, both born in the US and those who are naturalized, are eligible for public insurance if qualified. Public insurance includes

[9] Consider for instance any type of legislation, besides health care (i.e. cuts in spending for public education, low income taxes for the wealthiest, etc.), that sustain or strengthen income/wealth inequalities (Edsall, 1984; Lindert & Williamson, 2016; Piketty, 2014; Stanford Center on Poverty and Inequality, 2016). These laws impact access indirectly because they make it difficult for poorer people to exit poverty (DeNavas-Walt, Proctor, & Smith, 2013; Documet & Sharma, 2004; Fronstin, 2013; Hadley, 2003). Once they're stuck in poverty, healthcare legislation worsens their situation with respect to inequalities due to its impact on human capital.

[10] The meta-analysis chapter illustrates how potential and realized access are measured through most studies today.

mainly Medicaid (if under the federal poverty level, and under the ACA those who are included under Medicaid expansion in states that chose to do so) and Medicare (if 65 years or older). On the other hand, refugees and immigrants who are lawfully residing in the US but who have not become naturalized citizens do not always qualify for public insurance (see Table 2.1 for details).[11] Grieco (2004) finds that in the first years of the 21st century, immigrants were more than twice as likely to not have insurance when compared to native-born citizens. His findings confirm that immigration legislation is in fact discriminating against immigrants in healthcare access.

In the 1960s when Medicaid was passed, it was meant to cover the population excluded from employment-based insurance, those at poverty levels who took jobs that did not offer insurance or could not afford it if offered. Fast-forward to 2012, right after the ACA was passed (March 2010) but still not enacted, the US had 48 million people who were uninsured (this number excludes the underinsured). The majority of the uninsured population were mainly from lower income brackets but who did not fall below the federal poverty income level and hence did not qualify for Medicaid (DeNavas-Walt et al., 2013). The current poverty threshold was developed in 1963 (US Census Bureau, 2016), which is problematic because many things that defined poverty back then may not apply today. In health care, the old methodology used to calculate the federal poverty level has proven to impact the high rates of uninsured. The ACA sought to solve for this by allowing states to voluntarily expand Medicaid coverage by raising the level of poverty to qualify. In addition, the ACA added subsidies for those who would not qualify for Medicaid but who could still be unable to fully afford insurance.

[11] See also discussion and examples analyzed in the chapter on capitals on the issue of heterogeneity.

The ACA also intersects with immigration legislation. First, unlawful immigrants, with the exception of pregnant women (who receive coverage during pregnancy only), are excluded from Medicaid, Medicare, subsidies or even purchasing insurance through the exchange markets offered through the ACA. Employment-based insurance is also excluded for unlawful immigrants either because they are not offered to those taking the lowest paid jobs or when offered, they are blocked from using it when needed to access medical services. So, the first conclusion from these restrictions is that even the ACA, which was meant to expand coverage for those who were left out, is not a universal program. Again, the issue in this dissertation is not to argue in favor or against immigration legislation, but in favor of what is ethical when it comes to access to healthcare services, which is nothing more than saying that healthcare access has to be universal with no discrimination whatsoever. In other words, from a human rights perspective, healthcare legislation cannot be tied to issues of immigration. In addition to the limitations imposed on unlawful immigrants, refugees and lawful immigrants also face restrictions to access public insurance tied to the 1996 Welfare Reform Act (see Table 2.1). In the case of refugees, this issue is particularly striking because the US is accepting them into the country without offering them sufficient safety nets.

The term "lawfully residing"[12] excludes all unauthorized residents and provides some limitations to those who are not American citizens but are still legally residing in the US (USA.gov, 2015). Historically, unauthorized immigrants were already ineligible for federally funded assistance, in addition to being blocked from employment-based insurance as explained below. The 1989 Immigration Reform and Control Act and the

[12] Unlawful immigrants include those that either lawfully migrated to the US and then stayed beyond their authorization's expiration, as well as those who crossed the border without immigration control.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) further restricted access to immigrants, particularly Hispanics who compose the majority in this group (Derose, Escarce, & Lurie, 2007; Ginzberg, 1991). The welfare reform legislation passed in 1996 restricted access for lawfully present foreign nationals based on their immigration status, when they arrived in the US, and their length of residence (Office of the Assistant Secretary for Planning and Evaluation, 2012). So, legal discrimination against Hispanics, although already present earlier, has been intensifying since 1996. This looks like a similar strategy, as presented by Du Bois (1940/2011), implemented between 1895 and 1909 through a series of Jim Crow laws followed by further discrimination bills introduced during Woodrow Wilson's presidency that intended to make blacks a "subordinate caste" (p. 55) in the US.

The definitions included in the ACA on lawful residency are critical in order to understand that the law is far from universal as it explicitly excludes people from benefits that allow access to healthcare services depending strictly on their citizenship or immigration status. Furthermore, employment-based insurance sometimes offered to unauthorized immigrants, in practice usually cannot be used because other documentation regarding lawful residency is required by the insurance company when benefits are needed and requested (i.e. when someone has fallen ill or had an accident) (Johnson, 2004).[13] Therefore, through the ACA, citizenship and immigration status can either

[13] Employer based insurance can be difficult to use if you're unauthorized/undocumented because if the insurance company finds out about the unlawful status they may not honor a patient's claim and they will notify the employer. Once an employer gets this notice, it will usually fire the person to avoid exposing the company. The legalities of this approach by insurance companies is questionable, but we are dealing with a marginalized population that is not likely to challenge the authority of the company to honor their claim because they want to limit their chances of exposing their immigration status. It may be that the insurance company cannot legally do this, but the simple fact that they denounce the immigration status puts the person at risk of deportation. The fear of deportation is therefore being used by insurance companies to act

enhance or to a greater extent restrict Hispanics' opportunities to obtain insurance(Wallace, Torres, Sadegh-Nobari, & Pourat, 2013). It must be noted that within some of the classifications illustrated in Table 2.1 there are further sub-categories, which indicate how complex this system has become.

Regardless of citizenship and immigration status, healthcare legislation impacts anyone in the lower income brackets. The reason why this is particularly relevant for the Hispanic population is because a large portion of Hispanics fall within the lowest income levels, with the majority having migrated from Mexico (64%), Puerto Rico (9.6%) and Central America (9%) (Stepler & Brown, 2016). Immigrants from Mexico have historically been among the most discriminated groups in the US; like those who came during the railroad construction period in the early 1900s and those who were part of the Bracero Program during the mid-20th century. In general, the geographic location of Mexico, in conjunction with high levels of poverty in that country and lower skills labor market demands in the US, have given space over time to massive immigration. The majority of immigrants from Central America also fit a similar migration pattern as those from Mexico. Therefore, most immigrants from both Mexico and Central America come from lower income and education levels in their countries of origin and have migrated to the US to fill the unmet demands for unskilled labor. Once they fall in the lower income brackets, even if lawfully residing in the US, the neoliberal ideology explained earlier impacts their access. When we consider the intersection between immigration and healthcare legislation, we undoubtedly get a group that has today the lowest access to healthcare in the US, the Hispanic population. As the next chapter will argue, the

in this discriminative manner even though based on the constitution, people cannot be discriminated based on citizenship status.

structural barriers are not the only ones faced by Hispanics, there are also acculturation and social capital restrictions. Some of the structural barriers can be overcome, at least in the short-term, through increased levels of acculturation and expanding certain types of social capital.

D. Final Remarks

The purpose of this chapter was to present the state of the American healthcare system in order to provide the context in which Hispanics face limitations to access healthcare services. There is a current healthcare crisis in the US and Hispanics are not the only ones impacted by that. The analysis provided here concludes that the in-depth cause of the crisis is linked to neoliberal policies that came to dominate American politics beginning in the late 70s. Inequalities that came about from those policies over time are not restricted to health care, and extend to most sectors of society. As a result, crises are widespread in the US today and most sectors are in need of major overhaul.

The main problem though, stems from the cultural hegemony dominating society's worldviews and impacting policy. There is a need to educate the public better about the impact neoliberal policies have had on health care access. Inequalities in healthcare access present today are primarily structural in nature. Hispanics represent the largest group with the lowest access within this crisis, making them overall the most vulnerable population. However, there are other factors related to acculturation and social capital that are unique to the Hispanic population and exacerbate their vulnerability. Moreover, a major factor that makes Hispanics overrepresented in this crisis is that they overwhelmingly take jobs that do not offer health insurance in a system that primarily relies on employment-based coverage. In addition, Hispanics are not properly

acculturated to the complex American healthcare system and they do not possess the right types of social capital that can connect them better to services. There are two major implications from these facts. First, major structural changes that began with the ACA must continue towards turning the American healthcare system into a more social democratic model. Such transition could improve access for Hispanics in the long-term. However, a huge transition like this will take time, particularly when we consider the current cultural hegemony. Second, in the short-term, as presented in the next chapter, Hispanics must acculturate to the current system in order to improve their access. So, Chapter 3 argues that access could be improved through increasing the acculturation levels of the American healthcare system and expanding certain types of social capital that enable access among Hispanics. Becoming more acculturated and better connected to the system will not solve all the structural causes, but it could ameliorate things in the meantime.

Table 2.1. Public Insurance and Subsidies Available by Citizenship and Immigration Status Since ACA Enactment

	Government Funded Insurance Access When Qualified Based on Employment Status & Income[1]					
	Citizenship/Immigration Status	**Medicare[2]**	**Medicaid in Missouri[3]**	**Allowed to purchase insurance through ACA Marketplace**	**Tax Credit Toward Premium Costs through ACA Marketplace[7]**	**Subsidy for Cost-Sharing for Insurance purchased through ACA Marketplace[7]**
Non-foreign nationals	***Citizen (born in U.S.)***	Yes	Yes	Yes	Yes	Yes
Lawfully present foreign nationals	***Citizen (naturalized)***	Yes	Yes	Yes	Yes	Yes
	Lawful permanent residents (LPRs) - known as green card holders	Yes	5 yr waiting period (since 1996)[4]	Yes	Yes	Yes
	Asylees	Yes	Only for 8 months under Refugee Assistance Program[5]	Yes	Yes	Yes
	Refugees	Yes	Only for 8 months under Refugee Assistance Program[5]	Yes	Yes	Yes
	Admitted under nonimmigrant visas (student, work, etc.) who are in status	Yes	No. Except pregnant women during pregnancy period only.[6]	Yes	Yes	Yes
	Other classifications under the Immigration & Nationality Act (INA)	Yes	Some but not all. Complex legislation under each.	Yes	Yes	Yes
Not lawfully present foreign-nationals	***Unauthorized:[8] Admitted under nonimmigrant visas who are not in status (i.e. visa expired) OR undocumented (entered without a Visa)***	No	No. Except children in mixed status families who are lawfully residing and pregnant women during pregnancy period only.	No. Except for children in mixed status families if they are lawfully residing.	No. Except for children in mixed status families if they are lawfully residing.	No. Not allowed to buy any kind of insurance even at full cost. Except for children in mixed status families if they are lawfully residing.

1. Hispanic applicants must first qualify based on same restrictions that apply to any other American citizen and then further restrictions based on immigration apply.

2. Eligibility depends first on the person having worked for over 40 quarters (10 years). Recent immigrants, after 5 years are able to "buy" Medicare coverage, which is very expensive.

3. Eligibilty is based on federal poverty level. States that expanded Medicaid after ACA include now a higher level than the 100% poverty level. Missouri did not expand Medicaid.

4. States can choose to waive the 5yr ban for children & women. Missouri opted not to waive that requirement.

5. There are eligibility requirements for this program that further restrict access to Medicaid. In certain states refugees can apply for a 7 year coverage, but not in Missouri.

6. Coverage is based on the child who will be born in the US, so coverage for the mother literally ends the moment the child is born, but the child is elligible for CHIP if family income applies.

7. Eligibility is based on income between 100% and 400% federal poverty level in Missouri. In states that expanded Medicaid starting point is higher than 100%.

8. Unauthorized children and parents are ineligible for all publicly funded health services except perinatal and emergency room care, neither of which provide financial protection nor comprehensive access.

Children under DACA status continue to face same restrictions to health coverage as other undocumented immigrants.

Sources: (Centers for Medicare and Medicaid Services, 2014; "MedicareResources.org," 2016, "Missouri HealthNet (Medicaid) programs," 2016; Missouri Department of Social Services, 2016; Missouri Foundation for Health, 2016; National Immigration Law Center, 2011; US Department of Health and Human Services, 2012, 2016)

CHAPTER 3: THE ROLE OF CAPITAL IN HISPANICS' ACCESS TO HEALTH CARE

In Chapter 2, I presented the general context Hispanics face when accessing health care. In addition to the structural barriers presented there, Hispanics need to acculturate to the American healthcare system, conceptually included in public health as part of increasing health literacy. I would argue that health literacy should be conceptually separated from healthcare literacy though, particularly in the case of immigrants. Increasing the levels of healthcare literacy is therefore what I call acculturating to the healthcare system in this dissertation. Depending on how many years a Hispanic immigrant has lived in the US, what generation being born in the US they belong to, and in which community they reside, the acculturation level may vary. Moreover, the types of social capital individuals possess differ depending on their background and the local context. Social capital can enhance access by connecting people to the proper resources as well as by helping them acculturate to the system. This chapter provides a theoretical analysis on the role capital has in access to medical services as it applies to Latinos, with an emphasis on acculturation and social capital. Both acculturation and social capital are then further expanded in the meta-study in Chapter 4 and then measured in the statistical analysis.

A. Local Context

The state of Missouri, particularly the Kansas City area, received a flow of Hispanic immigrants in the late 19th and early 20th century. Most of these immigrants,

coming primarily from Mexico, were hired for the construction of railroads and meatpacking facilities (Serda, 2011). It was nearly another century before another significant inflow of Hispanic immigrants came to the state (Carr et al., 2012; Haverluk & Trautman, 2008; Passel et al., 2011; Kandel & Parrado, 2005).

Although the percentage of the Hispanic population in Missouri is still low - about four percent in 2014 (U.S. Census Bureau, 2014b) - compared to the national average of 17.4 percent (Krogstad & Lopez, 2015) as well as to other states, such as neighboring Illinois with 16.7 percent (U.S. Census Bureau, 2014a) - what is noteworthy is the group's population growth of almost 80 percent from 2000 to 2010 and 311 percent between 1990 to 2016 (Cambio Center, 2011; Missouri Census, 2017). The Hispanic population growth represents the most widespread migration ever in the state, occupying today every county in Missouri (114 total) (Dozi & Valdivia, 2007; Missouri Census, 2017). As a result, concerns regarding integration of Latinos in local communities are relatively recent, particularly when compared to states like Texas or California where the Hispanic population has been established for longer periods (Haverluk & Trautman, 2008).

B. Hispanics' Heterogeneity

Regardless of the confusion the Hispanic term has created through the years among both Hispanics and non-Hispanics, one thing is clear from the Census description (see Appendix 1: Glossary): Hispanics are treated as an ethnic group, as opposed to a racial one. Both race and ethnicity are deemed as social constructs by various social sciences scholars in fields like sociology (Haney-Lopez, 1994; Mora, 2014; Rumbaut,

2011; Shiao et al., 2012) or psychology (Smedley & Smedley, 2005). Confusion is expected, particularly when we consider the term Hispanic has been adopted by the Census relatively recently - in the late 20th century (Cohn, 2010). Hispanics often mistake ethnic with racial classifications as they're understood in American society (Mora, 2014; Rumbaut, 2011; Schur et al., 1987; Weinick et al., 2004). In addition to confusing race with ethnicity, Hispanics tend to associate "white" with status rather than race (Sandoval, 2015).

The Hispanic population encompasses a very heterogeneous group with a wide range of cultural backgrounds that mainly share just two things in common, the Spanish language and its colonial link to Spain located in the Hispanic peninsula in Western Europe. But even with respect to language, there are Hispanics, like those of 2nd or 3rd generation immigrants, who do not speak fluent Spanish or speak no Spanish at all. There are also Hispanics whose main language is of an indigenous origin other than Spanish, such as some from Mexico and Guatemala who speak a Mayan dialect.

Nowadays, the term Hispanic is used interchangeably with the term Latino. Latino adds to the confusion because Hispanic is linked to the Spanish language,[14] but Latino can be anyone whose language derived from Latin (i.e. Spanish, Portuguese, Italian, French, Romanian) (Mora, 2014; Rumbaut, 2011). The confusion caused by the use of these terms is sometimes problematic because it impacts how healthcare policy recommendations are being made in the US (Schur et al., 1987; Weinick et al., 2004). For the purposes of this study, Hispanic is used interchangeably with Latino as is already the

[14] Although Hispanic is linked to Spain and its colonies nowadays, historically the Roman Hispania belonged to the Iberian Peninsula which today includes Spain, Portugal, Andorra, and the British Overseas Territory of Gibraltar (Bowerstock et al., 1999).

norm in American society (Mora, 2014). Both terms are used to refer to those who reside in the US and whose official language is Spanish in their country of origin.

The heterogeneity present within this group matters when we consider the types and amount of capital that can be accessed. People with different backgrounds can have different starting points with respect to acculturating to the American way of life and consequently the healthcare system. The types of social capital to which these subgroups have access can vary widely. For example, it may be easier to acculturate for a Mexican immigrant from a high-income stratum who migrates already fluent in English and with a college diploma obtained in the US, than a Mexican immigrant of low income with no high school diploma whose primary language is Mayan hired to work in the fields picking strawberries. These two immigrants would also differ in their acculturation process from, for example, a Mexican descendant who is a third-generation-immigrant born in the US who only speaks English. The three examples are all Hispanics with a Mexican origin who will further have access to different types of social capital that can either facilitate or hinder their integration. So, we must acknowledge differences even among people whose background is traced to the same country of origin.. Simply put, when it comes to the Hispanic population, we have to be extremely cautious about generalizing how much they understand the healthcare system, as well as what types of social capital they possess that can help them access such a system.

On top of cultural heterogeneity related to country of origin, the issue of citizenship and immigration status among Hispanics must be noted (refer also to earlier discussion in Chapter 2 and later discussion in Chapter 4) (Pedraza & Rumbaut, n.d.; Portes, 1995,; Portes & Hao, 2002; Portes & Zhou, 1993). Separating them by some

common subgroups can serve best to illustrate this point. First, there are Puerto Ricans who regardless of being born in Puerto Rico or the continental US, are US citizens by birth. In other words, Puerto Ricans are not technically immigrants (i.e. by law). Second, there are Cubans who migrated during the Cold War and were given refugee status when stepping into US territory, accompanied by several privileged treatments including a relatively fast passage to citizenship. It must be noted such privileges given through immigration legislation to Cubans have not been given to immigrants from other Latin American countries. Following the recent change (if maintained) in legislation regarding Cuba, more recent Cuban immigrants will face a completely different scenario than those from Cold War era. To these two Caribbean origins, we must add the Dominican Republic, whose immigration statuses vary from both Puerto Rico and Cuba.

Third, immigrants from Mexico have historically been among the most discriminated groups in the US; like those who came during the railroad construction period in the early 1900s and those who were part of the Bracero Program during the mid-20th century. In general, the geographic location of Mexico, in conjunction with high levels of poverty in that country and lower skills labor market demands in the US, have given space over time to massive immigration. The large number of Mexican immigrants also include a portion that have come to be labeled with a negative connotation as "illegal immigrants."

The majority of immigrants from Central America, comprising the second largest group of Hispanics, fit a similar pattern as those from Mexico. Most immigrants from both Mexico and Central America come from lower income and educational levels in their countries of origin and have migrated to the US to fill the unmet demands for low

skilled jobs. Further, within these two subgroups, we also find those who have been born in the US and those who belong to upper income and educational levels. These slight differences are major because people from different socio-economic classes generally do not mix among each other, even if they are from the same country and live in the same town.

In the same way, those who have been here for several generations (like the Mexican-Americans established in Kansas City in the early 1900s) rarely interrelate with more recent immigrants of the same country of origin. In some cases, the longer established Hispanics do not want to be identified with the newcomers and may even act hostile to them. To complicate matters more, even among the newcomers, immigrants who are more integrated and are lawfully residing in the US, do not want to be related to unauthorized immigrants. Then there are those of South America who vary culturally by country, but whose farther geographical location - as opposed to Mexico, Central America and the Caribbean - diminishes the chances of massive lower-skills-level migration. As a result, those from South America represent the minority among Latinos in numbers.

This dissertation acknowledges the heterogeneity present in the US Hispanic population. However, because the aim in the end is to provide recommendations that could hopefully aid in improving healthcare access for Hispanics in Missouri, the focus adopted will be generally tied to vulnerability (i.e. factors that constrain access to healthcare for Hispanics in more vulnerable positions). Vulnerability within this group depends primarily on immigration status, income level, acculturation with respect to the

healthcare system, the types of social capital they possess and other issues that are directly or indirectly tied to these, such as country of origin.

C. Health Literacy vs. Healthcare Literacy

Since 2000, the US Department of Health and Human Services (2000) adopted the following definition for health literacy:

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Although there have been controversies on how people define, understand, and apply this term, this is perhaps the most widely used description nowadays (Berkman et al., 2010; Baker, 2006). For the purposes of this study, this definition will be expanded to subcategorize the portion referring to services. Due to the different types of skills and knowledge needed to navigate the complex US healthcare system, it is important to address literacy with respect to *accessing healthcare services* separate from the capacity to address one's own health.

To illustrate the need for this proposed separation, suppose an immigrant from Cuba is looking for a diabetes specialist in Columbia, Missouri and she is literate with respect to her health (i.e. has the capacity to ask good questions and easily understand medical instructions). This particular ability does not mean she also understands how someone goes about accessing a diabetics' specialist (i.e. normally having a primary care physician who will refer the patient to a specialist, plus having a healthcare insurance, which will be requested when setting the appointment).

In Cuba, everyone has guaranteed health insurance provided by the state, which covers all of an individual's healthcare needs (Keck & Reed, 2012; Magnussen et al., 2004). Most people go straight to a specialist when having a specific medical concern. Having a primary care physician is common for children, but not for adults. Further, a specialist's clinic would not need to verify for insurance status in order to set up an appointment, like clinics in the US are accustomed to doing. Hence, this person may be ignorant to the norms usually followed to make an appointment with a specialist in Missouri. It is first expected for her to have a primary care physician, who will refer her to the specialist. Second, she may also struggle to grasp that insurance is not a guaranteed right. So, if her job does not offer health insurance, she would have to obtain insurance on her own. If private insurance is too expensive for her income, she will need to understand what types of opportunities are available (if any) to people in her specific immigration status (i.e. refugee, permanent resident, naturalized citizen, etc.) through either public insurance (i.e. Medicaid or Medicare) or tax credits and subsidies (i.e. through the Marketplace based from the Affordable Care Act).

If the Cuban patient's English language fluency is low, it may pose additional obstacles in the process needed to understand her unique situation as an immigrant in the US trying to obtain insurance in order to be seen by a specialist. Following the appointment, this person may further suffer trying to understand the medical bills that will come in the mail. There would usually be no bills in Cuba since the government would cover the cost, but in the rare event any payments would be due by the patient, they would all be charged at the time of service. In the US, not only are services not charged at the time of service, but the patient is not even told the amount she will owe.

Furthermore, medical services for the same visit are billed separately (as opposed to the patient seeing only one bill already including all services). This hypothetical example briefly illustrates the additional hurdles an immigrant in the US goes through, on top of the hurdles other Americans also face in such a highly complex system. The difference is, regular Americans are accustomed to this complex system, and Hispanic immigrants are not.

The focus of this study is on Hispanics residing in the US, more specifically the state of Missouri. For this reason, healthcare literacy, adopted as a separate term from health literacy, refers to the degree of capacity people possess to access the *American* healthcare system. Capacity in this sense encompasses various impediments that are common to Hispanics in the US today, such as fluency in the English language, understanding how to go about obtaining insurance, learning about the importance of having a primary healthcare physician and so on.

In other words, there are specific skills and knowledge that an immigrant in the US must acquire in order to start accessing healthcare services and even more so to master the system. Therefore, health literacy must be conceptually divided in two parts: (1) health literacy as it applies to a patient being able to ask proper questions and understand medical directions regarding his/her health per se and; (2) healthcare literacy as it relates to the ability to access healthcare services in the US. It is important to also note that healthcare literacy is not a static concept, since people can change their level of literacy through time as discussed by Berkman et al. (2010). The term *healthcare literacy* then can be viewed in terms of having the proper capabilities to access health care, which is examined next in terms of the various forms of capital as they impact access.

D. The Role of Capital

Lin (2001) divides the historical development of capital as a concept in two types:

(1) the Classical theory that stems from Marx, in which capital is the surplus value generated and kept by capitalists. Under this notion, capital also represents an investment;

(2) subsequent neo-capitalist theories are still based on the classical theory, but the main difference is that anyone can be an investor.

Capital is viewed as resources that provide returns, which operate differently due to stratification in society's social structure. The different layers in turn create differences in how people located in different strata access capital. Bourdieu's view of capital fits in the social stratification model Lin describes. In other words, anyone can technically be an investor, but depending on the social strata an individual belongs to, the access to the various forms of capital will vary. Those belonging to lower strata usually have more limited access to capital that can help them climb the ladder of social stratification.

Bourdieu classifies capital primarily into three main types:

1) economic capital, "which is immediately and directly convertible into money and may be institutionalized in the form of property rights;" (2011, p. 84);

2) cultural capital, which requires cultural competence or the ability to properly interpret codes within a class (1984, p. 2) and is "encountered in a class society" deriving "social value from the power of social discrimination" (1993, p. 128); and

3) social capital, which is built on connections that are "made up of social obligations" (2011, p. 124).

In addition to these three types, Bourdieu introduces the notion of symbolic capital, which relates to but does not necessarily belong in the classification presented above. He refers to cultural capital as being institutionalized in society through symbolic capital, as it is made up of codes that people unconsciously use within a social class. Although he

does not specifically state that social capital can also be symbolic, it can be argued that social capital can, in some ways, also be expressed through symbolic capital.

The specific discussion on economic capital by Bourdieu (Bourdieu, 1984, 2011) is not lengthy. He spends more time on cultural and social capital as he is precisely trying to prove that these matter as much as economic capital. However, what is relevant from Bourdieu's argument on economic capital is that even though cultural and social capital do not immediately, in the strict economic sense, produce profits, over time they do transfer into increased earnings. That is, when we apply his idea to health care, the more capital someone accumulates, the more we can expect that person to increase her healthcare access level.

Economic capital is needed to pay for insurance premiums, copayments and deductibles. Publicly insured individuals may still face co-payments, coinsurance and deductibles, while some may even need to buy complementary insurance therefore also paying premiums. For those who do not qualify for public coverage, insurance has to be obtained either through employment or through independent markets. Those having access to employment-based insurance (i.e. partly subsidized by employer) still face the premium to be paid by the employee and family members tend to be excluded from the subsidy. What the employee is expected to pay for his/her insurance and his/her family may still be costly (Maxwell, Cortes, Schneider, Graves, & Rosman, 2011). Then there are those who lack any type of insurance (private or public), for whom any services accessed would require economic capital to afford full payments due. Hence, economic capital matters even among those who have access to public insurance (fully or partly subsidized) or are offered subsidized insurance through their jobs.

Employment-based insurance is the dominant source of healthcare coverage in the country, but the percentage of the population it covers has been declining, leaving many without potential access (Fronstin, 2013; Schur, Feldman, & Fund, 2001). Hispanics are disproportionately employed in jobs that do not offer insurance when compared to white Americans or even African Americans, the latter of who are also at a disadvantage (Doty & Holmgren, 2006). Latinos who do not qualify for public insurance, nor have access to insurance through employment are left with individual health insurance markets. The Affordable Care Act (if continued) is expected to provide subsidies for a portion of the Hispanic population, but it is not going to cover everyone as it is tightly tied to citizenship and immigration status (Refer to Table 2.1). Thus, we expect Hispanics with higher incomes and those with full-time jobs to possess higher levels of economic capital and hence better access to health care. Economic capital in this sense is tied closely with human capital. Individuals with higher levels of education are expected to correspondingly have higher incomes, giving them more access to economic capital and as a result higher levels of access.

In addition to economic capital, both cultural capital and social capital are needed by Hispanics to access healthcare services. Cultural capital, representing the "games of society" (Bourdieu, 2011, p. 83), is institutionalized through what Bourdieu refers to as "symbolic capital" (1993, p. 67). Those who lack the capacity to proficiently navigate the healthcare system have "cultural allodoxia"[15] (Bourdieu, 1984, p. 323), or are considered healthcare illiterate, meaning they are not able to decipher the codes needed to use the

[15] Bourdieu (1984) defined "cultural allodoxia" as "all the mistaken identifications and false recognitions which betray the gap between acknowledgement and knowledge" (p. 323). He also referred to it as "misapprehension" (p. 142).

system properly and efficiently to one's health benefit. So, the farther a person is from being acculturated to the American healthcare system, the more cultural allodoxia that person possesses or the more illiterate she is with respect to healthcare access. Hispanics who were not born in the US, who have resided for shorter periods in the US, and who possess lower levels of English fluency would be expected to have lower levels of acculturation - or lower levels of healthcare literacy - and therefore considered the most vulnerable. As a result, we would expect those with lower levels of acculturation to consequently have lower access to health care.

Social capital, on the other hand, can serve as an enabler to navigate the system and therefore has the potential to enhance access. In general, higher levels of social capital are expected to improve access. Nonetheless, as described later, it is important to separate the different types of social capital when measuring and trying to understand their impact because each one originates from different kinds of networks. For example, networks that are connected to the political system should in practice benefit Hispanics through legislation. Three different types of social capital are presented, analyzed and measured in this dissertation: bonding, bridging and linking.

Bourdieu presents the acquisition of capitals as a class issue and class as economic. The main constraint with his framework is that it is assumed that people are limited in accessing different forms of capital based on their class. Those from lower class levels do not have access to the codes necessary for upward mobility. In this sense, his framework is limited in explaining if people can actually acquire the social and cultural capital to access the American healthcare system. Furthermore, although Bourdieu introduces the concept of social capital, his framework does not explain the

different types acknowledged today (bonding, bridging, linking). His framework also does not provide many tools to understand how cultural and social capital can serve to facilitate access. To expand on this, we need to look at recent work expanding on the discussion of capital by viewing it from the perspective of how capital is used in livelihood strategies.

Bebbington (1999) discusses more types of capital than Bourdieu, and includes five different capitals in his framework. What is most relevant about his analysis is that we need to go beyond income when discussing capitals. There are two main important concepts from his framework: capabilities (which has roots in Amartya Sen) and meanings. Under this framework what matters is if people have the right capabilities to make strategic decisions that can in turn improve their livelihoods. That is, can they access the resources (i.e. capitals) that allow them to build livelihood strategies that improve their well-being? It is not just the stock of capitals that matter here, but also the types and strengths.

With respect to cultural capital, it is important to acknowledge that actions must have meaning to people. If they have meaning, then cultural capital can empower individuals in how they build their strategies. If we apply Bebbington's ideas to Hispanics accessing health care, we can say that people are empowered when they understand the importance of having the proper cultural capital to navigate the healthcare system. Empowering them goes beyond just the specific act of buying insurance and paying for deductibles, coinsurances and copayments. They must also be able to grasp how insurance plays a role in helping them to better access care. As Sen (1997) puts it, we are looking beyond just increasing income (i.e. economic capital), but providing them

with the proper capabilities that can complement their human capital and, as a result, serve to improve their social development and physical health. What is relevant above all is how we influence the well-being of Hispanics by allowing them to better access health care.

According to De Haan (2000), capital itself does not do justice to the nature of social relationships because these are not entirely oriented to material gain. What matters is if people possess access to resources when they need it. Human agency is critical here and relates to capabilities. That is, do individuals have the capacity to integrate experiences into their livelihood strategies? Moreover, can this capacity be used to reshape their social and material conditions? Agency is embodied in the individual, but it is embedded in social relations. Essentially, individuals need to have the capacity and be properly connected to access resources when they need them. If not, social exclusion is the most likely outcome. In the Hispanic case, if we apply De Haan's view, we are aiming at enhancing human agency so that individuals can make better decisions with respect to accessing healthcare services for themselves. By doing so, they are not just improving access themselves, but also their social standing in the society they now reside.

Similarly, Chambers and Conway (1991) enhance the notions of capabilities and livelihoods. Their emphasis is on equity and progress towards more equitable distribution of assets and opportunities. The authors mention how health, both preventive and curative, is critical to prevent disability. By improving their knowledge about the healthcare system, Hispanics can enhance their capability on how to navigate it. We

expect better capability in navigating the system will in turn improve their health outcomes and over time allow for less marginalization of individuals from this group.

Thus, Sen, Bebbington, De Haan, and Cambers and Conway expand Bourdieu's analysis of capitals. First, they state that we need to go beyond income (economic capital in Bourdieu). In Bourdieu's framework, cultural and social capitals are basically restricted within class and are also used in the end to access economic capital. The other authors extend his framework by moving beyond an income centered understanding of capital, to a focus on the well-being of individuals as well as improving their social development overall. In other words, we want individuals to possess the right capabilities that can empower them to navigate the healthcare system properly. By doing so they can make better decisions as part of their livelihood strategies.

Immigrants bring their own forms and stocks of capital, which can be facilitators or constraints in the new country. In addition, they acquire capital over time. According to Portes (1995), it matters not just what they bring with them as capital, but also the institutional context in which they land. For example, the privileges given to Cubans during the Cold War were not available to other Hispanic immigrants. As a result, Cubans had easy access to resources, such as Medicaid or Medicare. In addition, specific privileges such as scholarships for college education were granted to Cuban Americans that were not offered to other groups. During this same period, Mexicans were migrating in mass, some without legal authorization. As a result, by law, they were not only denied access to the same resources given to Cubans, but were actually associated with negative stereotypes, which lead to vulnerabilities and social exclusion. So, under the same Hispanic category (as applied in the US Census), Cubans experienced the potential of

upward mobility, while Mexicans continue to experience discrimination and exclusion in American society.

Roberts (1995) mentions how immigration laws impact the stigmas that are associated with immigrants. In health care, we see these stigmas expanding to access. The most obvious one is that undocumented immigrants are completely excluded, making healthcare access not a human right in the US. But there are others, such as access to Medicare, that impact immigrants based on the type of immigration status and also their length of residence. Dozi and Valdivia (2007) point out how laws can lead to vulnerability of immigrants, which relates to the policies that provide or restrict access to health care based on immigration status as discussed in this dissertation.

Further, we must look at what types of discrimination are already in place in the specific context immigrant groups exist, such as the color of their skin. Portes (1995) compares how black Haitians residing in south Florida in poor neighborhoods were associated with discriminative practices already in place. Their language barriers only exacerbate the problem. As a result, this group experienced downward assimilation, as opposed to the white Cubans who experienced upward assimilation.

The meta-analysis in Chapter 4 identifies different factors impacting Hispanics' access to health care that have been measured over the last fifty years. The vast majority of socioeconomic factors measured are linked to economic capital. Although some studies have measured the impact of acculturation and social capital, these are still a minority in the literature, particularly for social capital more so than acculturation. This dissertation emphasizes the importance of acculturation and social capital because I believe these can enhance access when we consider the complex American healthcare

system in place today and the fact that a large portion of Hispanics are foreign-born (about 34 percent) (Flores et al., 2017). The next two sections explore them in more detail. In the meta-analysis, these concepts are further examined in terms of how they've been measured in other studies focusing on Hispanics' access to health care. Then, the logistic regression tested in Chapter 5 measures the two as variables in order to understand their impact in access among Latinos in Missouri.

E. Acculturation

Acculturation requires accumulation of what Bourdieu calls cultural capital and depends on more than just the individual. It is embodied in the family, the community and institutions of all levels with which individuals interact or that impact their livelihoods. Although Bourdieu did not analyze cultural capital as it applies to health care, nor did he used the term acculturation, this study borrows from his theoretical notion of cultural capital and applies it to the American healthcare system. Therefore, I proceed under the assumption that the process of acquiring stocks of cultural capital characterizes the process of acculturating to the American healthcare system.

According to Bourdieu the "accumulation period covers the whole period of socialization" (2011, p. 86). Berry (2003) points out that acculturation strategies are not randomly adopted, but rather depend on the context in which they take place. Portes and Zhou (1993) introduce the idea of segmented assimilation to describe diverse possible outcomes in the process of adaptation taken by immigrants. Thus, "cognitive acquirement" – which involves a "decoding operation" or when a person mentally acquires a cultural code (Bourdieu, 1984, p. 3) matters in order to be able to access

healthcare services. The emphasis here is on the level of acculturation Hispanic individuals have with respect to the American healthcare system, meaning there is a starting point and a process to acquire the proper codes that enable access.

People need to acquire "cultural competence" (Bourdieu, 1984, p. 2) to be able to consume healthcare services with "practical mastery" that enables someone with the capacity to "feel" what "needs to be done, where to do it, how and with whom" (Bourdieu, 1993, p. 95). Experiences vary widely from one individual to another depending on "their position on the economic space" (Bourdieu, 1984, p. 101). This position does not depend solely on economic capital, but rather on practices that are structural and hence produce "structural relations" (Bourdieu, 1993, p. 29) that are not necessarily conscious.

The American healthcare system represents what Bourdieu refers to as the *field* of cultural production that covers "universes of belief which can only function in so far as they succeed in simultaneously producing products and the need for those products through practices" (Bourdieu, 1993, p. 82). In other words, the healthcare system as a field includes the ways of doing things that have evolved over time and continue to develop. This field is comprised of *traditions* that developed over time from a combination of policies, markets and cultural backgrounds in the US. The healthcare field is in turn closely tied to what Bourdieu calls *habitus*.

Habitus are the "systems of dispositions" (Bourdieu, 1984, p. 6), the "classifiable judgments and the systems of classifications of these practices" (Bourdieu, 1984, p. 170). Although habitus goes hand-in-hand with field, it applies to the individual. Hispanics interpret the US healthcare system differently than other groups who have been

established in the US for several generations. Latinos have different norms, expectations and dispositions that are brought with them from their country of origin, or acquired from their families' background if they were born in the US.

Habitus exists with respect to social classes. People are positioned at different levels on the "social ladder" (Bourdieu, 1984, p. 125) of accessing the healthcare system (the field). The habitus in this context is determined by different aspects including income, type of job, immigration status, length of time living in the US, English language fluency and so on. But habitus is not only a "structured structure" which "organizes practices and perception of practices" (Bourdieu, 1984, p. 170), it also encompasses the process of internalization that divides people into classes. Immigrants of lower socio-economic status are placed in this sense at the lowest level in the social ladder regarding access to health care.

The process of internalization described by Bourdieu is mainly what this study refers to as the process of acculturation or increasing someone's healthcare literacy. Nonetheless, acculturation is not a simple process for adults. As Mezirow (1991) points out "formative learning" (p. 3) happens mainly during childhood. Because the childhood period of formative learning is strong, "uncritically assimilated presuppositions" (p. 5) distort an individual's view of the world in her adult life. Hence, acculturating to a new healthcare system requires strategies that aim at changing those worldviews that are strongly ingrained in adult individuals.

Healthcare access is not treated as a universal human right by law in the US. On the other hand, in most Latin American countries including Argentina, Chile, Colombia, Costa Rica, Guatemala, Mexico and Peru, access to healthcare services is regarded as a

universal right by law (World Bank, 2013). This does not mean services are better in those countries than in the US, but it does mean people have a different mindset (cultural values) regarding health care. People bring their cultural backgrounds with them when they migrate, including their views on access to health care. As a result, Hispanics residing in the US have to acculturate to the American healthcare system, which is not a simple process and takes time, in many cases even several generations (Balcazar et al., 2015). In addition, the system is dynamic, meaning it is constantly evolving over time, often requiring readjustments by its users.

Acculturation has been studied in different disciplines since the early 20th century. More recently, researchers primarily in the fields of psychology and sociology, have expanded its use. Even though there are similarities in how the two fields conceptualize acculturation, there are also differences in both how it is defined and measured by different researchers.

Acculturation "refers to the process by which individuals whose primary lifestyle has been that of one culture acquire characteristic ways of living of another culture" (Morales, Lara, Kington, Valdez, & Escarce, 2002, p. 481). In sociology, acculturation has been mainly studied by scholars who focus on immigration. Emphasis on acculturation and assimilation began with the founders of the Chicago School of Sociology in the early 20th century, and more recently pursued by Portes and collaborators (Waters, Tran, Kasinitz, & Mollenkopf, 2010).

Earlier scholars from the Chicago school who studied acculturation viewed it as a linear process that ended in assimilation. These views resulted from studies on second-generation European immigrants in the early 20th century. Such scholars associated

acculturation with what Waters et al. (2010) calls the straight-line (standard) assimilation. Moreover, the earlier views also linked assimilation to upward economic mobility, like a study done on the Jewish community in Chicago (Rosenthal, 1960). In this sense, the concepts of acculturation and assimilation are viewed as nearly synonymous by sociologists.

In a sociology college textbook by Ferrante (Ferrante, 2011), acculturation is not even presented as a concept. Assimilation in this book is sub-classified in two types: absorption assimilation and melting pot assimilation. Absorption assimilation is defined as "a process by which members of a minority group adapt to the ways of the dominant culture" (p. 249). Melting pot assimilation is defined as "cultural blending in which groups accept many new behaviors and values from one another. The exchange produces a new cultural system, which is a blend of the previously separate systems" (p. 250). The melting pot assimilation relates more to how psychologists have been conceptualizing acculturation recently.

In psychology, acculturation is mainly studied in the sub-fields of cross-cultural psychology and intercultural psychology (Berry, 2005). The concept of acculturation in psychology seems to have been initially imported from anthropology. Redfield et al. (1936) - used as a main reference in Berry (2003) - state that "acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (p. 149).

Although there is confusion in the literature as to how psychologists conceptualize and operationalize acculturation, there seems to be more convergence in its

definition, but less so in how it is measured. Rudmin (2003) reviewed the literature on acculturation from 1918 to 1984 and found inconsistent terminology, poor citation of earlier research, conflicting and poorly tested predictions of acculturative stress, and lack of logic. However, a switch happens in the mid-eighties when scholars begin to adopt Berry's typology of acculturation (Yoon et al., 2013). From then on, most scholars seem to follow Berry's idea of acculturation treated as a bilinear concept as opposed to a previous unilineal one. Nonetheless, inconsistencies continue in how researchers operationalize the bilinear concept.

Berry (2005) defines acculturation as "the dual process of cultural and psychological change that takes place as a result of a contact between two or more cultural groups and their individual members" (p.698). The four strategies of acculturation proposed by Berry, which are measured by Marin and Gamba (1996) through a scale used in the survey questionnaire of this dissertation, include:

- Integration: maintain original culture but also seek interaction (this is equivalent to multiculturalism)
- Assimilation: seek daily interaction with other cultures (this is equivalent to the melting pot at the larger society level)
- Separation: hold their original culture and avoid interaction (this is equivalent to the segregation at the larger society level)
- Marginalization: little interest in maintaining culture but also no interaction sought. May be a result of failing when attempting to integrate, but may also be due to discrimination (at the society level this is exclusion).

The scale used by Marin and Gamba (1996) measures both how much individuals are maintaining their original culture and how much are they interacting with the new culture, therefore applying the bi-dimensional aspect introduced by Berry. In general, psychologists believe integration to be the best strategy because it causes less

acculturative stress to the individual overall (Berry, 2005). However, in the specific case of healthcare access, both assimilation and integration would be considered groups that are acculturated to the Anglo-American way of life, meaning we would expect those individuals to also be better acculturated to the healthcare system. Individuals who are separated or marginalized would face the need to acculturate to the system in order to better access the system. In other words, when it comes to accessing healthcare in the US, what matters is how much Hispanics have *acculturated to the Anglo-American way of life* because the healthcare system was structured within that culture. So, in order for people to access it, individuals must understand the cultural codes engrained in such a system.

F. Social Capital

The literature on social capital can also be confusing sometimes; overall, though, there is more convergence across disciplines in terms of how it is conceptualized and operationalized today when compared to acculturation. Both concepts, however, are connected when it comes to the analysis of accessing health care. As Bourdieu (1984) notes, social capital enables people to possess connections that are "needed to make the most of economic and cultural capital" (1984, p. 337). Although social capital emerges from social relationships, the relationships per se are not a form of capital, but rather the means through which capital is produced and accessed. In other words, in order for social capital to emerge from a relationship there has to be some type of cooperation that arises from continuous interactions (Fukuyama, 1999).

Social interactions over time can be seen as investments that produce social capital, which is expressed in the form of trust and valued social ties. Social ties include,

for example, friendships that are formed over time, as well as social linkages that an individual has to other individuals involving less personal matters (Woolcock, 2001). Family ties for instance, can produce social capital, like those formed through strong communicative relationships between parents and their children. The social capital that emerges from such interactions can form a social structure within which individuals acquire personal benefits (Bourdieu, 2011; Carpiano, 2007; Coleman, 1988; Lin, 2001; Portes, 1998; Putnam, 1995).

According to Putnam (1995), who is known for disseminating the concept of social capital outside of academia, the theoretical underpinnings can be linked to sociologists as far back as Durkheim. More recently, three main fields in the social sciences have been actively involved in the literature's debate of the concept. Putnam provided the political sciences framework, Coleman the sociological one, and Fukuyama the economic. Coleman (1990, 1998) gave social capital more rigorous empirical scrutiny and began to develop ways to operationalize the term (The Office for National Statistics UK Statistics Authority, 2001).

Although scholars have tried various ways to sub-classify social capital, there are now three commonly acknowledged types: bonding social capital, bridging social capital and linking social capital (Keeley, 2007). If we relate these to Granovetter's (1973) discussion, bonding belongs to strong ties, while bridging to weak ones. Both types can bring about benefits as well as can be detrimental or simply not useful depending on the context and what kind of impact is being measured. Linking social capital on the other hand, can depend on either strong or weak ties, but they strictly represent vertical forms of relationships, while bonding and bridging can be horizontal or vertical. What matters

in linking is the fact that they connect people to networks that have some sort of political or other form of influence in the community or a higher level, like state or federal. The three forms are based on the following foundations (Keeley, 2007, p. 6):

"**Bonds**: Links to people based on a sense of common identity ("people like us") – such as family, close friends and people who share our culture or ethnicity.

Bridges: Links that stretch beyond a shared sense of identity, for example to distant friends, colleagues and associates.

Linkages: Links to people or groups further up or lower down the social ladder."

The ways these are measured is still not consistent. However, it is clear that relying on homogenous ways to operationalize them may not be realistic since cultural specificity makes it difficult for researchers to rely on universal tools (The Office for National Statistics UK Statistics Authority, 2001). Moreover, benefits from each type can vary across different communities even within the same country. Coleman (1990) mentions that a given form of social capital can be beneficial in one community but harmful in another. O'Brien et al. (2005) for example, measure and compare how bonding social capital and bridging social capital differ in their impact across groups in different cultural contexts. Hence, we can say that context matters when it comes to how each type of social capital impacts individuals. When we apply the importance of context in the case of Hispanic immigrants in the US, it becomes imperative to measure social capital separately by its different forms when aiming to understand its impact on access to health care. In the survey study conducted for this dissertation we used a scale developed by Chen, Stanton, Gong, Fang, and Li (2009) that allows one to measure personally owned social capital across people with different backgrounds. This measure is discussed in more detail in Chapter 5.

Portes and Sensenbrenner (1993), who focus on immigrants, discuss how social capital is similar to other capitals in that it is a resource to help attain ends for individuals. A distinctive characteristic of social capital is that it is intangible and lies within relations. According to the authors' definition of social capital, there are expectations for action within the collectivity that affect economic goals and goal-seeking behavior of the members, even if these expectations are not oriented toward the economic sphere (p. 1323). Within immigrant communities, social capital can emerge in the form of bounded solidarity, which is a form of social capital that depends on the moral imperative (similar to what Marx proposed would form among the workers' group).

Furthermore, social capital is important because it can increase the efficiency of how people use resources in their livelihood strategies by cutting on transaction costs. Nonetheless, limitations exist when social inequalities are sometimes embedded in social capital (C. B. Flora, 2001). In healthcare access, Katz, Ang, and Suro (2012) find that, what I would label as bonding social capital, can be detrimental for Latinos of lower socioeconomic status, while those of higher levels tend to have bridging social capital that benefit them in access. In other words, Hispanics of lower socio-economic status rely more on close relations, like family members or relatives, who may not always be well connected to the resources they need. Hispanics of higher economic status seem to be linked to weak ties, like co-workers, that enable access. Similarly, although Gresenz et al. (2009) do not specifically discuss social capital, their findings provide empirical evidence illustrating that different types of social capital matter in how Hispanics access healthcare resources.

As Lin (2001) mentions, there are four critical elements in social capital that facilitate access to resources: (1) it facilitates the flow of information; (2) it influences how agents make decisions; (3) social credentials are facilitated through the networks and therefore facilitate access to resources; (4) it reinforces recognition. Nevertheless, in order for social capital to be useful in the improvement of individuals' well-being, it must lead to cooperation (Fukuyama, 1999). What is important to note is that identifying the different types of social capital, as well as understanding how they work within a specific community, can help in the creation of strategies that can either rely on existing social capital or create social capital to enhance access. Perez-Escamilla (2010) mention how the *promotoras de salud*[16] have been used for decades in developing countries to improve access to health care. More recently they are being used across the US to help Latinos access services and promote healthy lifestyles. The *promotoras* are a sort of bridging social capital created through government or community led programs. In other words, social capital can be created and/or fostered through policy.

In the specific analysis of access to healthcare we can expect all three forms of social capital to improve access. Friends and family, representing ties that create bonding social capital, can help an individual with translation, transportation and information regarding where to go, but in some instances, they can also act as a constraint when not integrated into the broader community. Neighbors who are more acculturated to the Anglo-American way of life can bring bridging social capital by providing helpful information that friends and family do not have. However, the most difficult type of

[16] *Promotoras de salud* are community health workers used in the US and Latin America who provide health education and outreach services within their own communities. They are basically health educators who are also knowledgeable healthcare navigators. They are usually hired by non-profit organizations or government entities.

social capital to measure through the type of survey we conducted is linking. Although linking social capital relates to networks at the community, state and federal levels, the major exclusion of Hispanics from the healthcare system happens through federal legislation as discussed in Chapter 2 and shown in the meta-analysis. Therefore, Hispanics need to be well connected to legislators in Washington D.C. in order to impact federal legislation in their favor. These kinds of vertical ties are difficult to measure through surveys conducted at the more local level.

Moreover, linking social capital connects to the current crisis between Republicans and Democrats over healthcare legislation. The Affordable Care Act was written with the philosophical background that access to health care represents a human right. However, by formally excluding unauthorized residents, the new law shows how political influence has led the law to fall short of universal coverage. Additionally, the law does not provide tax credits and subsidies for all Hispanics who are residing lawfully but still cannot afford the full cost of insurance in the market nor qualify for Medicaid (Refer to Table 2.1).

Ultimately, the type of immigration status plays a complex role in determining who receives what, how much and for how long. In addition, Hispanics who qualify for benefits must be able to navigate a complex healthcare system to actually access them. In Bourdieu's word, constraints applied through legislation are an illustration of "hermeticism" which functions to repress (Bourdieu, 1993, p. 73). This kind of systemic discrimination works to deter Hispanics from forming social connections outside of their tight circles, which basically transfers into low levels of linking social capital. Systemic discrimination faced by Hispanics in the US through healthcare laws are similar to what

Du Bois (1940/2011) refers to as "group imprisonment" (p. 132). According to Du Bois, economic motives attract immigrant workers for their cheap labor, but at the same time they are kept as a "subordinate caste" (p. 55). As a result, Latinos may face additional restrictions to access different types of social capital that can serve to aid them in accessing services.

The fear of being further penalized by a society, that in some ways continues to resist their integration, has led Hispanics in many instances to isolate themselves from the rest. Isolation and/or segregation of Hispanics into sub-communities impact the building of social capital (Heyman et al., 2009). In several communities, Hispanics cluster among themselves, a mechanism that on the one hand provides protection, but on the other hand distances the group from the rest of society. The scarce social capital that can be accessed outside these clusters, mainly bridging and linking, may in turn weaken Hispanics' access to healthcare services.

G. Final Remarks

The Hispanic population in the US is considered today the largest ethnic group in the country, but within this group there is significant heterogeneity. In the analysis of access to healthcare, heterogeneity is based primarily on cultural differences that are rooted in the countries of origin, as well as immigration statuses. The cultural and institutional contexts in which each immigrant or immigrant descendant grew up as a child, determines largely the worldviews different individuals carry with them when they face the American healthcare system. Because the new system they now face was created with different cultural values than those in their country of origin, immigrants find

themselves obligated to acculturate to the specificities of the American healthcare system. Hence, acculturation involves the accumulation of cultural capital required to comprehend and access this new system.

In addition to different worldviews that require acculturation, immigrants also face different immigration statuses which can be tied to their country of origin (as the case of Cuba during the Cold War) or be specific to an individual (i.e. when recruited by an American company with offices abroad). In the US, access to insurance (both public and employment based), which is considered one of the primary factors to access medical services (refer Chapters 2 and 4), is closely tied to citizenship and immigration status. Therefore, citizenship and immigration status largely determine if an individual is able to access health care.

The role of different types of capital in access to health care is important to understand when the aim is to improve access for Latinos. Economic capital provides the means to pay for premiums (i.e. buy insurance), pay for deductibles, coinsurances and copayments or paying for full service when not having insurance. Acculturation to the healthcare system, the process of improving healthcare literacy, increases the understanding of cultural codes and allows Hispanics to improve the way they navigate the American system. Alongside, social capital can serve as a means to speeding up the acculturation process and/or connecting individuals to the proper resources. Hence, the analysis in this chapter serves to primarily illustrate that initiatives that focus on increasing acculturation levels and offering the proper forms of social capital can enhance access to health care for Latinos.

The accumulation of cultural stocks and social capital as they serve to enhance access is a first step for Hispanics. Nonetheless, in the end the role is not just to acquire proper stocks and amount of capital, but also to possess the "right" capabilities that allow individuals to make strategic decisions that can improve their livelihoods. Healthcare access is one factor that may improve livelihoods. Therefore, the aim of this dissertation is to understand what resources are useful in improving Latinos' level of access. Acculturation and social capital are further examined in the next chapter, a meta-study that seeks to identify and quantify the studies that have explored or measured these two factors. The subsequent chapter then measures the impact of acculturation and social capital using primary data collected through a survey study in Missouri.

CHAPTER 4: A META-ANALYSIS ON HISPANICS' ACCESS TO HEALTH CARE

A. Purpose

The previous chapter provided a theoretical background that supports the need to explore and measure the role of acculturation and social capital in Latinos' access to health care. This chapter aims at identifying and quantifying the studies that have essentially done this already. The main purpose of this chapter is to complement the discussion in the previous chapter by supporting the relevance of the survey study conducted in Missouri, which is examined in Chapter 5. Two main objectives lead to this purpose. First, to identify the main barriers Hispanics face to access health care as analyzed by other studies. Second, to identify if and how other studies have studied the impact of acculturation and social capital on access to health care among Hispanics in the US.

B. Methods

Methodology

The methodology applied here involves a systematic review of the literature that seeks to identify through frequencies the main factors that have been studied in the area of Hispanic access to health care in the US. Quantitative, qualitative, literature reviews and mixed-methods studies are included in this review. The objectives are to identify what approaches (i.e. methods, type of data) have been used to study access to health care for this population, what variables have been mainly identified as relevant in access (i.e. explored in non-quantitative articles or measured in quantitative studies) and if

acculturation and social capital have been included among the factors studied. It is also relevant to understand how acculturation and social capital have been defined and measured in past studies. The data extraction is done through coding of collected studies which are then portrayed in tables that illustrate frequencies and percentages. This methodology can be considered a simplified version of vote counting in meta-analyses (Bushman & Wang, 2009; Qin & Grigsby, 2016).

Selection of Studies

Four databases were used. The first one, *Pais International,* was selected due to its emphasis on contemporary social, economic and political issues on public policy in the social sciences. After trying out several phrases to search in this database, one was selected: "hispanics AND access to healthcare." Different phrases returned a different set of titles, with the exception of "latinos AND access to healthcare," which returned nearly the same list as the selected one. After browsing through the different set of titles the selected phrase was clearly giving the most extensive and relevant results, providing a total of 94 articles.

Academic Search Complete, *Scopus*, and *Google Scholar* were the other three databases used due to their inter-disciplinary coverage. Several keywords were first tested and in the end two keyword phrases were selected: "hispanics access to healthcare" and "latinos access to healthcare." *Academic Search Complete* initially provided 35 articles, which was the longest list among all keywords tried. *Scopus* gave 3003 results, which were narrowed down to 913 by limiting the search to the social sciences, and then further narrowed to a total of 372 by requesting to include only studies in the US. *Google Scholar* provided a total of 93,400 articles when using the search phrase "hispanics

access to healthcare." Titles were browsed and the search was initially cut at 500 when results start to focus more on specific diseases and health overall and less on access to health care. When using the search phrase "latinos access to healthcare" *Google Scholar* came up with 41,700 results. Titles were browsed and then cut at 200 when results start to focus more on specific diseases and health overall and less on access to health care. Many of the articles that resulted from the two keywords' phrases in *Google Scholar* were duplicates.

The first round of selection came from reading the abstracts from the 94 articles obtained from *Pais International,* 35 articles obtained from *Academic Search* Complete, 372 results from *Scopus,* and 700 from *Google Scholar.* Before reviewing the abstracts, duplicates appearing in the four databases had already been eliminated. The final selection from this first round gave a total of 40 articles published between 1981 and 2016. From those 40 articles, 25 more articles were selected from their references' list after browsing through all titles and then reviewing abstracts. The third and final round of searching involved a further selection of articles from references' lists in those 25 articles attained in the second round. A final count of 85 articles were selected after three rounds using a combination of keyword searches and selection from references' lists. After reading all these articles, two articles were further eliminated, so the final count included in this meta-study is 83 (Table 4.1).

Multiple sets of keywords were not used in the selection for three reasons. First, when using the two selected phrases, the lists obtained under each database were extensive and inclusive. Second, when trying out other combinations of search terms, there were too many repetitive titles showing up in the various lists. Hence, these two

Table 4.1. List of Publications Included in Meta-Study

#	Year Published	Authors	Title	Journal / Published by
1	2002	Alegría, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A. N.	Mental HC for Latinos: Inequalities in sue of specialty mental health services among Latinos, African Ams, and Non-Latino whites.	Psychiatric Services
2	1986	Andersen, R. M., Giachello, A. L., & Aday, L. A.	Access of Hispanics to health care and cuts in services: A state of the art overview	Public Health Reports
3	1981	Andersen, R., Lewis, S. Z., Giachello, A. L., Aday, L. A., & Chiu, G.	Access to medical care among the Hispanic population of the southwestern US.	Journal of Health and Social Behavior
4	2015	Balcazar, A. J., Grineski, S. E., & Collins, T. W.	The durability of immigration-related barriers to hc access for Hispanics across generations	Hispanic Journal of Behavioral Sciences
5	2015	Bauer, Scott R., Monuteaux, Michael C., & Fleegler, Eric W.	Geographic disparities in access to agencies providing income-related social services	Journal of Urban Health
6	2004	Blewett, Lynn A., Casey, Michelle, & Call, Kathleen Call	Improving access to primary care for a growing Latino population: The role of safety net providers in the rural Midwest	The Journal of Rural Health
7	2003	Blewett, Lynn A.,Smaida, Sally A., Fuentes, Claudia, & Zuehlke, Ellie U.	Health care needs of the growing Latino population in rural America: Focus group findings in one midwestern state	The Journal of Rural Health
8	2009	Britigan, Denise H., Murnan, Judy, & Rojas-Guyler, Liliana	A qualitative study examining Latino functional health literacy levels and sources of health information	Journal of Community Health
9	2000	Brown, E. R., Wyn, R., & Teleki, S.	Disparities in health insurance and access to care for residents across US cities	UCLA Center for Health Policy Research
10	2009	Byrd, Theresa L. & Law, Jon G.	Cross-border utilization of health care services by United States residents living near the Mexican border	Pan American Journal of Public Health
11	2004	Callahan, S. T., & Cooper, W. O.	Gender and uninsurance among young adults in the US	Pediatrics
12	2005	Callahan, S. T., & Cooper, W. O.	Uninsurance and hc access among young adults in the US	Pediatrics
13	2006	Callahan, S. T., Hickson, G.B., & Cooper, W. O.	Health care access of Hispanic young adults in the US	Journal of Adolescent Health
14	2000	Carrasquillo, O., Carrasquillo, A. I., & Shea, S.	Health insurance coverage of immigrants living in the US: Differences by citizenship status and country of origin	American Journal of Public Health
15	2014	Castañeda, Heide & Melo, Milena A.	Health care access for Latino mixed-status families: Barriers, strategies and implications for reform	American Behavioral Scientist
16	2012	Chavez, Leo R.	Undocumented immigrants and their use of medicla services in Orange County, California	Social Science and Medicine
17	2008	Cristancho, Sergio, Garces, Marcela, Peters, Karen & Mueller, Benjamin	Listening to rural Hispanic immigrants in the Midwest: A community-based participatory assessment of major barriers to health care access and use	Qualitative Health Research
18	2013	Dembe, Allard E., Biehl, Jeffrey M., Smith, Alicia D. & Garcia de Gutierrez, Teresa	Employers' role in helping Latino workers obtain access to health care services: Results of a community-based pilot demonstration project	Journal of Immigrant and Minority Health
19	2007	Derose, K. P., Escarce, J. J., & Lurie, N.	Immigrants and health care: Sources of vulnerability	Health Affairs
20	2004	Documet, P. I., & Sharma, R. K.	Latinos' health care access: Financial and cultural barriers	Journal of Immigrant Health (Currently Journal of Immigrant and Minority Health)
21	2006	Doty, M. M., & Holmgren, A. L.	Health care disconnect: Gaps in coverage and care for minority adults	The Commonwealth Foundation
22	2013	Durden, Elizabeth T. & Dean, Lucy G.	Health insurance coverage of Hispanic adults: An assessment of subgroup difference and the impact of immigration	The Social Science Journal
23	2006	Durden, T. E., & Hummer, R. A.	Access to healthcare among working-aged Hispanic adults in the United States	Social Science Quarterly
24	2006	Echeverria, Sandra E., & Carrasquillo, Olveen	The roles of citizenship status, acculturation, and health insurance in breast and cervical cancer screening among immigrant women	Medical Care
25	2006	Escobedo, L. G., & Cardenas, V. M.	Utilization and purchase of medical care services in Mexico by residents in the United States of America, 1998-1999	Revista Panamericana de Salud Publica
26	2002	Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G.	Disparities in health care by race, ethnicity, and language among the insured: findings from a national sample	Medical Care
27	2010	Fonseca-Becker, Fannie, Perez-Patron, Maria J., Munoz, Beatriz, O'Leary, Michael, Rosario, Evelyn & West, Sheila K.	Health competence as predictor of access to care among Latinos in Baltimore	Journal of Immigrant and Minority Health
28	2013	Fronstin, P.	Sources of health insurance and characteristics of the uninsured: analysis of the March 2011 current population survey	EBRI Issue Brief
29	1991	Ginzberg, E.	Access to health care for Hispanics	The Journal of the American Medical Association
30	2001	Granados, Gilberto, Puvvula, Jyoti, Berman, Nancy & Dowling, Patrick T.	Health care for Latino children: Impact of child and parental birthplace on insurance status and access to health services	American Journal of Public Health
31	2006	Graves, J.A. & Long, S.K.	Why do people lack health insurance?	Urban Institute (Health Policy Online: Timely Analyses of Current Trends and Policy Options series.)
32	2009	Gresenz, C.R., Rogowski, J. &Escarce J.J.	Community demographics and access to health care among US Hispanics	Health Research & Educational Trust
33	2004	Grieco, Elizabeth	Health insurance coverage of the foreign born in the United States: Numbers and trends	Migration Policy Institute
34	2000	Guendelman, Sylvia & Wagner, Todd H.	Health services utilization among Latinos and white non-Latinos: Results from a national survey	Journal of Health Care for the Poor and Underserved
35	2014	Gutierrez, Natalia, Kindratt, Tiffany B., Pagels, Patti, Foster, Barbara & Gimpel, Nora E.	Health literacy, health information seeking behaviors and Internet use among patients attending a private and public clinic in the same geographic area	Journal of Community Health

Table 4.1. List of Publications Included in Meta-Study (cont.)

#	Year Published	Authors	Title	Journal / Published by
36	2003	Hadley, J.	Sicker and poorer—The consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income	Medical Care Research and Review (formerly Medical Care Review)
37	1997	Halfon, N., Wood, D. L., Valdez, R. B., Pereyra, M., & Duan, N.	Medicaid enrollment and health services access by Latino children in inner-city Los Angeles	The Journal of the American Medical Association
38	2003	Hargraves, J. Lee & Hadley, Jack	The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care	Health Services Research
39	2009	Heyman, J. M., Núñez, G. G., & Talavera, V.	Healthcare access and barriers for unauthorized immigrants in El Paso County, Texas	Family and Community Health
40	1991	Hubbell, F. A., Waitzkin, H., Mishra, S. I., Dombrink, J., & Chavez, L. R.	Access to medical care for documented and undocumented Latinos in a southern California county	Western Journal of Medicine
41	2015	Jadav, S., Rajan, S. S., Abughosh, S., & Sansgiry, S. S.	The role of socioeconomic status and health care access in breast cancer screening compliance among Hispanics	Journal of Public Health Management and Practice
42	2002	Jones, Mary Elaine, Cason, Carolyn L. & Bond, Mary Lou	Access to preventive health care: Is method of payment a barrier for immigrant Hispanic women?	Women's Health Issues
43	2013	Kamimura, Akiko, Christensen, Nancy, Tabler, Jennifer, Ashby, Jeanie & Olson, Lenora M.	Patients utilizing a free clinic: Physical and mental health, health literacy, and social support	Journal of Community Health
44	2012	Katz, Vikki S., Ang, Alfonso, & Suro, Roberto	An ecological perspective on U.S. Latinos' health communication behaviors, access, and outcomes	Hispanic Journal of Behavioral Sciences
45	2001	Ku, L., & Matani, S.	Left Out: Immigrants' Access To Health Care And Insurance	Health Affairs
46	2005	Lara, Marielena, Gamboa, Cristina, Kahramanian, M. Iya, Morales, Leo S. & Hayes Bautista, David E.	Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context	Annual Review of Public Health
47	2011	Law, J., & VanDerslice, J.	Proximal and distal determinants of access to health care among Hispanics in El Paso County, Texas	Journal of Immigrant and Minority Health (formerly Journal of Immigrant Health)
48	2009	Livingston, G. (2009)	Hispanics, health insurance and health care access	Pew Research Center
49	2001	Macias, E.P. & Morales L.S.	Crossing the border for health care	Journal of Health Care for the Poor and Underserved
50	2001	Manos, M. Michele, Leyden, Wendy A., Resendez, Cynthia I., Klein, Elizabeth G., Wilson, Tom L. & Bauer, Heidi M.	A community-based collaboration to assess and improve medical insurance status and access to health care of Latino children	Public Health Reports
51	1991	Markowitz, M. A., Gold, M., & Rice, T.	Determinants of health insurance status among young adults	Medical Care
52	2011	Maxwell, J., Cortes, D. E., Schneider, K. L., Graves, A., & Rosman, B.	Massachusetts' health care reform increased access to care for Hispanics, but disparities remain	Health Affairs
53	1989	McManus, Margaret A., Greaney, Ann M. & Newacheck, Paul W.	Health insurance status of young adults in the United States	Pediatrics
54	2002	Morales, Leo S., Kington, Raynard S., Valdez, Robert O. & Escarce, Jose J.	Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes	Journal of Health Care for the Poor and Underserved
55	2014	Padilla, Yolanda C., Scott, Jennifer L. & Lopez, Olivia	Economic insecurity and access to the social safety net among Latino farmworker families	Social Work
56	2008	Pearson, W.S., Ahluwalia, I.B., Ford, E.S. & Mokdad, A.H.	Language preference as a predictor of access to and use of healthcare services among Hispanics in the US	Ethnicity and Disease
57	2009	Perez, Debra, Ang, Alfonso & Vega, William A.	Effects of health insurance on perceived quality of care among Latinos in the United States	Journal of General Internal Medicine
58	2010	Perez-Escamilla, Rafael	Health care access among Latinos: Implications for social and health care reforms	Journal of Hispanic Higher Education
59	2000	Quinn, K., Schoen, C., & Buatti, L.	On their own: Young adults living without health insurance.	Commonwealth Foundation. Task Force on the Future of Health Insurance
60	2013	Ruiz, Erika, Aguirre, Regina T.P. & Mitschke, Diane B.	What leads non-US-born Latinos to access mental health care	Social Work in Health Care
61	2000	Schoen, C., & DesRoches, C.	Uninsured and unstably insured: the importance of continuous insurance coverage	Health Services Research
62	2015	Schoen, C., Radley, D., & Collins, S. R.	State trends in the cost of employer health insurance coverage, 2003-2013	Commonwealth Foundation. Task Force on the Future of Health Insurance
63	1995	Schur, C. L., Albers, L. A., & Berk, M. L.	Health care use by Hispanic adults: Financial vs. non-financial determinants	Health Care Financing Review
64	2001	Schur, C. L., Feldman, J. J., & Fund, C.	Running in place: How job characteristics, immigrant status, and family structure keep Hispanics uninsured	The Commonwealth Foundation. Task Force on the Future of Health Insurance
65	1987	Schur, Claudia L, Bernstein, Amy B. & Berk, Marc L.	The importance of distinguishing Hispanic subpopulations in the use of medical care	Medical Care
66	2007	Sharma, Ravi K., McGinnis, Kathleen A. & Documet, Patricia I.	Disparities in health status and health-service utilization among Hispanic ethnic subgroups	Social Work in Public Health (formerly Journal of Health & Social Policy)
67	2014	Siskin, A., & Lunder, E. K.	Treatment of noncitizens under the Affordable Care Act	Congressional Research Service
68	1990	Solis, Julia, M., Marks, Gary, Garcia, Melinda, & Shelton, David	Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982-84	American Journal of Public Health
69	2015	Stone, Lisa Cacari, Boursaw, Blake, Bettez, Sonia P., Marley, Tennille Larzelere & Waitzkin, Howard.	Place as a predictor of health insurance coverage: A multivariate analysis of counties in the United States	Health and Place
70	2013	Talavera-Garza, L., Ghaddar, S., Valerio, M., & Garcia, C.	Health care access and utilization among Hispanic manufacturing workers along the Texas-Mexico border	Journal of Health Care for the Poor and Underserved

Table 4.1. List of Publications Included in Meta-Study (cont.)

#	Year Published	Authors	Title	Journal / Published by
71	2013	The Henry J. Kaiser Family Foundation	Medicaid and the uninsured: Key facts on health coverage for low-income immigrants today under the Affordable Care Act	The Henry J. Kaiser Family Foundation
72	2013	Torres, Essie, Erwin, Deborah O., Treviño, Michelle & Jandorf, Lina	Understanding factors influencing Latina women's screening behavior: A qualitative approach	Health Education Research
73	2008	Torres, Myriam, Parra-Medina, Deborah, Bellinger, Jessica, Johnson, Andrew O. & Probst, Janice C.	Rural hospitals and Spanish-speaking patients with limited English proficiency	Journal of Healthcare Management
74	1991	Treviño, F. M., Moyer, M. E., Valdez, R. B., & Stroup-Benham, C. A.	Health insurance coverage and utilization of health services by Mexican Americans, mainland Puerto Ricans, and Cuban Americans	The Journal of the American Medical Association
75	1993	Valdez, Burciaga, Giachello, Aida, Rodriguez-Trias, Helen, Gomez, Paula & de la Rocha, Castulo	Improving access to health care in Latino communities	Public Health Reports
76	2013	Valenzuela, Jessica M., McDowell, Tiffany, Cencula, Lindsey, Hoyt, Lupe & Mitchell, Monica J.	¡Hazlo bien! A participatory needs assessment and recommendations for Health Promotion in Growing Latino Communities	American Journal of Health Promotion
77	2009	Vargas Bustamante, Arturo, Fang, Hai, Rizzo, John A. & Ortega, Alexander N.	Understanding observed and unobserved health care access and utilization disparities amogn U.S. Latino adults	Medical Care Research and Review (formerly Medical Care Review)
78	2013	Wallace, S. P., Torres, J., Sadegh-Nobari, T., & Pourat, N.	Undocumented and uninsured: barriers to Affordable Care for immigrant population	UCLA Center for Health Policy Research AND Commonwealth Fund
79	2002	Weigers Vitullo, Margaret & Taylor, Amy K.	Latino adults' health insurance coverage: An examination of Mexican and Puerto Rican subgroup differences	Journal of Health Care for the Poor and Underserved
80	2004	Weinick, Robin, Jacobs, Elizabeth, Stone, Lisa Cacari, Ortega, Alexander & Burstin, Helen	Hispanic healthcare disparities: Challenging the myth of a monolithic Hispanic population	Medical Care
81	2011	Wilkin, Holley A. & Ball-Rokeach, Sandra J.	Hard-to-reach? Using health access status as a way to more effectively target segments of the Latino audience	Health Education Research
82	2007	Wu, Shinyi, Ridgely, M. Susan, Escarce, Jose J., & Morales, Leo S.	Language access services for Latinos with limited English proficiency: Lessons learned from *Hablamos Juntos*	Journal of General Internal Medicine
83	2014	Zhan, F. Benjamin & Lin, Yan	Racial/Ethnic, socioeconomic, and geographic disparities of cervican cancer advanced-stage diagnosis in Texas	Women's Health Issues

phrases seemed to provide a solid way to obtain the broadest range of sources. Third, the further selection done through reviewing the list of references provided a good complement to the initial search mechanism. One way to feel confident about the mechanisms used was the presence of several repeat sources encountered in the list of references.

Data Extraction

The selection of articles for this study was done primarily based on those that included any type of analysis on issues that impact access to health care among Hispanics in the US. From the 85 articles fully read, 83 were included in the final count using this criterion. The first step of analysis involved identifying the various factors that are included in the 83 studies and then further separating the ones that covered acculturation and social capital. Acculturation and social capital aside, Table 4.2 includes the main factors that I found relevant to first highlight for this study: Hispanic ethnicity, Mexican ancestry/nativity, insurance, citizenship/immigration status and visit to a doctor's office.

Table 4.2. Main Variables Identified as Relevant to Hispanics' Access to Health Care

Main Variables Identified	Frequency of Quantitative Studies that Measured	Percentage of Quantitative Studies that Measured	Frequency of Quantitative Studies that Find Significance/ Importance	Percentage of Quantitative Studies that Find Significance / Importance	Frequency of Non-Quantiative Articles that find Relevant	Pecentage of Non-Quantitative Articles that Find Relevant	Frequency of Studies that Find Not Relevant (quantitative and non-quantitative)	Percentage of Studies that Find not Relevant (quantitative or non-quantitative)
Ethnicity. Hispanics have highest rates of uninsured (mainly used to measure potential access to health care) and/or lowest realized access to health care when compared to non-Hispanic whites and blacks. [1]	35	42%	33	40%	8	10%	2	2%
Mexican ancestry or nativity makes up the largest group of Hispanics and also the one with the lowest access to health care when compared to other Hispanic subgroups. [2]	14	17%	13	16%	3	4%	1	1%
Insurance treated as primary requirement to access medical services (i.e. main factor representing potential access) [3]	41	49%	40	48%	12	14%	1	1%
Insurance treated as a dependent variable that measures healthcare access.[4]	24	29%	N/A	N/A	N/A	N/A	N/A	N/A
Citizenship/immigration status included among major barriers to access medical services.	23	28%	21	25%	7	8%	2	2%
Visit to a doctor's office (past 12 months) treated as a variable to measure access.[5]	32	39%	NA	N/A	10	12%	0	0%

1. In some studies Asian/Pacific Islander also included, but not all. When included, most times Hispanics still worst off among all four major racial/ethnic groups.

2. Subgroups are primarily divided into: Mexicans, Pto. Ricans, Cubans, Central/SouthAmerican, and Other.

3. For quantitative studies this row includes the ones that include insurance as an independent variable or measure it comparing across other variables. All of the studies counted in this row (100%) used data collected before the ACA mandate that required insurance.

4. In 10 studies insurance was tested as both IV and DV.

5. Besides insurance and visit to a doctor's office (in past 12 months), other variables most commonly used to measure access include having a regular source of care, hospital use (past 12 months), screening (past 12 months), having continuous insurance, prescription drug expenditure (past 12 months), flu shot (past 12 months), and satisfaction with medical services accessed. Two other common variables used were counted among "visit to a doctor's office" for this study: going without needed care due to cost (past 12 months), returning for follow-up (past 12 months), having routine checkup (past 12 months). Counting in quantitative studies included those used as dependent variables. Counting in qualitative studies could be potentially used in quantitative either as an independent or dependent variable if measured.

Among those that included acculturation and social capital, studies were further classified as specifically measuring them (labeled "YES" in Tables 4.6 and 4.7) or alluding to them (labeled "ALLUDED" in Tables 4.6 and 4.7). In some of these studies, the terms acculturation and social capital were not used, but other terms used were identified as fitting into the definition of or being linked to the two concepts. For example, the study by Balcazar, Grineski, and Collins (2015) uses the term "cultural capital for healthcare access" to refer to acculturation. Other terms identified as being tied to acculturation include: cultural barriers (Callahan, Hickson, & Cooper, 2006); community health navigators (Dembe, Biehl, Smith, & de Gutierrez, 2013); cultural practices (Escobedo & Cardenas, 2006); educational efforts on preventive health (Ginzberg, 1991); cultural beliefs (Jadav, Rajan, Abughosh, & Sansgiry, 2015); cultural and linguistic differences (Jadav et al., 2015); health literacy (Kamimura, Christensen, Tabler, Ashby, & Olson, 2013); navigating an unfamiliar care system (Maxwell et al.,

2011); cultural factors (Maxwell et al., 2011; Schur, Albers, & Berk, 1995); health education services (Talavera-Garza, Ghaddar, Valerio, & Garcia, 2013) and; cultural competency (M. Torres, Parra-Medina, & Johnson, 2004).

With respect to social capital, an example includes the article by Documet and Sharma (2004) that addresses the importance of "informal arrangements" to access health care in the qualitative portion of the study. Other terms that relate to social capital in the literature include: informal arrangements (Documet & Sharma, 2004); social support (Fonseca-Becker et al., 2010); health educational programs conducted by community groups (Ginzberg, 1991); social networks (Gresenz et al., 2009; E. Torres, Erwin, Trevino, & Jandorf, 2013); networks (Heyman et al., 2009); interpersonal networks (Heyman et al., 2009); sense of community (Heyman et al., 2009); social support (Kamimura et al., 2013); informal health communication ecology (Katz et al., 2012); community-based organizations (Maxwell et al., 2011); social integration (Padilla, Scott, & Lopez, 2014); patient navigators (Perez-Escamilla, 2010); community health workers (Perez-Escamilla, 2010); social health capital (E. Torres et al., 2013); social support networks (Valenzuela, McDowell, Cencula, Hoyt, & Mitchell, 2013) and; integrated storytelling network (Wilkin & Ball-Rokeach, 2011).

In order to understand the worldviews that have been applied in these studies two other categories were used to extract data: field or disciplinary background of publication and methods applied. Websites for all journals and think tanks included in the 83 studies were reviewed to understand the focus of each and then they were classified into five groups: (1) PH, which stands for public health, applies to general or more applied (i.e. to a specific population and/or a specific disease) topics in health and health care from a

public policy perspective; (2) SS, which stands for social sciences, applies to other fields in the social sciences not specifically focusing on public health policy; (3) M, which stands for medical, applies to those oriented more towards medical issues (i.e. health itself but not tied to health services, such as treatments for specific diseases that have proven to be effective) but that also publish some articles on healthcare services; (4) B, which stands for business, are those focusing more on the business, economics, financial, and organizational structure of health care and; (5) PP, which stands for public policy, applies to general public policy (not just specifically to health and health care).

Studies were further classified by the type/s of methods applied. The Methods were divided into six categories: quantitative, qualitative, mixed, literature review, policy review and government report. These were further classified based on the region they covered including: national, local (community, city, or county level), multi-state, regional within a state (more than one county or several towns inside a state) and state-wide studies. Finally, publications were also identified as relying on primary or secondary data and the year/s the data was collected was specified.

C. Results

Findings in this section will be presented in the form of six main highlights, which will be briefly discussed and further supported by tables illustrating results. In addition to the variables in Table 4.2, the following variables appear often in the literature either as independent or control variables in quantitative studies or are discussed as relevant in non-quantitative studies:

- **Age** (16 studies): younger generation (ages 18-24) usually have lower access than older ones.
- **Gender** (14 studies): females tend to have better access than men overall.
- **Marital status** (10 studies): people who are married (and with children) tend to have better access than those who are single.
- **Income** (36 studies): households with lower income (still above federal poverty level, but low) and those in poverty have lower access than those of upper income.
- **Education** (24 studies): people with lower education levels in general have lower access when compared to those with higher levels.
- **Geographic location** (14 studies): there is a higher concentration of households with lower access in sates located in the South and West. In addition, some studies measure geographic distribution within cities, counties or states where there tends to be higher concentrations of poverty (Stone et al., 2015).
- **Sector** in which individual is employed (3 studies): people who are employed in agriculture, forestry, fishing, mining and construction tend to have less access than those in other sectors. Also, those employed by public sector tend to have better access than those in private sector.
- **Size of firm** in which individual is employed (2 studies): those employed by small firms tend to have lower access than those working for larger ones.
- **Job status** (17 studies): people who are employed in positions that are among the lowest paid (even within same large firms) tend to have lower access than those in upper positions. These positions include both part-time and full-time. Job status affects

potential access usually because either the firm does not offer insurance for lower-paid positions and/or part-time jobs or, when offered it is too costly based on salaries earned.

- **Cost/Affordability** of insurance and/or health care services (8 studies): this variable is taken into account for those who do not have insurance but also among those who have insurance. Some studies measure the increase in cost of premiums and deductibles over the years since the 1990s.

When we consider the variables above in conjunction, studies note that Hispanics overall are: overrepresented in the younger generation population (Quinn, Schoen, & Buatti, 2000); have a higher percentage of its population in lower income and poverty brackets (Callahan et al., 2006; Durden & Dean, 2013); have a higher representation of workers employed in agriculture, forestry, fishing, mining and construction (. Schur et al., 2001); tend to work for smaller firms (Vitullo & Taylor, 2002) , and there are higher concentrations of Hispanics established in states located in the South and West as well as within cities, states or counties where there are higher poverty concentrations (Stone et al., 2015). In general, lower paid jobs where Hispanics are overrepresented do not offer employer sponsored insurance in a country that primarily relies on this type of coverage. Even so, in full-time jobs that do offer employer sponsored insurance, blacks are far more likely to have insurance when compared to Hispanics (Vitullo & Taylor, 2002). As Heyman et al. (2009) point out, there is no single factor that can be said impacts the low levels of access of health care among Hispanics, but it is rather a web of interrelated issues. In the following highlights, more of these issues are presented.

1. A) A plethora of published articles, as well as number of journals, exist on Hispanics' access to health care in the field of public health

A total of 37 journals and 8 think tanks are included in this study. PH dominates the disciplinary background of publications, with 25 journals (63% of 37) and four think tanks (50% of 8) belonging to this field. The 25 journals identified in PH are responsible for a total of 44 publications or 53% of total articles identified (Tables 4.3 and 4.4). The four PH think tanks identified published seven studies and include: UCLA Center for Health Policy Research, The Commonwealth Foundation, Health Research and Educational Trust and The Henry J. Kaiser Family Foundation. Moreover, the majority of publications identified are peer-reviewed (71 articles; 85.5% of 83). The number of articles that focus on PH, whether peer reviewed journals or think tank publications, also represent the vast majority (51 articles or 61% of 83). The reason publications from these think tanks were included in addition to peer reviewed articles is because they appear to have a significant presence in the searches and they are often cited in several peer reviewed articles.

Table 4.3. Publications Classified by Disciplinary Background of Publication

Journal Classification Based on Field/Disciplinary Background	Frequency of Publications	Percentagge of Publications	Frequency of Peer Reviewed	Percentage of Peer Reviewed	Frequency published by Think Tanks	Percentage Published by Think Tanks
Business, economics, financial, or organizational (B)	10	12%	8	10%	1	1%
Medical issues but that also publish some general PH topics (M)	9	11%	8	10%	2	2%
General or more applied (i.e. to a specific population) topics in health and health care (PH)	51	61%	44	53%	7	8%
General public policy not strictly focused on PH (PP)	5	6%	0	0%	5	6%
Other social sciences not focusing on PH (SS)	7	8%	7	8%	0	0%
Mixed PH and SS	1	1%	1	1%	0	0%
TOTAL	**83**	**100%**	**68**	**82%**	**15**	**18%**

These numbers illustrate there is a rich literature in access to health care focusing on Hispanics. Accordingly, in the past 35 years, from 1981 to 2016, a large portion of these publications have been in outlets that focus on public health and less so on other social sciences fields. Likewise, the number of journals (25) and think tanks (4) focusing today on PH is notable.

Table 4.4 List of Journals in Public Health

	Journal / Published by	Disciplinary Background of Publication
1	American Journal of Health Promotion	PH
2	American Journal of Public Health	PH
3	Annual Review of Public Health	PH
4	Ethnicity and Disease	PH
5	Family and Community Health	PH
6	Health Affairs	PH
7	Health and Place	PH
8	Health Education Research	PH
9	Health Services Research	PH
10	Journal of Adolescent Health	PH
11	Journal of Community Health	PH
12	Journal of Health and Social Behavior	PH and SS
13	Journal of Health Care for the Poor and Underserved	PH
14	Journal of Immigrant and Minority Health	PH
15	Journal of Public Health Management and Practice	PH
16	Journal of Urban Health	PH
17	Pan American Journal of Public Health	PH
18	Psychiatric Services	PH
19	Public Health Reports	PH
20	Qualitative Health Research	PH
21	Social Science and Medicine	PH
22	Social Work in Health Care	PH
23	Social Work in Public Health (formerly Journal of Health & Social Policy)	PH
24	The Journal of Rural Health	PH
25	Women's Health Issues	PH

1. B) Epidemiological worldview dominates, while sociology is underrepresented

The epidemiological worldview has a disproportionate representation in the results obtained and is closely linked to the previous highlight discussed. Applying the epidemiologist lenses to research means that problems (i.e. research questions) are viewed through factors as opposed to having a holistic view of the issue.[17] In other words, if we use disease as an analogy, researchers are focusing on the symptoms, as

[17] A useful way to understand this is through the definitions of epidemiology offered by the Merriam Webster dictionary: (1) a branch of medical science that deals with the incidence, distribution, and control of disease in a population. (2) the sum of the factors controlling the presence or absence of a disease or pathogen.

opposed to the disease itself. Public health researchers are strongly influenced by this viewpoint, which also dominates the medical field and was likely borrowed from medicine (Raphael, 2006). As a result, the social determinants of health care identified in this meta-study lack a sociologist's perspective. As presented in Chapter 2, a true sociological perspective would focus the discussion on what is causing the inequalities in access, as opposed to solely the inequalities per se (Coburn, 2004; Eckersley, 2001; Waitzkin, 1978). Hence, the overrepresentation of the epidemiologist ideology goes hand in hand with an underrepresentation of the disciplinary field of sociology. Through the epidemiologist worldview, inequalities observed in healthcare access and health are often separated and measured by variables (i.e. the "symptoms" of the problem), but the underlying causes of those symptoms is not considered.

In the group of articles classified as SS (7 or 8% of 83), there are six journals and no think tanks (Table 4.5). In addition, there is one publication classified as both PH and SS, which is published by the American Sociological Association. All of these articles still address the issue primarily by applying the epidemiological lenses. Those that do touch on the structural problem of health care in the US, which is where this dissertation argues the root of the causes is found, still do not do so as part of their main analysis. The literature is hence a mirror of how access to health care has been addressed in the US for decades, a focus on the *symptoms* as opposed to the *disease.* Because research on this topic has practically ignored the structural causes, recommendations to improve access tend to solve the issue in a "patching" manner (Waitzkin, 1978).

Table 4.5. Publications in Social Sciences (non PH) Journals

# from Table 1	Year Published	Author/s	Title	Journal / Published by	Article addresses Structural Causes
3	1981	Andersen, R., Lewis, S. Z., Giachello, A. L., Aday, L. A., & Chiu, G.	Access to medical care among the Hispanic population of the southwestern US.	Journal of Health and Social Behavior	NO.
4	2015	Balcazar, A. J., Grineski, S. E., & Collins, T. W.	The durability of immigration-related barriers to hc access for Hispanics across generations	Hispanic Journal of Behavioral Sciences	BRIEFLY ALLUDES. The way "cultural capital for health care" (p. 131) is discussed in the conclusion alludes to structural causes, but the study does not specifically adress that.
15	2014	Castañeda, Heide & Melo, Milena A.	Health care access for Latino mixed-status families: Barriers, strategies and implications for reform	American Behavioral Scientist	SORT OF. Although structural issues are addressed, they focus more on immigration law as opposed to how the health care system is structured. The article does illustrate though how health care and immigration legisltation act in conjunction to discriminate against immigrants.
22	2013	Durden, Elizabeth T. & Dean, Lucy G.	Health insurance coverage of Hispanic adults: An assessment of subgroup difference and the impact of immigration	The Social Science Journal	YES, BUT IT DOES NOT QUESTION. "Structural acculturation" is discussed as a main issue to be addressed in order to increase access for Hispanics, but the emphasis is on expanding insurance coverage. Hence the structural issues in the health care system are not necessarily questioned. Instead, it is recommended that programs seeking to increase access focus on how to acculturate Latinos to the system.
23	2006	Durden, T. E., & Hummer, R. A.	Access to healthcare among working-aged Hispanic adults in the United States	Social Science Quarterly	SORT OF.Structural issues are partially addressed in the conclusion, but focus on how immigration legislation could solve for most of the divergences observed in low access among Hispanics, not on the healthcare system per se. The article does illustrate though how health care and immigration legisltation act in conjunction to discriminate against immigrants.
44	2012	Katz, Vikki S., Ang, Alfonso, & Suro, Roberto	An ecological perspective on U.S. Latinos' health communication behaviors, access, and outcomes	Hispanic Journal of Behavioral Sciences	NO. However, social networks called "inoformal health communication ecologies" are addressed as a means through which Hispanics could understand better the health care system and therefore improve their access.
55	2014	Padilla, Yolanda C., Scott, Jennifer L. & Lopez, Olivia	Economic insecurity and access to the social safety net among Latino farmworker families	Social Work	NO. But indirectly refers to immigration legislation and its negative impact on Hispanics' access to social welfare programs, among them public healthcare insurance.
58	2010	Perez-Escamilla, Rafael	Health care access among Latinos: Implications for social and health care reforms	Journal of Hispanic Higher Education	SORT OF. Among the policy recommendations given, there are some structural components discussed, such as, the need to shift emphasis from a "curative" model to a "preventive" model. Nonetheless, this shift will still focus on the individual more so than on the structure. Another policy recommendation focuses on universal access and ties this to immigration reform as well. In addition, it mentions how navigating such a complex health care system is a "daunting task," which alludes to the structural causes, but recommendations still focus on how to help individuals to navigate.

2. The way acculturation is covered as a factor impacting access is confusing

Of the 83 articles examined, 16 (19%) specifically aimed at understanding the impact of acculturation on access to health care among Hispanics (Table 4.6). However, not all of these articles use the term acculturation and the way acculturation is measured varies widely. All of the 16 studies, with the exception of three, find that acculturation does impact access. Overall, the impact of acculturation is measured on top of structural barriers imposed in conjunction with immigration and healthcare legislation, in most cases measured through insurance coverage. For the studies that measure or explore its impact, the general conclusion is that, on top of the structural barriers, Hispanics face cultural adjustment barriers when it comes to knowing how to access and navigate the healthcare system in the US. Navigating the system includes basic issues that most

Table 4.6. Studies Covering Acculturation

# from Table 1	Year Published	Authors	Title	Journal / Published by	Acculturation included as variable that impacts access
4	2015	Balcazar, A. J., Grineski, S. E., & Collins, T. W.	The durability of immigration-related barriers to healthcare access for Hispanics across generations	Hispanic Journal of Behavioral Sciences	YES. Acculturation , referred to as *cultural capital for healthcare access* , is tested through several proxy variables and found to be a barrier beyond 3rd generation Hispanic immigrants. It is specified that this kind of capital goes beyond just being fluent in English and having health insurance.
13	2006	Callahan, S. T., Hickson, G.B., & Cooper, W. O.	Health care access of Hispanic young adults in the US	Journal of Adolescent Health	YES. Variability in rates of uninsurance and health care access/utilization is tested and compared among Hispanic subgroups. The differences found among subgroups is attributed mainly to citizenship and sociodemographic factors, but authors also point that these do not account for all differences. Although acculturation is not specifically mentioned, cultural barriers, which is assumed vary by country of origin, are analyzed in the discussion. Overall, study recommends that the heterogeneity present within the Hispanic population should be taken into account when addressing issue of access. Term used *cultural barriers*.
14	2000	Carrasquillo, O., Carrasquillo, A. I., & Shea, S.	Health insurance coverage of immigrants living in the US: Differences by citizenship status and country of origin	American Journal of Public Health	ALLUDED. Study does not discuss acculturation, but it is alluded that acculturation is not the big issue to access health care as immigration laws that inhibit many Hispanics to obtain insurance are.
18	2013	Dembe, Allard E., Biehl, Jeffrey M., Smith, Alicia D. & Garcia de Gutierrez, Teresa	Employers' role in helping Latino workers obtain access to health care services: Results of a community-based pilot demonstration project	Journal of Immigrant and Minority Health	YES. Acculturation not discussed but difficulties in navigating the healthcare system allude to that. Study shows how a qualified community health navigator can be of great help in enhancing access among Hispanics, despite the absence of conventional health insurance coverage. Term used *community health navigators* .
20	2004	Documet, P. I., & Sharma, R. K.	Latinos' health care access: Financial and cultural barriers	Journal of Immigrant Health (Currently Journal of Immigrant and Minority Health)	YES. Although study finds no significant impact on acculturation on the quantitative portion, several cultural aspects emerged in the qualitative portion of study, including preference for warmer relationships with providers. Findings conclude that even if all Latinos had health insurance, there will still be large racial/ethnic disparities in access due to cultural issues. Acculturation measured using a scale tested in 1987 among Hispanics.
22	2013	Durden, Elizabeth T. & Dean, Lucy G.	Health insurance coverage of Hispanic adults: An assessment of subgroup difference and the impact of immigration	The Social Science Journal	YES. Acculturation and assimilation used interchangeably. Acculturation is tested based on time living in US and different Hispanic subgroups are compared. Study finds that disparities in health insurance coverage persist among subgroups even after accounting for immigration status and sociodemographic factors. The final analysis on the ACA concludes that the intersection with immigration legislation (i.e. structural barriers) will continue to be the major barrier to access among Hispanics, with acculturation to the system also being an issue.
23	2006	Durden, T. E., & Hummer, R. A.	Access to healthcare among working-aged Hispanic adults in the United States	Social Science Quarterly	ALLUDED. Study does not measure acculturation, but conclusions hint to the fact that acculturation may not be as significant of a factor as structural barriers related to immigration status and other usual barriers also faced by native-born individuals in the US.
24	2006	Echeverria, Sandra E., & Carrasquillo, Olveen	The roles of citizenship status, acculturation, and health insurance in breast and cervical cancer screening among immigrant women	Medical Care	YES. Acculturation is tested using a scale published by Marin et al. in 1987 but it is not clearly defined or explained. Disparities found in screening among Latinas and other groups disappear when accounting for acculturation. This study raises the importance of acculturation by saying that when acculturated to the importance of screening, sociodemographic factors and insurance coverage are not as important anymore for Latinas to access screenings.
25	2006	Escobedo, L. G., & Cardenas, V. M.	Utilization and purchase of medical care services in Mexico by residents in the United States of America, 1998-1999	Revista Panamericana de Salud Publica	ALLUDED. Medication purchases across the border in Mexico by NM residents are concluded to be linked to cultural practices common in Mexico. The cultural practices mentioned here refer to being accustomed to a specific type of healthcare system, which varies by country based on domestic legislation (in this case regulation of drugs betweem the US and Mexico). Cultural barriers (such as types of relationships formed between patients and providers) may also be impacting crossing the border for medical services as well. Still, structural barriers, mainly tied to insurance coverage, are found to be the key problem in accessing care in the US and the reason why so many cross the border for services. Term used *cultural practices*.
27	2010	Fonseca-Becker, Fannie, Perez-Patron, Maria J., Munoz, Beatriz, O'Leary, Michael, Rosario, Evelyn & West, Sheila K.	Health competence as predictor of access to care among Latinos in Baltimore	Journal of Immigrant and Minority Health	YES. Health Competence is tested through several variables that fall under two categories: "enabling factors" and "perceived barriers" which are found to impact access on top of socio-demographic factors. Acculturation is measured through English proficiency and length of residency, as part of the Health Competence scale used and is found to be a contributing factor in access.
29	1991	Ginzberg, E.	Access to health care for Hispanics	The Journal of the American Medical Association	ALLUDED. The discussion on the need to increase educational efforts on preventive health alludes to being acculturated to the American healthcare system, although it is not specifically discussed. Term used *educational efforts on preventive health.*
31	2006	Graves, J.A. & Long, S.K.	Why do people lack health insurance?	Urban Institute (Health Policy Online: Timely Analyses of Current Trends and Policy Options series.)	ALLUDED. Although acculturation was not specifically discussed here, the fact that less than 3% of uninsured Hispanics reported they did not need insurance means that the cost of insurance may be more relevant than cultural ideas linked to access for Hispanics.
32	2009	Gresenz, C.R., Rogowski, J. &Escarce J.J.	Community demographics and access to health care among US Hispanics	Health Research & Educational Trust	ALLUDED. Acculturation is not discussed in this paper, but the fact that US-born Mexican Americans who reside in heavily populated Spanish-speaking communities have less access than those who live in other communities hints to the idea that, a low level of acculturation to the healthcare system may be embedded in heavy Spanish-speaking communities.
40	1991	Hubbell, F. A., Waitzkin, H., Mishra, S. I., Dombrink, J., & Chavez, L. R.	Access to medical care for documented and undocumented Latinos in a southern California county	Western Journal of Medicine	YES. This article indirectly measures acculturation. Findings do not support the notion that health beliefs in the traditional Mexican culture strongly influence the behavior of Latinos seeking medical care. It is structural factors, primarily related to insurance coverage, that impact access the most for this group according to their findings. Term used *health beliefs in the traditional Mexican culture.*
41	2015	Jadav, S., Rajan, S. S., Abughosh, S., & Sansgiry, S. S.	The role of socioeconomic status and health care access in breast cancer screening compliance among Hispanics	Journal of Public Health Management and Practice	ALLUDED. Study does not address acculturation, but findings corroborate that low rates of screening as part of preventive medicine are not due to cultural beliefs, but structural barriers. When Hispanic women are educated about screening, the disparities with non-Hispanic white women practically disappear. Terms used *cultural and linguistic differences* and *cultural beliefs*.
42	2002	Jones, Mary Elaine, Cason, Carolyn L. & Bond, Mary Lou	Access to preventive health care: Is method of payment a barrier for immigrant Hispanic women?	Women's Health Issues	ALLUDED. Acculturation is not specifically measured, but it is alluded that Hispanics who are not acculturated to the system lack access.
43	2013	Kamimura, Akiko, Christensen, Nancy, Tabler, Jennifer, Ashby, Jeanie & Olson, Lenora M.	Patients utilizing a free clinic: Physical and mental health, health literacy, and social support	Journal of Community Health	ALLUDED. Health literacy, as the part that applies to accessing healthcare services, included in this study can be tied to acculturation of the healthcare system and is found to impact access. Terms used *health literacy.*
45	2001	Ku, L., & Matani, S.	Left Out: Immigrants' Access To Health Care And Insurance	Health Affairs	ALLUDED. Study briefly mentions that immigrants' health care use increases as they acculturate (but no definition or further analysis provided).
46	2005	Lara, Marielena, Gamboa, Cristina, Kahramanian, M. Iya, Morales, Leo S. & Hayes Bautista, David E.	Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context	Annual Review of Public Health	YES. The term acculturation is extensibly analyzed providing a historical perspective on the use of the term as well as how it's been used interchangeably with assimilation.
49	2001	Macias, E.P. & Morales L.S.	Crossing the border for health care	Journal of Health Care for the Poor and Underserved	ALLUDED. The fact that the majority of people crossing the border for care would prefer to access care in the US alludes to the lack of acculturation to the complex healthcare system they might have due to the fact that there is available assistance at the local level, for which most would qualify.
50	2001	Manos, M. Michele, Leyden, Wendy A., Resendez, Cynthia I., Klein, Elizabeth G., Wilson, Tom L. & Bauer, Heidi M.	A community-based collaboration to assess and improve medical insurance status and access to health care of Latino children	Public Health Reports	ALLUDED. The complexity and bureaucratic healthcare system are proven to be a barrier to access health care for Latino children. The lack of understanding of how the system functions alludes to the need of being acculturated to the system.
52	2011	Maxwell, J., Cortes, D. E., Schneider, K. L., Graves, A., & Rosman, B.	Massachusetts' health care reform increased access to care for Hispanics, but disparities remain	Health Affairs	YES. Although acculturation is just briefly mentioned, one of the main recommendations is to simplify enrollment and reenrollment processes of the state's health insurance system in order to improve access for Latinos. Also recommend to provide assistance in finding a provider and navigating an unfamiliar care system. These factors hint precisely to the lack of acculturation to the complex healthcare system. There is confusion first in getting insurance, then in using insurance, then in keeping insurance continuously, and finally finding and keeping a primary care provider. Just existing outreach and enrollment programs that are more common across the nation may not be enough (i.e. getting them insured) for increasing access for Hispanics. Hispanics in this study serve to illustrate how awkward, expensive and complex the American healthcare system has come to be. Terms used *navigating an unfamiliar care sytstem* and *cultural factors*.
54	2002	Morales, Leo S., Kington, Raynard S., Valdez, Robert O. & Escarce, Jose J.	Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes	Journal of Health Care for the Poor and Underserved	YES. Acculturation reviewed in this paper as part of health paradox (as access increases, health worsens) assumed among Latinos in the US. Health paradox is confirmed overall for Hispanics, but, subgroups do not confirm the paradox: health paradox is most striking among Mexican origin; when analyzing by disease paradox disappears; Puerto Ricans appear to be the ones least exhibiting health paradox.
56	2008	Pearson, W.S., Ahluwalia, I.B., Ford, E.S. & Mokdad, A.H.	Language preference as a predictor of access to and use of healthcare services among Hispanics in the US	Ethnicity and Disease	YES. Results suggest that acculturation does play a role with access and is linked to time spent in the US, citizenship status, and type of employment. Acculturation is measured through citizenship and employment status.
58	2010	Perez-Escamilla, Rafael	Health care access among Latinos: Implications for social and health care reforms	Journal of Hispanic Higher Education	ALLUDED. Acculturation not discussed in this study, but the finding that patient navigators/community health workers increase access for Latinos allude to the importance of the need to acculturate to the healthcare system.
60	2013	Ruiz, Erika, Aguirre, Regina T.P. & Mitschke, Diane B.	What leads non-US-born Latinos to access mental health care	Social Work in Health Care	YES. The Marin & Gamba (1996) scale is used to measure acculturation. Authors conclude acculturation (marginalized, separated, integrated, assimilated) is not found to be a factor in acces (but the English portion of the scale is found to be significant, which alludes to assimilation being a factor).
63	1995	Schur, C. L., Albers, L. A., & Berk, M. L.	Health care use by Hispanic adults: Financial vs. non-financial determinants	Health Care Financing Review	YES. Acculturation is referred to as *cultural factors* and measured through "language spoken," but is found to not be a significant factor as opposed to financial factors. Insurance is identified as primary financial factor.
66	2007	Sharma, Ravi K., McGinnis, Kathleen A. & Documet, Patricia I.	Disparities in health status and health-service utilization among Hispanic ethnic subgroups	Social Work in Public Health (formerly Journal of Health & Social Policy)	ALLUDED. Acculturation is not mentioned nor discussed, but some of the considerable heterogeneity in health status and healthcare utilization among Hispanic subgroups could possibly tie to cultural differences that impact access. The majority of these differences though are tied to immigration status and socioeconomic factors that also widely differ among subgroups.
68	1990	Solis, Julia, M., Marks, Gary, Garcia, Melinda, & Shelton, David	Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982-84	American Journal of Public Health	YES. Acculturation (measured by level of spoken and written English) does not predict access as much as structural factors.
70	2013	Talavera-Garza, L., Ghaddar, S., Valerio, M., & Garcia, C.	Health care access and utilization among Hispanic manufacturing workers along the Texas-Mexico border	Journal of Health Care for the Poor and Underserved	ALLUDED. The study does not measure or discuss acculturation, but one of their main recommendations is for employers to offer worksite health education services on the use of preventive care, which alludes to acculturation of the American healthcare system. Term used *health education services.*
72	2013	Torres, Essie, Erwin, Deborah O., Treviño, Michelle & Jandorf, Lina	Understanding factors influencing Latina women's screening behavior: A qualitative approach	Health Education Research	ALLUDED. Although this study only once mentions acculturation as an issue, findings overall hint to the fact that women who were more acculturated to the healthcare system had better access. Term used *cultural competency.*
73	2008	Torres, Myriam, Parra-Medina, Deborah, Bellinger, Jessica, Johnson, Andrew O. & Probst, Janice C.	Rural hospitals and Spanish-speaking patients with limited English proficiency	Journal of Healthcare Management	ALLUDED. This study measures barriers more from a providers' perspective, so the lack of cultural competency among healthcare providers can be linked to acculturation but more from the side of the receiving community.
76	2013	Valenzuela, Jessica M., McDowell, Tiffiny, Cencula, Lindsey, Hoyt, Lupe & Mitchell, Monica J.	¡Hazlo bien! A participatory needs assessment and recommendations for Health Promotion in Growing Latino Communities	American Journal of Health Promotion	ALLUDED. Although acculturation is briefly mentioned as part of the health paradox, in general the study is focusing on the importance of helping Latinos to acculturate to the healthcare system in order to improve access.
77	2009	Vargas Bustamante, Arturo, Fang, Hai, Rizzo, John A. & Ortega, Alexander N.	Understanding observed and unobserved health care access and utilization disparities amogn U.S. Latino adults	Medical Care Research and Review (formerly Medical Care Review)	YES. Although this study does not specifically label any variables as acculturation, the "country of origin" variable measures cultural differences among subgroups in the Latino population. The authors point out that cultural values regarding how people access health care in their home country impact this. It is also briefly stated that the acculturation process specifically tied to the healthcare system may take longer than other types of acculturation.

Note: In Italics, terms used that relate to acculturation when acculturation is not explicitly used.

Americans are already used to (although may not be satisfied with), such as understanding that you will be asked for your insurance when trying to set up an appointment with a specialist, or knowing that you do not get the medical bill when you check out from a hospital/clinic (and will instead receive it in the mail), or knowing the need to have a prescription to purchase a common antibiotic, and so on.

In addition, there are 18 (22% of 83) studies that allude to acculturation as an impact on access, but six of those only minimally discuss acculturation as a possible link to access. Four of the articles measure disparities in access by subgroups within the Hispanic population, therefore addressing the heterogeneity present. However, the heterogeneity is not just due to cultural differences, but also from effects stemming from immigration legislation as well as socioeconomic differences.[18]

The main problem encountered in the literature regarding the impact of acculturation is that the majority (not all though) do not really define acculturation. Some discuss acculturation briefly in the literature review, but not much explanation is offered on how the decision to operationalize was made when measuring it as a variable. In fact, most of the studies simply assume the reader is familiar with the term. The problem with this assumption, as illustrated in Chapter 3, is that acculturation varies widely in its definition.

There is also no consensus among researchers in how they think acculturation should be operationalized. Because there is no overall agreed upon theory on acculturation, researchers must do a better job specifying definitions and explaining why they decided to operationalize this variable in the way they did. In other words, it is important for others to be able to understand the logic behind why they are choosing

[18] Examples may help in understanding the impact of such. Puerto Ricans for instance, are American citizens, so they qualify for public health insurance. Mexican immigrants are usually a target of discrimination through immigration and healthcare legislation. Hence, Mexican immigrants, if undocumented do not have access to public health insurance as Puerto Ricans do (Vitullo & Taylor, 2002). During the Cold War, Cubans who migrated to the US were given a refugee status and several preferential treatments, including gaining quick citizenship status. In addition, most of the Cubans who migrated to the US were of higher socioeconomic status with higher educational levels. As a result, Cubans gained access to things that Mexican immigrants of low socioeconomic status and lower educational levels do not have, such as access to medical insurance (Portes, 1995).

certain definitions and ways to measure acculturation. Here are some examples of how authors are operationalizing acculturation:

- Balcazar et al. (2015) measures access to health care through binary logistic regressions using immigrant generational status (measured through nativity of children, nativity of parents and nativity of all grandparents) as the main independent variable. Being "fully assimilated" is then tested through a set of dependent variables including: person has insurance, has a regular doctor, has transportation to get to medical care, has no financial barriers and speaks fluent English. Fully assimilated is therefore used interchangeably with being acculturated (i.e. being fully able to navigate the healthcare system) meaning having "great stocks of cultural capital" or that they have "formal and informal knowledge related to navigating the healthcare system to achieve better access and outcomes" (p. 131).
- Callahan et al. (2006) measure access through having insurance, having a usual source of care, not delaying care due to cost, and having a health professional contact. Different backgrounds within the Hispanic population are compared and differences in access among subgroups are partly attributed to acculturation. In this case, acculturation per se is not measured, but it is implied that different cultural backgrounds among the subgroups may play a role in access.
- Documet and Sharma (2004) use a scale developed by Marin, Sabogal, Marin, Otero-Sabogal, and Perez-Stable (1987).
- Durden and Dean (2013) use the term "structural acculturation" and measure this through nativity, duration (length of time living in the US) and naturalization. In this study, acculturation and assimilation are used interchangeably.

- Echeverria and Carrasquillo (2006) also use the scale developed by (Marin et al., 1987).
- Fonseca-Becker et al. (2010) measure acculturation through language proficiency and length of residence.
- Maxwell et al. (2011) rely on language and cultural factors, which mainly refer to the ability to navigate the American healthcare system by having insurance and a primary care provider.
- Pearson, Ahluwalia, Ford, and Mokdad (2008) measure acculturation through citizenship status and employment status. They assume that those most acculturated have acquired the capitals that enabled them to obtain citizenship and better jobs and therefore should also be more acculturated to the healthcare system.
- Ruiz, Aguirre, and Mitschke (2013) use the Marin and Gamba (1996) scale[19] of acculturation. They find that acculturation has no impact on access. They use both the English and the Spanish portion of the scale to conclude this based on the four types of acculturation levels that rely on this multi-dimensional scale: marginalized, separated, integrated, and assimilated. However, when including only the English portion of the scale, the results show that these have impact on access.
- Schur et al. (1995) measure acculturation through "language spoken."
- Solis et al. (1990) use level of spoken and written English to measure acculturation.

[19] This is the same scale used in the survey study in the next chapter of this dissertation. In this dissertation only the English portion of the scale that measures how acculturated people have become to the American way of life is used, while the Spanish portion is not included. More on this is discussed in the next chapter.

- Vargas Bustamante, Fang, Rizzo, and Ortega (2009) do not specifically use acculturation, but differences in access found among Hispanic subgroups hint to cultural differences partly being responsible for impacting access.

Regardless of some inconsistencies in the research, it is nonetheless clear from the literature reviewed in the previous chapter and from this meta-study that an acculturation process to the complex American healthcare system is (informally) required in order to access medical services for Hispanics who come from families with different worldviews. Consequently, the first hypothesis tested in the next chapter is:

H_1: Higher levels of acculturation to the American way of life among Hispanics are associated with higher chances of accessing health care.

Furthermore, all articles addressing acculturation touch on the importance of structural barriers imposed by federal immigration and healthcare legislation. As presented in Chapter 2, health insurance in the US is first dependent on citizenship and immigration status. Immigrants who are unlawfully residing in the US (labeled as unauthorized, undocumented or illegal) cannot purchase insurance through the Affordable Care Act's marketplace, nor usually get employment-based insurance (if they get it, they most certainly cannot use it), nor access any of the public-based insurance (Medicaid, CHIP, or Medicare). Hence, no matter how acculturated someone is to the American way of life, if that person is undocumented, it is highly unlikely for that person to have insurance.[20] In

[20] "Highly unlikely" is used here instead of "impossible," because some undocumented workers are offered insurance, but at the time they need to use it, they can't because insurance companies will use their immigration status to deny access. Typically, the insurance company will notify the employer of the undocumented status and the employer will usually follow by firing the employee. Situations like this happen because some employers do not ask for immigration documentation when hiring, the driver's

addition, there are further restrictions on lawfully residing immigrants to obtain subsidies through the ACA (Refer to Table 2.1). In other words, no matter how acculturated an immigrant is, there will be restrictions to obtain insurance coverage that is imposed through federal legislation. Thus, there is an interactional effect between acculturation and health insurance that derives from legal status that in the end impacts access to health care. From this, I derive the second hypothesis:

H_2: There is an interactional effect between acculturation and health insurance status that derives from legal status that impacts access to health care.

If this hypothesis proves to be significant, it implies that acculturation alone may not be enough to overcome the structural barriers imposed through federal legislation for undocumented Hispanics and perhaps those who are not qualifying for subsidies.

3. Social capital is not covered in depth as a factor impacting access

Social capital is much less covered than acculturation in the literature (Table 4.7). There are 7 (8% of 83) publications that specifically measure social capital, although only one of them uses the term. Additionally, there are 7 articles that allude to social capital by minimally directly or indirectly discussing social capital, among them only one explicitly uses the term. So, among all publications included in this study, only two actually use the term social capital. For those that actually measure the impact of social capital, the ways it is being measured also varies as it did with acculturation. The following are examples of how studies are operationalizing social capital:

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license will suffice and drivers' licenses in some states do not require immigration documents. In other cases, the employee uses a fake identification when being hired and when needed to access insurance this will be spotted by the insurance company.

- Documet and Sharma (2004) explore the impact of social capital by identifying how "social arrangements" can make a difference in access through a qualitative study.
- Kamimura et al. (2013) use the first eight questions (5-point Likert scale) from the Medical Outcomes Study Social Support Survey (MOS-SSS) that measure emotional social support available. There is not much description of the questions, except that one is given as an example: "is there someone you can count on to listen to you when you need to talk?" (p. 718).
- Katz et al. (2012) explore whether a rich set of informal health communication connections to friends, family, radio, television, Internet, newspapers, magazines, churches, and community organizations can aid in access. This set is referred to as the "informal health communication ecology" index.
- Maxwell et al. (2011) test the importance of community-based organizations in helping people navigate the healthcare system after the Massachusetts' Health Care Reform (on which the ACA was modeled) was implemented. These organizations are proven to have a positive impact on access for Hispanics after applying quantitative and qualitative studies in the state of Massachusetts.
- Perez-Escamilla (2010) identifies an important variable in the literature that has proven to impact access: patient navigators/community health workers. These are also known as *promotoras de salud* or peer counselors, which, according to the author, have proven to work effectively in developing countries before being used in the US.
- Through a qualitative study, E. Torres et al. (2013) identify how "social health capital" (which could be interpreted as bridging social capital) is a factor that

impacts screening utilization among Latinas. Also, "social networks" (which could be interpreted as bonding social capital) are identified as important in improving screening for Latinas.

- Wilkin and Ball-Rokeach (2011) measure the impact of bonding social capital through family and friends and bridging social capital through health professionals. Those who are better connected to people who understand the healthcare system have better access.

Table 4.7. Studies Covering Social Capital

# from Table 1	Year Published	Authors	Title	Journal / Published by	Social Capital included as variable that impacts access
4	2015	Balcazar, A. J., Grineski, S. E., & Collins, T. W.	The durability of immigration-related barriers to healthcare access for Hispanics across generations	Hispanic Journal of Behavioral Sciences	ALLUDED. Social capital is not specificially measured, but it is discussed that as future generations of immigrants accumulate social capital, they are expected to improve their access as a result of that.
20	2004	Documet, P. I., & Sharma, R. K.	Latinos' health care access: Financial and cultural barriers	Journal of Immigrant Health (Currently Journal of Immigrant and Minority Health)	YES. Although social capital is not specifically measured, the importance of social networks (*informal arrangements*) to access health care appeared in the qualitative portion of study. The social networks represent a form of social capital.
27	2010	Fonseca-Becker, Fannie, Perez-Patron, Maria J., Munoz, Beatriz, O'Leary, Michael, Rosario, Evelyn & West, Sheila K.	Health competence as predictor of access to care among Latinos in Baltimore	Journal of Immigrant and Minority Health	ALLUDED. Bonding social capital is alluded but not specifically stated or measured as social capital.Term used *social support.*
29	1991	Ginzberg, E.	Access to health care for Hispanics	The Journal of the American Medical Association	ALLUDED. Although social capital is not mentioned, discussion briefly recommends the use of community groups to educate Hispanics on preventive health care. Term used *health educational programs conducted by community groups.*
32	2009	Gresenz, C.R., Rogowski, J. &Escarce J.J.	Community demographics and access to health care among US Hispanics	Health Research & Educational Trust	ALLUDED. Social capital is not explicitly measured or discussed, but *social networks* are discussed as a possible impact in heavily populated Spanish-speaking communities. For recent immigrants, living in areas more heavily populated by Spanish-speakers is associated with better access, the opposite is true for US-born Mexican Americans. The differences observed in access between more recent immigrants compared to US-born Hispanics, raise the importance for researchers to compare different types of social capital among different Hispanic sub-groups.
39	2009	Heyman, J. M., Núñez, G. G., & Talavera, V.	Healthcare access and barriers for unauthorized immigrants in El Paso County, Texas	Family and Community Health	ALLUDED. Social capital is not explicitly analyzed here, but the resilience patterns discussed that promote access to health care, which included use of networks and sense of community, allude to social capital being an enabler in access. Terms used *networks, interpersonal networks* and *sense of community.*
43	2013	Kamimura, Akiko, Christensen, Nancy, Tabler, Jennifer, Ashby, Jeanie & Olson, Lenora M.	Patients utilizing a free clinic: Physical and mental health, health literacy, and social support	Journal of Community Health	YES. But it is referred to as *social support* (not further specified) and is found to enhance access.
44	2012	Katz, Vikki S., Ang, Alfonso, & Suro, Roberto	An ecological perspective on U.S. Latinos' health communication behaviors, access, and outcomes	Hispanic Journal of Behavioral Sciences	YES.The term *informal health communication ecology* index is treated in this study as social capital. What can be classified as bonding social capital (term not used in the study) can be detrimental to improve access for Hispanics of lower social status. Hispanics of higher social status have more valuable social capital overall that improves access.
52	2011	Maxwell, J., Cortes, D. E., Schneider, K. L., Graves, A., & Rosman, B.	Massachusetts' health care reform increased access to care for Hispanics, but disparities remain	Health Affairs	YES. Social capital is not specifically mentioned, but *community-based organizations* that provided enrollment counseling services were found to be crucial in helping bridge disparities in insurance coverage. These organizations would be classified as bridging social capital.
55	2014	Padilla, Yolanda C., Scott, Jennifer L. & Lopez, Olivia	Economic insecurity and access to the social safety net among Latino farmworker families	Social Work	ALLUDED. *Social integration* in this study can be related to social capital as an enabler to access welfare programs in the US.
58	2010	Perez-Escamilla, Rafael	Health care access among Latinos: Implications for social and health care reforms	Journal of Hispanic Higher Education	YES. Social capital not discussed in this study, but the finding that *patient navigators* and *community health workers* increase access for Latinos refer to the importance of this type of social capital (i.e. bridging) that can be instituted at the community level.
72	2013	Torres, Essie, Erwin, Deborah O., Treviño, Michelle & Jandorf, Lina	Understanding factors influencing Latina women's screening behavior: A qualitative approach	Health Education Research	YES. *Social health capital* (used as bridging social capital) emerged as a factor impacting screening utilization among Latinas. Also, "social networks" (used as bonding social capital) do appear to impact screening for Latinas.
76	2013	Valenzuela, Jessica M., McDowell, Tiffany, Cencula, Lindsey, Hoyt, Lupe & Mitchell, Monica J.	¡Hazlo bien! A participatory needs assessment and recommendations for Health Promotion in Growing Latino Communities	American Journal of Health Promotion	ALLUDED. Social capital is not discussed but the recommendations they give regarding the need to provide *social support networks* as part of health promotion programs allude to bridging social capital.
81	2011	Wilkin, Holley A. & Ball-Rokeach, Sandra J.	Hard-to-reach? Using health access status as a way to more effectively target segments of the Latino audience	Health Education Research	YES. Although social capital is not mentioned in this paper, two forms of social capital are alluded to in what they measured: family and friends (bonding social capital) and health professionals (bridging social capital). Findings suggest that those better connected to an *integrated storytelling network* have better access regardless of having insurance or regular source of care.

Note: In Italics, some terms used that relate to social capital when the terms is not explicitly used

Overall, there is inconsistency in how researchers label social capital and almost no study in the sample uses this term specifically. The literature on social capital discussed in the previous chapter illustrates that there is already some consensus in the social sciences in how to define the term. Therefore, the literature on Hispanics' access to

health care would benefit from adopting the use of the term social capital. In addition, the need to further classify social capital into different types – mainly bonding, bridging and linking – is critical when measuring impact. In the case of immigrants, this differentiation becomes even more critical when we observe that the possibility of social capital stemming from networks that are not integrated into the American society could be present and if so, it may actually be detrimental to access, as the studies by Gresenz et al. (2009) and Katz et al. (2012) illustrate.

Overall, the general analysis on social capital in Chapter 3 leads us to infer that the three types of social capital can all act as enablers to access healthcare. However, in the case of immigrants the answer may be: it depends on how integrated their networks of social capital are to the American society. For instance, if most of the family members with whom a Mexican immigrant interacts with are residing in Mexico, then bonding social capital for this particular immigrant will be useless in helping this immigrant to access health care in the US. For this reason, it is important that different types of social capital be measured separately.

In five articles, based on the descriptions provided, I was able to further classify the types of social capital they were using. Both bonding and bridging social capital appear in the literature as having been measured or at least discussed as an enabler to access health care. It is clear from these articles that bridging social capital increases access. However, bonding social capital show mixed results, in some cases serving as an enabler and in others as a constraint. Again, none of these studies explicitly uses these terms. Thus, based on what was discussed in the previous chapter and what was found in

this meta-analysis, three hypotheses for social capital are tested in the next chapter separating the three types:

H_3: Higher levels of bonding social capital are associated with higher levels of access to health care.

H_4: Higher levels of bridging social capital are associated with higher levels of access to health care.

H_5: Higher levels of linking social capital are associated with higher levels of access to health care.

I want to clarify that based on the mixed results found in the literature, I recognize H_3 could be stated in the opposite direction (i.e. higher levels of bonding social capital may hinder access). The fact that Hispanics are relatively newcomers to the state of Missouri makes me more inclined to hypothesize the way I selected to do so. There is one study in particular that discusses how bonding social capital enables access for recent newcomers, but it could hinder access for Hispanics who have been born in the US or residing for longer periods (Gresenz et al., 2009). It is difficult, however, to draw the line that defines how many years are needed to be considered a more established resident.

4. Quantitative studies relying on national secondary data sets dominate, while Missouri is not represented in states or regional studies

Among the 83 publications included, 51 (61%) are national, 19 (23%) are local, 3 multi-state, 3 regional within a state, and 3 state-wide studies (Table 4.8). Texas and California are overrepresented in the groups that do not belong to national. A total of 10 (12%) focus on Texas and 8 (10%) on California. On the other hand, 7 studies focus on the Midwest, three of those are solely in Ohio, and none include the state of Missouri.

Quantitative studies dominate in the topic of Hispanics' access to health care, with 64 (77%) belonging to quantitative; 8 (10%) are literature review, policy review or government report; 8 (10%) qualitative; and, 3 (4%) mixed-methods. In the same way, secondary data is overrepresented with 46 (55%) articles relying on it, 30 (36%) use primary data, while 3 use a combination of primary and secondary. Further, the 51 national studies include 43 (52%) quantitative that primarily rely on secondary data and 8 that are literature review, policy review or government report. Of the literature reviews included, none specify being a meta-study, but two could be partly classified as such.

5. Hispanics having the least access to health care is a recurring problem in the US

Publications in this meta-analysis illustrate that the issue of Hispanics being the group having the lowest access to health care has been a recurring problem for over five decades, since the 1960s. The data used in all these studies corroborate this problem. Data in the studies included were collected between the periods of 1975 and 2014 (Table 4.8), while the literature reviews, policy reviews and government report studies cite references that date from 1960 to 2014. Moreover, every article analyzed, with the exception of one, treats insurance (either explicitly or implicitly) as the first informal requirement to access medical services. When accounting solely for insurance, 53 (64%) of the articles, measure or discuss it at as an important factor in access (Table 4.2). Displayed in Table 4.2, it can be observed that Hispanics have recurrently been identified as the largest group, mainly compared to non-Hispanic whites and blacks[21] (and

[21] In the introduction I presented the following numbers to illustrate the differences. Hispanics consistently show the highest rates of uninsured (29%) when compared to non-Hispanic-white (11%), blacks (19%), or Asian (15%) (DeNavas-Walt et al., 2013; Doty & Holmgren, 2006).

sometimes including Asian/Pacific Islander), that have the lowest access to health care (primarily, but not solely measured by having insurance coverage) in the US, both at the national and local levels; 35 (42%) studies measure Hispanic ethnicity while 8 (10%) others non-quantitatively analyze it as relevant. Among those studies, only 2 (2%) find that Hispanic ethnicity is not an issue in potential (mainly measured by insurance coverage) and realized access.

From a sociology perspective, what is most relevant about the insurance requirement is that it was not formal (i.e. required by law) until the Affordable Care Act came into effect in late 2014. Among the studies that explicitly measure or discuss insurance as a primary requirement to access health care in the US, 53 (64%), none use data after the ACA enforcement (Table 4.2). So, the particular outcome of a high proportion of Hispanics recurrently showing a lack of the first needed requirement to access health care, indicates that structural barriers and institutionalized discrimination are present. These concepts are further discussed in Chapter 2. Accordingly, insurance is included in the logistic regression model in the next chapter as a **control variable**.

The high levels of uninsured among Hispanics relate to two other factors: the over-reliance on employment-based insurance and the intersection between federal immigration and healthcare legislation. Employment-based coverage is the primary source of insurance in the US (Fronstin, 2013). The neoliberal worldview that governs health care assumes the market would eventually cover everyone who has a job. However, the numbers point not only to exclusion of certain groups, but also to trends

Table 4.8. Methods Used

#	Year Published	Authors	Title	Journal / Published by	Methods	Data used	Region Covered	Year/s of Data Used
1	2002	Alegría, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., & Ortega, A. N.	Mental HC for Latinos: Inequalities in sue of specialty mental health services among Latinos, African Ams, and Non-Latino whites.	Psychiatric Services	Quantitative using Survey	2ary	National	1990 to 1992
2	1986	Andersen, R. M., Giachello, A. L., & Aday, L. A.	Access of Hispanics to hc and cuts in services: A state of the art overview	Public Health Reports	Quantitative using Survey	2ary	National	1982
3	1981	Andersen, R., Lewis, S. Z., Giachello, A. L., Aday, L. A., & Chiu, G.	Access to medical care among the Hispanic population of the southwestern US.	Journal of Health and Social Behavior	Quantitative using Survey	1ary	National	1975-1976
4	2015	Balcazar, A. J., Grineski, S. E., & Collins, T. W.	The durability of immigration-related barriers to hc access for Hispanics across generations	Hispanic Journal of Behavioral Sciences	Quantitative using survey	1ary	El Paso, Texas	2012
5	2015	Bauer, Scott R., Monuteaux, Michael C., & Fleegler, Eric W.	Geographic disparities in access to agencies providing income-related social services	Journal of Urban Health	Quantitative using Census and mapping data	2ary	Boston	2000 & 2010
6	2004	Blewett, Lynn A., Casey, Michelle, & Call, Kathleen Call	Improving access to primary care for a growing Latino population: The role of safety net providers in the rural Midwest	The Journal of Rural Health	Qualitative using multiple case study plus Census Data to select locations	1ary and 2ary	Midwest: Marshalltown, IA; Great Bend, KS; and Nofolk, NE	2000, 2001 & 2002
7	2003	Blewett, Lynn A.,Smaida, Sally A., Fuentes, Claudia, & Zuehlke, Ellie U.	Health care needs of the growing Latino population in rural America: Focus group findings in one midwestern state	The Journal of Rural Health	Qualitative using focus groups	1ary	Minnesota: Worthington, Pelican Rapids, St James.	1999
8	2009	Britigan, Denise H., Murnan, Judy, & Rojas-Guyler, Liliana	A qualitative study examining Latino functional health literacy levels and sources of health information	Journal of Community Health	Qualitative using interviews	1ary	Ohio: 2 southwest counties	2007
9	2000	Brown, E. R., Wyn, R., & Teleki, S.	Disparities in health insurance and access to care for residents across US cities	UCLA Center for Health Policy Research	Quantitative using 2 surveys	2ary	National	1995, 1996 & 1998
10	2009	Byrd, Theresa L. & Law, Jon G.	Cross-border utilization of health care services by United States residents living near the Mexican border	Pan American Journal of Public Health	Quantitative using survey	1ary	Texas: El Paso	2007
11	2004	Callahan, S. T., & Cooper, W. O.	Gender and uninsurance among young adults in the US	Pediatrics	Quantitative using same survey for different years	2ary	National	1998, 1999 & 2000
12	2005	Callahan, S. T., & Cooper, W. O.	Uninsurance and hc access among young adults in the US	Pediatrics	Quantitative using same survey for different years	2ary	National	1998 to 2001
13	2006	Callahan, S. T., Hickson, G.B., & Cooper, W. O.	Health care access of Hispanic young adults in the US	Journal of Adolescent Health	Quantitative using same survey for different years	2ary	National	1998 to 2001
14	2000	Carrasquillo, O., Carrasquillo, A. I., & Shea, S.	Health insurance coverage of immigrants living in the US: Differences by citizenship status and country of origin	American Journal of Public Health	Quantitative using survey	2ary	National	1998
15	2014	Castañeda, Heide & Melo, Milena A.	Health care access for Latino mixed-status families: Barriers, strategies and implications for reform	American Behavioral Scientist	Qualitative using interviews	1ary	Texas: Lower Rio Grande Valley of Texas (border counties)	not specified
16	2012	Chavez, Leo R.	Undocumented immigrants and their use of medicla services in Orange County, California	Social Science and Medicine	Quantitative using survey	1ary	California: Orange County	2006
17	2008	Cristancho, Sergio, Garces, Marcela, Peters, Karen & Mueller, Benjamin	Listening to rural Hispanic immigrants in the Midwest: A community-based participatory assessment of major barriers to health care access and use	Qualitative Health Research	Qualitative using focus groups	1ary	Illinois: 3 rural communities	2004-2005
18	2013	Dembe, Allard E., Biehl, Jeffrey M., Smith, Alicia D. & Garcia de Gutierrez, Teresa	Employers' role in helping Latino workers obtain access to health care services: Results of a community-based pilot demonstration project	Journal of Immigrant and Minority Health	Mixed using focus groups and intervention	1ary	Ohio: Columbus	2009
19	2007	Derose, K. P., Escarce, J. J., & Lurie, N.	Immigrants and health care: Sources of vulnerability	Health Affairs	Literature review	N/A	National	References published between 1997 to 2007
20	2004	Documet, P. I., & Sharma, R. K.	Latinos' health care access: Financial and cultural barriers	Journal of Immigrant Health (Currently Journal of Immigrant and Minority Health)	Mixed-Methods using survey and participant observation	1ary	Southwestern Pennsylvania	1999 & 2000
21	2006	Doty, M. M., & Holmgren, A. L.	Health care disconnect: Gaps in coverage and care for minority adults	The Commonwealth Foundation	Quantitative using survey	1ary	National	2005
22	2013	Durden, Elizabeth T. & Dean, Lucy G.	Health insurance coverage of Hispanic adults: An assessment of subgroup difference and the impact of immigration	The Social Science Journal	Quantitative using survey	2ary	National	2008-2009
23	2006	Durden, T. E., & Hummer, R. A.	Access to healthcare among working-aged Hispanic adults in the United States	Social Science Quarterly	Quantitative using same survey for different years	2ary	National	1999-2001
24	2006	Echeverria, Sandra E., & Carrasquillo, Olveen	The roles of citizenship status, acculturation, and health insurance in breast and cervical cancer screening among immigrant women	Medical Care	Quantitative using survey	2ary	National	2000
25	2006	Escobedo, L. G., & Cardenas, V. M.	Utilization and purchase of medical care services in Mexico by residents in the United States of America, 1998-1999	Revista Panamericana de Salud Publica	Quantitative using survey	1ary	Southern New Mexico (6 counties)	1998-1999
26	2002	Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G.	Disparities in health care by race, ethnicity, and language among the insured: findings from a national sample	Medical Care	Quantitative using survey	2ary	National	1996-1997
27	2010	Fonseca-Becker, Fannie, Perer-Patron, Maria J., Munoz, Beatriz, OLeary, Michael, Rosario, Evelyn & West, Sheila K.	Health competence as predictor of access to care among Latinos in Baltimore	Journal of Immigrant and Minority Health	Quantitative using survey	1ary	Maryland: Baltimore	2010
28	2013	Fronstin, P.	Sources of health insurance and characteristics of the uninsured: analysis of the March 2011 current population survey	EBRI Issue Brief	Quantitative using Census data	2ary	National	1989 through 1994
29	1991	Ginzberg, E.	Access to health care for Hispanics	The Journal of the American Medical Association	Policy review	N/A	National	N/A
30	2001	Granados, Gilberto, Puvvula, Jyoti, Berman, Nancy & Dowling, Patrick T.	Health care for Latino children: Impact of child and parental birthplace on insurance status and access to health services	American Journal of Public Health	Quantitative using survey	1ary	California: Los Angeles (Wilmington)	1997
31	2006	Graves, J.A. & Long, S.K.	Why do people lack health insurance?	Urban Institute (Health Policy Online: Timely Analyses of Current Trends and Policy Options series.)	Quantitative using same survey for different years	2ary	National	1998,1999, 2003,2004
32	2009	Gresenz, C.R., Rogowski, J. &Escarce J.J.	Community demographics and access to health care among US Hispanics	Health Research & Educational Trust	Quantitative using same survey for different years and some other 2ary data	2ary	National	1996-2002
33	2004	Grieco, Elizabeth	Health insurance coverage of the foreign born in the United States: numbers and trends	Migration Policy Institute	Quantitative using same survey for different years	2ary	National	2001 to 2003
34	2000	Guendelman, Sylvia & Wagner, Todd H.	Health services utilization among Latinos and white non-Latinos: Results from a national survey	Journal of Health Care for the Poor and Underserved	Quantitative using survey	2ary	National	1994
35	2014	Gutierrez, Natalia, Kindratt, Tiffany B., Pagels, Patti, Foster, Barbara & Gimpel, Nora E.	Health literacy, health information seeking behaviors and Internet use among patients attending a private and public clinic in the same geographic area	Journal of Community Health	Quantitative using survey	1ary	Texas: Dallas (one private and one county clinic)	2009
36	2003	Hadley, J.	Sicker and poorer—The consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income	Medical Care Research and Review (formerly Medical Care Review)	Literature review	N/A	National	References used published between 1969 and 2003
37	1997	Halfon, N., Wood, D. L., Valdez, R. B., Pereyra, M., & Duan, N.	Medicaid enrollment and health services access by Latino children in inner-city Los Angeles	The Journal of the American Medical Association	Quantitative using Survey	1ary	East and South Central Los Angeles (inner-city areas)	1992
38	2003	Hargraves, J. Lee & Hadley, Jack	The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care	Health Services Research	Quantitative using survey	2ary	National	1998-1999
39	2009	Heyman, J. M., Núñez, G. G., & Talavera, V.	Healthcare access and barriers for unauthorized immigrants in El Paso County, Texas	Family and Community Health	Qualitative using interviews	1ary	El Paso, Texas	2007 or 2008
40	1991	Hubbell, F. A., Waitzkin, H., Mishra, S. I., Dombrink, J., & Chavez, L. R.	Access to medical care for documented and undocumented Latinos in a southern California county	Western Journal of Medicine	Quantitative using survey	1ary	Orange County, California	1987-1988

Table 4.8. Methods Used (cont.)

#	Year Published	Authors	Title	Journal / Published by	Methods	Data used	Region Covered	Year/s of Data Used
41	2015	Judav, S., Rajan, S. S., Abughosh, S., & Sansgiry, S. S.	The role of socioeconomic status and health care access in breast cancer screening compliance among Hispanics	Journal of Public Health Management and Practice	Quantitative using same survey for different years	2ary	National	2000 to 2010
42	2002	Jones, Mary Elaine, Cason, Carolyn L. & Bond, Mary Lou	Access to preventive health care: Is method of payment a barrier for immigrant Hispanic women?	Women's Health Issues	Quantitative using survey	1ary	Dallas, Texas	1999
43	2013	Kanimura, Akiko, Christensen, Nancy, Tabler, Jennifer, Ashby, Jeanie & Olson, Lenora M.	Patients utilizing a free clinic: Physical and mental health, health literacy, and social support	Journal of Community Health	Quantitative using survey	1ary	Local (not specified)	2012
44	2012	Katz, Vikki S., Ang, Alfonso, & Suro, Roberto	An ecological perspective on U.S. Latinos' health communication behaviors, access, and outcomes	Hispanic Journal of Behavioral Sciences	Quantitative using survey	2ary	National	2007
45	2001	Ku, L., & Matani, S.	Left Out: Immigrants' Access To Health Care And Insurance	Health Affairs	Quantitative using survey	2ary	National	1997
46	2005	Lara, Marielena, Gamboa, Cristina, Kahramanian, M. Iya, Morales, Leo S. & Hayes Bautista, David E.	Acculturation and Latino health in the United States: A review of the literature and its sociopolitical context	Annual Review of Public Health	Literature review	2ary	National	not specified
47	2011	Law, J., & VanDerslice, J.	Proximal and distal determinants of access to health care among Hispanics in El Paso County, Texas	Journal of Immigrant and Minority Health (formerly Journal of Immigrant Health)	Quantitative using registry	2ary	El Paso, Texas	2005
48	2009	Livingston, G. (2009)	Hispanics, health insurance and health care access	Pew Research Center	Quantitative using several surveys and Census data	1ary and 2ary	National	2007
49	2001	Macias, E.P. & Morales L.S.	Crossing the border for health care	Journal of Health Care for the Poor and Underserved	Quantitative usingsurvey	1ary	Lennox, California	no given
50	2001	Manos, M. Michele, Leyden, Wendy A., Resendez, Cynthia I., Klein, Elizabeth G., Wilson, Tom L. & Bauer, Heidi M.	A community-based collaboration to assess and improve medical insurance status and access to health care of Latino children	Public Health Reports	Quantitative using survey	1ary	San Rafael, CA	1999
51	1991	Markowitz, M. A., Gold, M., & Rice, T.	Determinants of health insurance status among young adults	Medical Care	Quantitative using Survey	1ary	National	1980
52	2011	Maxwell, J., Cortes, D. E., Schneider, K. L., Graves, A., & Rosman, B.	Massachusetts' health care reform increased access to care for Hispanics, but disparities remain	Health Affairs	Quantitative using Survey	2ary	Massachusetts	2005 and 2009
53	1989	McManus, Margaret A., Greaney, Ann M. & Newacheck, Paul W.	Health insurance status of young adults in the United States	Pediatrics	Quantitative using survey	2ary	National	1984
54	2002	Morales, Leo S., Kington, Raynard S., Valdez, Robert O. & Escarce, Jose J.	Socioeconomic, cultural, and behavioral factors affecting Hispanic health outcomes	Journal of Health Care for the Poor and Underserved	Literature review with some quantification applied	2ary	National	References used published between 1967 and 2001
55	2014	Padilla, Yolanda C., Scott, Jennifer L. & Lopez, Olivia	Economic insecurity and access to the social safety net among Latino farmworker families	Social Work	Quantitative using survey	2ary	National	2005-2009
56	2008	Pearson, W.S., Ahluwalia, I.B., Ford, E.S. & Mokdad, A.H.	Language preference as a predictor of access to and use of healthcare services among Hispanics in the US	Ethnicity and Disease	Quantitative using survey	2ary	National	2005
57	2009	Perez, Debra, Ang, Alfonso & Vega, William A.	Effects of health insurance on perceived quality of care among Latinos in the United States	Journal of General Internal Medicine	Quantitative using survey	2ary	National	2007-2008
58	2010	Perez-Escamilla, Rafael	Health care access among Latinos: Implications for social and health care reforms	Journal of Hispanic Higher Education	Literature review	2ary	National	2001-2009
59	2000	Quinn, K., Schoen, C., & Buatti, L.	On their own: Young adults living without health insurance.	Commonwealth Foundation. Task Force on the Future of Health Insurance	Quantitative using 3 surveys	1ary and 2ary	National	1988, 1995, 1998, 1999
60	2013	Ruiz, Erika, Aguirre, Regina T.P. & Mitschke, Diane B.	What leads non-US-born Latinos to access mental health care	Social Work in Health Care	Quantitative using survey	1ary	Clinic in Texas	N/A
61	2000	Schoen, C., & DesRoches, C.	Uninsured and unstably insured: the importance of continuous insurance coverage	Health Services Research	Quantitative using 3 surveys	2ary	National	1995-1997
62	2015	Schoen, C., Radley, D., & Collins, S. R.	State trends in the cost of employer health insurance coverage, 2003-2013	Commonwealth Foundation. Task Force on the Future of Health Insurance	Quantitative using two surveys for different years and other government datasets	2ary	National	2003,-04, 2010,2013-14
63	1995	Schur, C. L., Albers, L. A., & Berk, M. L.	Health care use by Hispanic adults: Financial vs. non-financial determinants	Health Care Financing Review	Quantitative using survey	2ary	National	1987
64	2001	Schur, C. L., Feldman, J. J., & Fund, C.	Running in place: How job characteristics, immigrant status, and family structure keep Hispanics uninsured	The Commonwealth Foundation. Task Force on the Future of Health Insurance	Quantitative using three surveys	2ary	National	1996, 1997, 1999, 2000
65	1987	Schur, Claudia L, Bernstein, Amy B. & Berk, Marc L.	The importance of distinguishing Hispanic subpopulations in the use of medical care	Medical Care	Quantitative using survey	2ary	National	1977-1978
66	2007	Sharma, Ravi K., McGinnis, Kathleen A. & Documet, Patricia I.	Disparities in health status and health-service utilization among Hispanic ethnic subgroups	Social Work in Public Health (formerly Journal of Health & Social Policy)	Quantitative using same survey for different years	2ary	National	1999 to 2002
67	2014	Siskin, A., & Lunder, E. K.	Treatment of noncitizens under the Affordable Care Act	Congressional Research Service	Government report	N/A	National	2014
68	1990	Solis, Julia, M., Marks, Gary, Garcia, Melinda, & Shelton, David	Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982-84	American Journal of Public Health	Quantitative using survey	2ary	National	1982 -1984
69	2015	Stone, Lisa Cacari, Boursaw, Blake, Bettez, Sonia P., Marley, Tenaille Larzelere & Waitzkin, Howard.	Place as a predictor of health insurance coverage: A multivariate analysis of counties in the United States	Health and Place	Quantitative using Census	2ary	National	2008-2012
70	2013	Talavera-Garza, L., Ghaddar, S., Valerio, M., & Garcia, C.	Health care access and utilization among Hispanic manufacturing workers along the Texas-Mexico border	Journal of Health Care for the Poor and Underserved	Quantitative using survey	1ary	Lower Rio Grande Valey, Texas (border)	2010
71	2013	The Henry J. Kaiser Family Foundation	Medicaid and the uninsured: Key facts on health coverage for low-income immigrants today under the Affordable Care Act	The Henry J. Kaiser Family Foundation	Quantitative using survey and mapping data	2ary	National	2011
72	2013	Torres, Essie, Erwin, Deborah O., Treviño, Michelle & Jandorf, Lina	Understanding factors influencing Latina women's screening behavior: A qualitative approach	Health Education Research	Qualitative using interviews	1ary	Arkansas and New York.	NA
73	2008	Torres, Myriam, Parra-Medina, Deborah, Bellinger, Jessica, Johnson, Andrew O. & Probst, Janice C.	Rural hospitals and Spanish-speaking patients with limited English proficiency	Journal of Healthcare Management	Quantitative using survey	1ary	National	2005
74	1991	Treviño, F. M., Moyer, M. E., Valdez, R. B., & Stroup-Benham, C. A.	Health insurance coverage and utilization of health services by Mexican Americans, mainland Puerto Ricans, and Cuban Americans	The Journal of the American Medical Association	Quantitative using two surveys for different years	2ary	National	1982 through 1984 and 1989
75	1993	Valdez, Burciaga, Giachello, Aida, Rodriguez-Trias, Helen, Gomez, Paula & de la Rocha, Castulo	Improving access to health care in Latino communities	Public Health Reports	Policy review	2ary	National	1960-1993
76	2013	Valenzuela, Jessica M., McDowell, Tiffany, Cencula, Lindsey, Hoyt, Lupe & Mitchell, Monica J.	¡Hazlo bien! A participatory needs assessment and recommendations for Health Promotion in Growing Latino Communities	American Journal of Health Promotion	Mixed: Survey and focus groups	1ary	Norwood, Ohio	N/A
77	2009	Vargas Bustamante, Arturo, Fang, Hai, Rizzo, John A. & Ortega, Alexander N.	Understanding observed and unobserved health care access and utilization disparities amogn U.S. Latino adults	Medical Care Research and Review (formerly Medical Care Review)	Quantitative using survey	2ary	National	1999 to 2007
78	2013	Wallace, S. P., Torres, J., Sadegh-Nobari, T., & Pourat, N.	Undocumented and uninsured: barriers to Affordable Care for immigrant population	UCLA Center for Health Policy Research AND Commonwealth Fund	Quantitative using same survey for different years	2ary	California	2009
79	2002	Weigers Vitullo, Margaret & Taylor, Amy K.	Latino adults' health insurance coverage: An examination of Mexican and Puerto Rican subgroup differences	Journal of Health Care for the Poor and Underserved	Quantitative using survey	2ary	National	1996
80	2004	Weinick, Robin, Jacobs, Elizabeth, Stone, Lisa Cacari, Ortega, Alexander & Burstin, Helen	Hispanic healthcare disparities: Challenging the myth of a monolithic Hispanic population	Medical Care	Quantitative using survey	2ary	National	1997
81	2011	Wilkin, Holley A. & Ball-Rokeach, Sandra J.	Hard-to-reach? Using health access status as a way to more effectively target segments of the Latino audience	Health Education Research	Quantitative using survey	1ary	Los Angeles, CA	2002-03
82	2007	Wu, Shinyi, Ridgely, M. Susan, Escarce, Jose J., & Morales, Leo S.	Language access services for Latinos with limited English proficiency: Lessons learned from *Hablamos Juntos*	Journal of General Internal Medicine	Qualitative: multi-site case study	1ary	South (4), Northeast (2), West (3) and Midwest (1)	2004-2005
83	2014	Zhan, F. Benjamin & Lin, Yan	Racial/Ethnic, socioeconomic, and geographic disparities of cervican cancer advanced-stage diagnosis in Texas	Women's Health Issues	Quantitative using state registry	2ary	Texas	1996 through 2008

showing things have worsened over time for the overall population, particularly in terms of increased premiums and deductibles (Pear, 2015, 2016b; Sanger-Katz, 2016; Schoen, Radley, & Collins, 2015).

In 2012, 58.2% of the non-elderly population was covered through their employment, which is down from 69.3% in 2000 (Fronstin, 2013). During an earlier period, between 1994 and 1997, this proportion was steady at about 73.5%. Although, this percentage seems to have stabilized in 2011, there are other numbers that show worrisome trends. Since the 1990s, deductibles and co-payments have been on the rise. These increases are referred to as higher cost-sharing and put people at higher risks of

being underinsured. A poll conducted among people who are currently facing problems with underinsurance, by the New York Times and the Kaiser Family Foundation, found that 63% report having depleted their savings, 42% have taken an extra job or are working extra hours, among other strategies (Sanger-Katz, 2016). Furthermore, health insurance premiums - for both people using the federal exchange instituted by the Affordable Care Act and those insured through employment - have been increasing, adding to the problem of higher cost-sharing (Lubotsky & Olson, 2015; Pear, 2016a; Schoen et al., 2015). Ironically, on the other hand, the top income earners seem to be gaining from this system. Just recently, the New York Times published an article describing how the wealthiest individuals in the US get special treatment through direct and immediate access to top physicians, luxury hotel services during hospitalizations, fast scheduling of surgeries, and so on (Schwartz, 2017).

Many low paying jobs do not offer health insurance, but some do. Higher cost-sharing impacts everyone with employment-based coverage, but for those who occupy lower level positions who do not qualify for public insurance or subsidies, the risk of being underinsured is greater. Hispanics consistently are found to be employed in positions that do not offer insurance, or if they do, these workers cannot afford the premiums nor understand the complexities linked to premiums, deductibles and co-payments.

Among the studies that measure or discuss insurance as a primary factor in access (Table 4.2), 37 (45%) specifically include the impact of employment-based coverage on the Hispanic population, of those, 13 (16%) specifically measure its impact. Moreover, as Schoen and DesRoches (2000) prove, the issue is not just the lack of insurance, but also

continuous insurance coverage. Because Latinos are disproportionately employed in jobs that have high turnovers or layoffs, their reliability on employment coverage is problematic because so many switch jobs often or are employed in seasonal jobs. In other words, there is no consistency in the availability of employment-based insurance among the different jobs Latinos usually take.

Trends happening around employment-sponsored insurance are indicators of structural barriers, but they don't just apply to Latinos. As Hadley (2003) shows, they impact those of lower income levels in general. Consequently, lower income or poor individuals are proven to face more problems with health than those of higher incomes due to lack of access. Nonetheless, what is important to note here is that, because a large portion of Latinos fall into lower levels of income and assuming jobs through which they cannot access employment-based insurance, within a neoliberal system, these facts alone place them at higher risks of being uninsured, underinsured and/or lack of continuous insurance than the average American. In 2014, 23.5% of Latinos were at the federal poverty level compared to the 14.8% US average, while their median family income was $42,200 compared to the average median income of $53,713 (Posey, 2016; Stepler & Brown, 2016).

These numbers are averages, so caution must be applied when drawing conclusions from them. As analyzed in previous chapters, heterogeneity is an important element present within the Hispanic population in the US, who are too often treated as a homogeneous ethnic group. Several studies (12; 14% of 83) either discuss or measure differences across subgroups. Historically, the largest subgroup in overall numbers of Hispanics in the US have been those of Mexican origin. Although the share of Mexican

origin has decreased over time and the mix has also diversified significantly over the last half century, Mexican origin still comprises the largest proportion of Hispanics in the US, about 64% of the Hispanic population (Stepler & Brown, 2015, 2016). Interestingly, those of Mexican ancestry or nativity also make up the largest subgroup classified as having the least access, presented in 17 (20%) of the articles (Table 4.2).

Immigrants from Mexico and Central America, are primarily from low income and low educational levels and migrate to fill lower skill jobs in the US. In this sense, it is the geographical location of Mexico and Central America, in conjunction with labor market demands for low skill jobs in the US which are being perceived in the countries of origin as better than the ones offered home, that are the main drivers of immigration from these countries. Over time, in practice, these factors have turned the Hispanic population in the US to one that is predominantly of lower education occupying lower paid jobs. Hence, income and education are often linked to each other and commonly included as part of the analysis or as variables being measured in the literature identified. Of the 83 studies, 36 (43%) measure income and 24 (29%) measure education as variables impacting access. Because our survey study was not able to collect a sufficient amount of data on income (i.e. many participants were reluctant to provide this information through personal interviews), in the logistic regression tested in the next chapter, educational level is included as a **control variable** in the model.

The second structural barrier, immigration status, applies more specifically to Latinos because not all Latinos are US citizens. Among the articles analyzed, 30 (36%) either include as relevant or measure the impact of citizenship/immigration status on access (Table 4.2). Legal discrimination observed today against immigrants in health care

is the result of the intersection between federal immigration and healthcare legislation. The 1989 Immigration Reform and Control Act and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) are considered major contributors to further restricting access to medical care for immigrants, particularly Hispanics who compose the majority in this group (Derose et al., 2007; Ginzberg, 1991). Although it must be mentioned that some local efforts did compensate for some of the losses, most of these struggle with funding

The Affordable Care Act (ACA), which came into effect in 2014, is expected to increase access over time, for the most part, for Latinos who are lawfully residing in the US. Conversely, it is expected to increase the chances for discrimination against those who are undocumented, and imposes some additional barriers for those who are not citizens and are at the age to enroll in Medicare (but are lawfully residing). Moreover, the ACA made the expansion of Medicaid an option for states. So, in states that didn't expand Medicaid (including Missouri), Latinos are being highly impacted by such decision (Castañeda & Melo, 2014). More details on how the ACA intersects with citizenship/immigration status and how this is seen as a structural barrier, is offered in Chapter 2.

6. Having visited a doctor's office is treated as a common way to measure access

"Access to health care refers to the degree to which people are able to obtain appropriate care from the health care system in a timely manner" (Escarce & Kapur, 2006, p. 411).

Researchers further distinguish between potential access and realized access. People with potential access would be considered to have access to health care on a timely manner. Realized access on the other hand, refers more to the quantity actually

received (Escarce & Kapur, 2006). The differentiation between potential and realized is important when we consider the emphasis put on acquiring insurance in the US. In this sense, having insurance gives an individual the potential to seek services when needed, but realized access is generally measured by the actual visits to the doctor's office done recently (usually within one year). In the articles identified for this meta-analysis, 42 (51%) either use a recent visit to a doctor's office as a dependent variable to measure of access or discuss it as a relevant one in non-quantitative studies (Table 4.2). Therefore, the next chapter, will use the variable "visit to a doctor's office" as the **dependent variable** in the logistic regression applied.

D. Conceptual Model

From the findings identified in this meta-study and the discussion in the previous chapters, the conceptual model - tested through a logistic regression in the next chapter - uses the proxy recent "visit to a doctor's office" from the survey questionnaire to measure access to health care (Figure 4.1). Four main independent variables, plus one interaction variable, stemming from the hypotheses listed above are part of the logistic regression model. In addition, four control variables are included.

The four independent variables include: acculturation, bonding social capital, bridging social capital, and linking social capital. The interaction is a variable constructed from moderating acculturation and insurance, and the four control variables are education and insurance coverage. The variable operationalization that applies to this conceptual model is included in the next chapter.

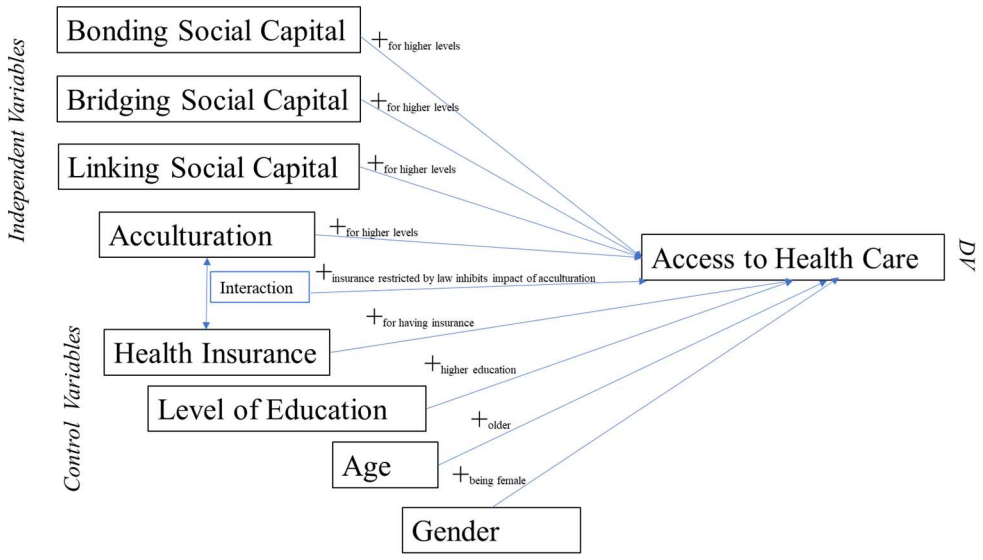

Figure 4.1. Conceptual model.

E. Final Remarks

Focault (1973) provides a remarkable archaeological analysis of the historical transformation medicine went through since the Middle Ages. In his analysis, he explains how, as a society, we have come to think of health in terms of symptoms. Such transformation has turned medicine into a highly-specialized field, what he calls the "classificatory rule" in medical theory and practice (p. 4). Findings in this meta-analysis and discussions in previous chapters demonstrate how this same type of specialization has impregnated the field of public health and other social sciences that have researched Hispanics' access to health care. Most of these studies focus on the variables that measure the *symptoms* of the problem, but are not really getting to the root of the issue, the *disease* per se.

Measuring disparities by variables is nonetheless important because these numbers serve as proof to illustrate that inequalities in fact exist, and even more so, that they have been recurrent for over five decades. Such studies also help in comparisons across groups,

like in the healthcare access case where the Hispanic population is worse off than others. When analyzing disparities through different variables, the identification of similar patterns (i.e. geographical regions more highly concentrated by Hispanics as well as types of jobs that hire higher rates of Hispanics) help further identify if there might for instance be discrimination behind legislation that targets excluding Latinos. Hence, the persistence of inequalities serves as an indication of a broader problem or broader issues to be considered with more caution. The articles examined provide sufficient evidence to say that researchers may be trapped in a vicious cycle of putting too much emphasis on the variables in order to address the inequalities observed, while ignoring the underlying causes of the broader picture. The question becomes, why is there so much hesitancy to ignore the underlying causes? The answer to this question goes beyond this section's discussion but is addressed in Chapter 2 when discussing the underlying neoliberal culture that dominates the healthcare system in this country (i.e. cultural hegemony).

The overrepresentation of an epidemiologist worldview accompanied by an underrepresentation of a sociologist perspective identified in the literature have consequences through their impact on policy recommendations given over time. As a result, the emphasis has been on how to improve access without questioning the system, which ironically has turned the US health care into the most unequal, inefficient, expensive, and complex in the developed world (OECD, 2015b; C. Schoen, Osborn, How, Doty, & Peugh, 2009; C. Schoen, Osborn, Squires, & Doty, 2013; Squires & Anderson, 2015). As Sanger-Katz (2016) puts it, the US is "the most expensive place in the world to get sick." According to Waitzkin (1978), society is simply "patching" (p. 273) the wounds.

In a way, Hispanics, who represent the largest group being excluded from access in the US (DeNavas-Walt et al., 2013), and are, in a way, newcomers to this system, also serve to illustrate the idiosyncrasies of health care. Significant reforms are urgently needed that go

way beyond what the Affordable Care Act (ACA) has introduced so far. This dissertation does not propose dismantling the healthcare system overnight. Such a proposal would be unrealistic when considering first, the size of this sector as part of the American economy,[22] and second, the underlying cultural environment in which such system was not just created, but was also allowed to thrive. My recommendation to other researchers instead, is to switch the focus to studies that can show how the capitalist ideology is hurting not just Hispanics, but Americans overall. With respect to the Hispanic population, the focus should be more on policy discrimination that is happening in addition to the structural barriers that are already in place. In other words, there is a need to do a better job of educating the public over time about the facts on which types of policies seem to work better from examples seen around the world.[23] This recommendation relies on targeting the underlying causes of the structural barriers as a long-term strategy.

Cognizant that system level changes will take time, it is important to acknowledge the issue of potential and realized access in the short-term (Escarce & Kapur, 2006). The ACA's health insurance mandate is, in a way, a simplistic mechanism to ensure access. As the state of Massachusetts case illustrates, increasing insurance coverage among Hispanics alone is not going to do the job (Maxwell et al., 2011). Efforts focused solely on expanding insurance coverage could increase potential access, but it does not guarantee realized access. A common way these studies are measuring realized access is through recent visits to a doctor's office, which usually refer to a primary care physician or a specialist. In the

[22] In addition to being a large portion of the US economy about $3 trillion – a size larger than the economy of France or the UK - (Blumenthal, 2014) the two most profitable sectors in the US are health care and technology (The Economist, 2016a).

[23] To be fair, many healthcare systems in the developed world are struggling with costs, but in comparison, the US is by far the worst (Coburn, 2004; Reeves, McKee, Basu, & Stuckler, 2014; Squires & Anderson, 2015)

publications reviewed, people who have been identified as having a primary care physician or having visited a specialist are considered to have greater access.

Two factors must be accounted for when considering realized access for Hispanics: (1) recent trends showing an increase in cost-sharing, which in turn increases the risks of being underinsured, are linked to structural barriers and; (2) other factors that can serve as enablers to access have been less covered in the literature, such as acculturation and social capital. The fact that Latinos are at higher risk than the average American of being underinsured as a result of increased cost sharing, is an outcome of the structural barriers that have proven to be on the rise in the American neoliberal system (Schoen et al., 2013; Squires & Anderson, 2015; Waitzkin, 1978). Therefore, it is important to measure insurance, but insurance per se, is not a measure of realized access; instead it provides a means to achieve actual access (i.e. visits to the doctor, clinic, hospital, etc.).

It is also important to consider that the mandatory requirement on health insurance may actually hurt more than help some underinsured Latinos, as it is already observed in others who are underinsured (Pear, 2015). On the one hand, the number of Latinos being enrolled could increase as a result of insurance now being mandatory. Both the Massachusetts case and more recent reports show Latinos are in fact experiencing the highest decline in rates of uninsured (Doty & Collins, 2017; Maxwell, et al., 2011). Nonetheless, these new trends observed after the ACA implementation must be seen with caution because the starting point for Latinos is very low. On the other hand, the higher cost-sharing that is happening simultaneously could hurt many who are now getting insurance.

The increased deductibles mean, that if an underinsured person falls ill, this person would now pay for both the cost of insurance and the cost of services not covered due to higher deductibles. In other words, if insured under higher deductibles, those that get ill and don't reach the annual amount of their deductible, would be worse off now financially than if

they were uninsured, because their annual costs go up simply by having to pay for the mandatory insurance that cannot be used. [24] Furthermore, when compared to individuals placed in different income levels who are paying the same price for insurance, the percentage being spent on insurance among those of lower incomes matter more than those at higher income brackets.

As can be inferred, when the focus is on lower income families, the more the issue is examined, the more complex it becomes. In a neoliberal system relying highly on employment-based insurance, people who occupy lower paid jobs face various difficult constraints when it comes to insurance. First, the employer may not offer insurance to those positions assuming those people will be covered by Medicaid. Second, if offered, the portion that is the employee's responsibility is usually still too expensive for her, even though it's partly subsidized by the employer. Third, these positions usually face high turnovers or layoffs and involve high health risks. If there is no consistency across these jobs, then workers taking these jobs face high risks of lacking continuous insurance. Some, like in construction, may lose their jobs when having an accident and as a result lose their employment-based insurance.

There is also an ethical consideration that needs to be highlighted. As mentioned above, the labor market demand for low skill positions present today in the US is, on the one hand, attracting immigrants mainly from Mexico and Central America. Potential migrants from these two places have an advantageous geographical location when compared to other countries that also have high poverty rates and could have segments of their population being attracted to these jobs in the US. On the other hand, for over five decades, American society

[24] It must be noted that under the ACA's mandate, people are not allowed to carry insurance that covers just catastrophic cases for instance, which are expected to cost much less. The way it is set up now, everyone is forced to carry full insurances, but it is up to the insurance companies to decide on deductibles, premiums and co-payments.

has shown, through the enactment of legislation targeting low-income immigrants, that it is reluctant to offer access to health care for them, even though their cheap labor is welcomed. Thus, there is an ethical dilemma for American society to consider more seriously and less superficially as has been done in the past.

Nevertheless, it is understandable that in a country facing the most expensive healthcare system in the world, politicians are desperately looking for places to cut on costs. Even so, Hispanic immigrants are not the reason why the system is expensive. This fact in itself needs to be clear to the public. Targeting immigrants serves as a political distraction to avoid focusing on the real in-depth health care related issues that need to be considered more seriously in today's society. Further, having proper access to health care is a human right; it is immoral for a society to obstruct such access in any circumstances. This is especially the case when such a society needs the cheap labor provided by the at risk population. This should not be part of the left vs. right ideological war; it is instead a moral consideration. Simply put, the health of an individual should not be used as a political tool to avoid addressing the real causes of the healthcare system's failures and the unmet demands of the labor market in the US. As the literature points out, these two intersect in federal legislation to legally discriminate against Hispanics, who are particularly the most vulnerable.

When it comes to acculturation and social capital, studies that focus on Hispanics' access to health care should account better for acculturation and also incorporate the use of the term social capital. Because there is still no consensus in how researchers define and operationalize acculturation, those who address it must do a better job in specifying what definition they adopt and how they intend to measure the variable. In practice, strategies that account for acculturation need to consider first, the high complexity of the American healthcare system, as well as account for any heterogeneity that might be present with respect to country of origin. Hispanics of different country of origin have different cultural

backgrounds; therefore, worldviews on healthcare access vary across subgroups. Consequently, different healthcare worldviews matter when it comes to the process of acculturating to a new system. Enabling Hispanics to become more acculturated to the healthcare system will not solve all of the access issues stemming from structural barriers, but it will certainly help.

In addition, immigrants from different countries may be subject to different treatment by federal law based on how immigration and healthcare legislation intersect in Hispanics' particular case. This intersection impacts not just immigrants, but also their children, even when they are US-born citizens. For example, a Cuban couple who migrated as refugees during the Cold War would have been subjected to preferential treatment under immigration laws. In contrast, a Mexican couple who crossed the border unlawfully would be discriminated through federal legislation. The children of that Cuban couple would be born into a very different family status than the children of the Mexican couple, who would now be part of a mixed-status family facing discrimination and fear issues as a consequence of their parents' unlawful immigration status. A Puerto Rican, who is an American citizen since birth, has access to public insurance that may not be available to a Dominican Republic immigrant who is not an American citizen, and so on. These differentiations created by law now have strong social consequences across Hispanic subgroups.

With respect to social capital, it is clear that researchers have been trying to include the importance of social networks as enablers to access. The problem is that the literature identified does not adopt the term social capital and as a result, there is no consensus in how it is being applied as a variable impacting access. Incorporating the term social capital and measuring the different forms of social capital separately may prove to be an important step, not just when addressing Hispanics' access, but also other immigrant groups.

When acknowledging the importance of acculturation and social capital, it is also relevant to note that they should not be seen as substitutes, but rather complements, to other barriers Hispanics face. It is clear from the literature that structural barriers are strong for this group and they should not be ignored at the cost of acknowledging the impact of acculturation and social capital. Nevertheless, it is also clear that in the hypothetical event these structural barriers were to be eliminated, Hispanics would still face the need to acculturate to a system that differs from their own worldviews of health care linked to their countries of origin.

Consequently, different types of social capital can serve as a means to help Latinos acculturate and therefore learn to navigate such a different system. Educational programs must be in place and ongoing and could be channeled through different social networks where social capital is already in place or where there is potential to build such capital (i.e. healthcare navigators are an example of a created form of bridging social capital). The literature emphasizes issues with continuity when similar programs have been offered in the past. This should be considered moving forward. Furthermore, when targeting Hispanics to increase their levels of acculturation and social capital, the fact that a large portion have low educational levels and some lack English language skills must also be considered.

Finally, it can be said that there are today a considerable number of studies that focus on Hispanics' access to health care. The low rates of access observed in this population is well documented. However, a large portion of these studies apply quantitative methodologies and rely on national secondary data sets. Among those that focus more on state, county or community levels, Texas and California appear overrepresented, while there are not many studies with primary data from the Midwest, and in particular, none from Missouri. Therefore, our survey study (Chapter 5) which

collected primary data in Missouri adds value to this literature. Furthermore, the fact that our study first collected qualitative data that was used to prepare the survey questionnaire, potentially increases its legitimacy on how the primary data was collected.

CHAPTER 5: STATISTICAL ANALYSIS FROM A SURVEY STUDY CONDUCTED IN MISSOURI

The previous two chapters provided evidence from the literature that acculturation and social capital could have impact on access to health care for Hispanics. This chapter relies on that literature and attempts to add to it through empirical evidence obtained from a survey study conducted in Missouri. Five main hypotheses are derived from discussions in previous chapters. The hypotheses are tested in this chapter through a binary logistic regression analysis and include the following:

H_1: Higher levels of acculturation to the American way of life among Hispanics are associated with higher chances of accessing health care.

H_2: There is an interactional effect between acculturation and health insurance status that derives from legal status that impacts access to health care.

H_3: Higher levels of bonding social capital are associated with higher levels of access to health care.

H_4: Higher levels of bridging social capital are associated with higher levels of access to health care.

H_5: Higher levels of linking social capital are associated with higher levels of access to health care.

A. Data Collection and Sample

From 2011 to 2013, the Missouri Health Equity Collaborative (MOHEC) in the Center for Health Policy at the University of Missouri conducted qualitative interviews of immigrants and refugees in order to better understand attitudes towards health, how they access health services and what it is like for them to receive services. The study found there are many cultural and linguistic barriers, long waits in emergency rooms, issues with affordability, lack of insurance and a host of other issues. However, there are also

stories of how people are able to successfully access resources, sometimes with the help of others in the community.

This dissertation does not address the qualitative study done as part of the bigger project on immigrants and access to health care in Missouri. However, the survey study, from which the data in this chapter relies on, is linked to that qualitative study. Building on the qualitative findings, the team developed a survey instrument (Appendix 2) to measure the extent to which issues reached across the community to identify patterns that can be addressed through policy change and/or community services. This chapter relies on the data obtained from the survey to provide some statistical analysis using binary logistic regression.

The survey was conducted among 245 Latinos from across the state of Missouri and was divided in several sections. The first part of the questionnaire are mainly questions constructed from personal experiences obtained from the qualitative study. In addition, four scales are included in the questionnaire. These scales were designed to obtain data that can verify if trust, networking of support, and integration affect access.

Seven communities with significant Latino populations were selected to represent the pool of potential participants, meaning the county and/or surroundings contained a higher percentage than the 4 percent state average of Latinos and/or have experienced significant growth in the Hispanic population since 1990. Interview locations included areas in the east central (St. Louis county), west central (Jackson county), north central (Sullivan county), central (Pettis and Boone counties), southwest (Barry county) and southeast (Dunklin county) (Figures 5.1 and 5.2). Four are rural communities in different parts of the state, one is a small city in the middle of the state and the other two are the main

metropolitan areas in Missouri of St. Louis and Kansas City. Oversampling of the rural areas was done in order to obtain data than can help determine if there is a more rural dimension to concerns on healthcare access for the broader study (not covered here).

The survey was conducted during the summer/fall months of 2014 and January of 2015 after approval by the Institutional Review Board in early June of 2014. The questionnaire was long (45 minutes) and was enumerated by graduate students from University of Missouri. Student enumerators were trained by project staff and were native Spanish speakers. A snowball process was used to identify participants that profiled the Latino population of Missouri. Considering the difficulties to recruit minorities for research studies and the recognition that trusted connections are recommended to do so, local facilitators in target communities were hired to help recruit participants (Yancey, Ortega, & Kumanyika, 2006). Leaders who helped came from NGOs that support causes related to Hispanics' needs, church leaders, health care and public schools in each community. In most communities, more than one facilitator was used. Facilitators recruited initial participants from their respective communities and then participants were asked to refer other possible respondents. Recruitment was done using a combination of phone calls, social media, flyers (posted in churches, stores and restaurants), knocking on doors of houses accompanied by facilitators or previous participants, and visiting Hispanic stores and restaurants.

The enumeration process was slow and often the men recruited to participate were not willing to wait to be interviewed. Participants received a $15 gift card from Walmart for partaking in the study. Data from the survey was manually entered into a database. Every

20th survey was double checked to make sure that data entry was correct. The database includes more than 500 variables.

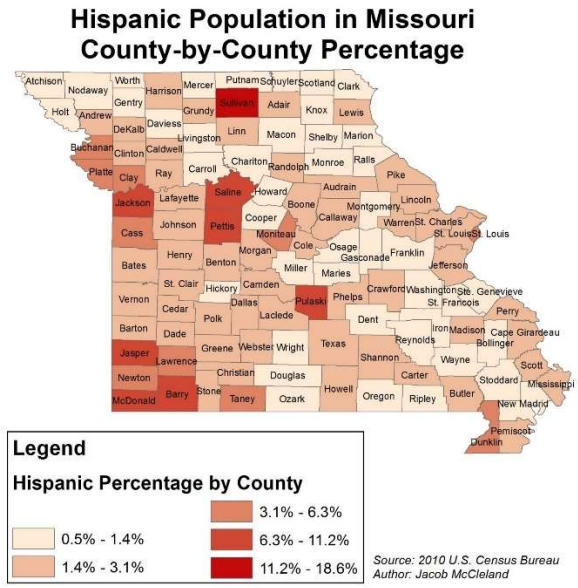

Figure 5.1. Hispanic population by county in the state of Missouri.

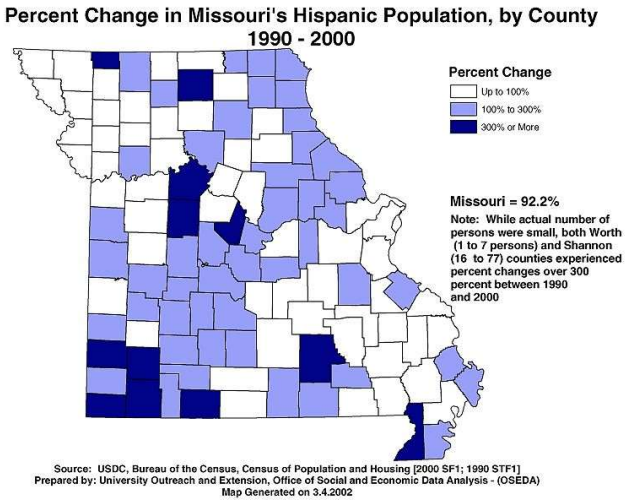

Figure 5.2. Hispanic population growth by county in Missouri 1990 to 2000.

B. Sample Demographics

Participants in the survey are from seven locations in the state including Columbia, Kansas City, Milan, Monett, Sedalia, St Louis and the Bootheel region of Southeast Missouri (Table 5.1). Forty-one percent are from the metropolitan areas of St. Louis and Kansas City. A further 12% are from the city of Columbia and the balance, 47%, is from rural areas in the Northeast, Southwest, West Central and Southeast Missouri.

Women are overrepresented in the sample (64%). However, women tend to be the primary decision-maker on healthcare issues for many Latino families. In addition, women in general tend to seek health care more so than men and are usually in charge of the children's health in the family (Addis & Mahalik, 2003; Fox & Duggan, 2013; Galdas, Cheater, & Marshall, 2005; Gleason et al., 2014; Norcross, Ramirez, & Palinkas, 1996; Vogel, Wester, Hammer, & Downing-Matibag, 2014).

Table 5.1. Interviews Locations

	Number	Percent
Bootheel	31	13%
Columbia	29	12%
Kansas City	52	21%
Milan	28	11%
Monett	25	10%
Sedalia	30	12%
St Louis	50	20%
TOTAL	**245**	**100%**

Most of the participants were born outside the United States (87%) and come from ten countries with the majority migrating from Mexico (72%). The second largest group of foreign-born is mainly from Central America (11%), including Guatemala (7%), El Salvador (2%) and Honduras (2%) (Table 5.2). As discussed in Chapter 3, country of origin composition is important when considering cultural barriers. Table 5.2 and Figure

5.3 illustrate how diversified this population is even if we were to focus just on those of Mexican origin. With respect to acculturation it is also important to note that 70% of participants have resided in the US for over eight years and 17% have lived in the US all of their lives. Likewise, 68% have resided in the state of Missouri for over eight years and 10% all of their lives.

The racial composition is difficult to ascertain based on the data obtained. Thirty-two percent consider themselves white, less than 1% black and 14% indigenous. However, more than half selected "Other" (34%) or didn't answer the question (19%). Most seemed confused by the question about race. Latinos often do not distinguish between race and ethnicity, making it difficult to get an accurate assessment of the racial characteristics. In addition to confusing race with ethnicity, Hispanics tend to associate "white" with status rather than race (Sandoval, 2015).

Table 5.2. Country of Origin

Country of Origin	%
Mexico	72%
US	13%
Guatemala	7%
El Salvador	2%
Honduras	2%
Others: Argentina, Colombia, Cuba, Ecuador, Puerto Rico, Peru	4%
TOTAL	**100%**

English use is limited among many of the participants with 46% of the sample speaking English often (21%) or almost always (25%) (Table 5.4). Contrast that to 94% who speak Spanish often (18%) or very often (75%). Even fewer think in English often

(20%) or almost always (18%). When asked to assess their language proficiency in English many of the participants felt they spoke English poorly (36%) or very poorly (29%). Thirty six percent felt they spoke English well (16%) or very well (20%). The level of proficiency in reading and writing in English is similar to their proficiency levels in speaking English, although writing proficiency is lower, with 69% writing in English poorly or very poorly.

Table 5.3. Participants from Mexico: Locations of Origin

State	Number	Percentage
Michoacan	22	13%
Tamaulipas	20	11%
Mexico D.F.	15	9%
Estado de Mexico	14	8%
Jalisco	12	7%
Nuevo Leon	12	7%
Chihuahua	11	6%
Zacatecas	10	6%
Guanajuato	9	5%
Oaxaca	8	5%
Durango	7	4%
Veracruz	7	4%
Chiapas	5	3%
Coahuila	4	2%
Guerrero	4	2%
Hidalgo	4	2%
Puebla	3	2%
Sinaloa	3	2%
Baja California	2	1%
Colima	1	1%
Sonora	1	1%
Tabasco	1	1%
Yucatan	1	1%
TOTAL	**176**	**100%**

Educational attainment among participants in the study is relatively low (Table 5.5). Nearly one third (29%) have a sixth-grade education or less and over half (53%) have less than a high school diploma. A high school diploma was attained by 27% and some attended college.

Figure 5.3. Participants from Mexico: Locations of origin
Note: Includes only locations specified by participants.

Table 5.4. English Proficiency

	How well Speak English	How well Read English	How well Write English
Very Poorly	29%	30%	36%
Poorly	36%	34%	33%
Well	16%	16%	12%
Very Well	20%	20%	20%

Note: numbers are rounded so may not add up to 100.

To collect information on insurance, participants were asked specifically what type of insurance they possessed and given the following options to select all the coverage they carry: “no insurance”, “Medicaid”, “Medicare”, “Health Insurance Marketplace” (interviewers were trained to clarify that this was the same as “Obamacare”), “VA Program (Veterans)”, “Insurance through the job”, “Self-Paid Insurance”, and “Other” (Table 5.6 and Appendix 2 question #31).

Table 5.5. Level of Education

Level of Education Completed	Percentage of Respondents	Percentage of Spouse/Partners
Elementary/M.S. Education	29%	45%
Some HS but no diploma	24%	23%
HS diploma	27%	20%
Some college (no degree)	6%	4%
Associate Degree	5%	4%
BS degree	5%	4%
MS degree	2%	0%
PHD degree	1%	1%
TOTAL	**100%**	**99%**

Note: numbers are all rounded

Participants in the survey were not asked directly if they were undocumented. However, they were asked their citizenship or immigration status with "other" serving as a proxy for those who would likely be undocumented. Those who answered the question with "other" constitute 34%, which is higher than the national estimates - about 15% of Latinos are estimated to be unauthorized (in 2015) (Krogstad & Lopez, 2015; Krogstad & Passel, 2015; Passel & Cohn, 2017). In addition, 29% report being US citizens, 21% permanent residents and 10% temporary residents (Table 5.7). In the categories used, all except "other" are considered lawfully residing in the US as defined by federal immigration legislation and the Affordable Care Act (Siskin & Lunder, 2014).

Table 5.6. Health Insurance

	Percentage of Respondents
No Insurance	61
Medicaid	5
Medicare	5
Health Ins. Marketplace	3
VA	<1
Insured through work	25
Separate Insurance	<1

Note: Numbers are rounded so may not add to 100.

Table 5.7. Citizenship and Immigration Status

	US citizen born in US	US citizen born out of US	Permanent resident	Temporary resident*	Other	Missing	Total
In Numbers	32	40	52	25	83	13	245
In Percentages	13%	16%	21%	10%	34%	5%	100%

**Temporary residents are usually those with a work Visa among Latinos.Refugees make up a very small portion, mainly those from Cuba. Student Visas are also rare in this group.*

C. Variable Operationalization

Binary logistic regression is used to analyze the chances of improving access to health care. Several models were tested before the final model offered here is applied to present final results. All tests were estimated using IBM-SPSS Statistics 23 software.

Table 5.8 provides illustrations of how variables are grouped to be used in the logistic regression model. Access to health care, the dependent variable (DV), is measured by a binary categorical variable labeled "better access" that asked participants if they were seen by a medical practitioner at a doctor's office in the last two years (Appendix 2 question #30). The DV is equal to 0 when participant has not been seen at a doctor's office and 1 when having seen one. As a dummy variable, empty boxes (representing NO) are coded 0 and marked boxes (representing YES) coded 1. The same question also asked participants if they were seen at a community health clinic, emergency room, urgent care, hospital (other than emergency room or urgent care) and other in the last two years. The reason doctor's office was chosen as a proxy for better access is because it is assumed that those accessing a doctor's office are either attending a specialist or have a primary care physician. These two assumptions represent a higher level of access in the

Table 5.8. Variable Operationalization

Items in Questionnaire	Responses (codes/scales used)
DEPENDENT VARIABLE	
Better Access: Participant reported to have been seen at a doctor's office in last 2 years	No (0); Yes (1)
INDEPENDENT VARIABLES	
IV 1: Acculturation (Cronbach Alpha: Anglo portion = 0.965; Hispanic portion = 0.884)	
1. Language Use: (a) How often do you speak English? (b) How often do you speak in English with your friends? (c) How often do you think in English? (d) How often to do you speak Spanish (e) Ho often do you speak Spanish with your friends? (f) How often do you think in Spanish?	Almost Never (1); Sometimes (2); Often (3); Almost Always (4)
2. Linguistic Proficiency: (g) How well do you speak English? (h) How well do you read in English? (i) How well do you understand television programs in English? (j) How well do you understand radio programs in English? (k) How well do you write in English? (l) How well do you understand music in English? (m) How well do you speak Spanish? (n) How well do you read in Spanish? (o) How well do you understand television programs in Spanish? (p) How well do you understand radio programs in Spanish? (q) How well do you write in Spanish? (r) How well do you understand music in Spanish?	Very Poorly (1); Poorly (2); Well (3); Very Well (4)
3. Electronic Media: (s) How often do you watch television programs in English? (t) How often do you listen to radio programs in English? (u)How often do you listen to music in English? (v) How often do you watch television programs in Spanish? (w) How often do you listen to radio programs in Spanish? (x)How often do you listen to music in Spanish?	Almost Never (1); Sometimes (2); Often (3); Almost Always (4)
IV2: Bonding Social Capital (1- 4 combined with Cronbach Alpha = 0.818)	
1. Please indicate frequency/number of interactions you have with other people: (a) Family members (b) Relatives (c) Friends	None (1); A few (2); Some (3); Most (4); All (5)
2. With how many people in each of the following categories do you keep contact? (a) Family members (b) Relatives (c) Friends	
3. Among these people, how many can you trust? (a) Family members (b) Relatives (c) Friends	
4. How many wll help you upon request? (a) Family members (b) Relatives (c) Friends	
IV3: Bridging Social Capital (1- 8 combined with Cronbach Alpha = 0.893)	
1. Please indicate frequency/number of interactions you have with other people: (a) Neighbors (b) Community Members	None (1); A few (2); Some (3); Most (4); All (5)
2. With how many people in each of the following categories do you keep contact? (a) Neighbors (b) Community Members	
3. Among these people, how many can you trust? (a) Neighbors (b) Community Members	
4. How many wll help you upon request? (a) Neighbors (b) Community Members	
5. Please indicate frequency of interaction you have with other people (a) Government, political, social, economic groups/organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.) (b) Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	
6. Do you participate in activities for how many of each of these groups and organizations? (a) Government, political, social, economic groups/organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.) (b) Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	
7. Among each type of group and organization, how many represent your rights and interests? (a) Government, political, social, economic groups/organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.) (b) Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	
8. How many will help you upon request? (a) Government, political, social, economic groups/organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.) (b) Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	
IV4: Linking Social Capital (1- 2 combined with Cronbach Alpha = 0.924)	
1. How many possess the following assets/resources? (a) Certain political power (b) Wealth or owner of a large business (c) Broad connections with others (d) High reputation/influential (e) Connected to educational resources (f) With a professional job	None (1); A few (2); Some (3); Most (4); All (5)
2. When all groups and organizations are considered, how many possess the following assets/resources? (a) Significant power for decision making (b) Solid finanancial basis (c) Broad social connections (d) Great social influence	
CONTROL VARIABLES	
CV 1: Educational Level	
Scale was built based on approximate number of years in school	No schooling completed (0); Nursery School to 4th grade (4); 5th to 6th grade (5.5); 7th to 8th grade (7.5); 9th grade (9); 10th grade (10); 11th grade (11); 12 grade, No diploma (11.5); HS diploma (12); 1 or more years of college, no degree (13); Associate's degree (14); Bachelor's degree (16); Masters' degree (18); Professional's degree (19); Doctorate's degree (20)
CV2: Health Insurance (participant has health insurance)	NO (0); YES (1)
CV3: Age	Age as reported
CV4: Gender	Female (0); Male (1)
INTERACTION VARIABLE	
Interaction between Acculturation and Health Insurance	Constructed by multiplying the Acculturation variable with the Health Insurance variable

US as discussed in the meta-analysis chapter. Therefore, access to health care is measured by a dummy variable that stands as a proxy.

Four independent variables derived from the previously discussed hypotheses are used in this study: acculturation, bonding social capital, bridging social capital and linking social capital. Acculturation is measured through a four-point Likert scale established by Marin and Gamba (1996) using "almost never" (1), "sometimes" (2), "often" (3) and "almost always" (4) for the language use (Appendix 2: #13 a-f) and electronic media (Appendix 2: #13 s-x) dimensions. The linguistic proficiency (Appendix 2: #13 g-r) dimension uses "very poorly" (1), "poorly" (2), "well" (3), and "very well" (4). The acculturation variable is therefore constructed from 24 questions (Appendix 2: #13 a-x) - 12 that measure the Anglo culture and 12 that measure Latino culture - that are used to classify each participant in one of the four categories: integrated, separated, assimilated, or marginalized. I first averaged all the responses that belong to each, the English (measuring Anglo culture) and the Spanish (measuring Latino culture) questions in the three dimensions separately. The Cronbach Alpha of all the Anglo questions in the scale is 0.965 while the Latino portion is 0.884. To assign each participant to one of the four acculturation categories the following was done:

- Marginalized individuals: those with an average equal or greater than 2.5 for English (Anglo) and less than 2.5 for Spanish (Latino).
- Separated individuals: those with an average equal or greater than 2.5 for Spanish (Latino) and equal or less than 2.5 for English (Anglo).
- Integrated individuals: those with an average equal or greater than 2.5 for both English (Anglo) and Spanish (Latino).
- Assimilated individuals: those with an average equal or greater than 2.5 for English (Anglo) and equal or less than 2 for Spanish (Latino).

The three types of social capital are measured through a five-point Likert scale developed (Chen et al., 2009) with answers “none” (1), “a few” (2), “some” (3), “most” (4) and “all” (5). Bonding social capital includes 12 questions that measure close social ties including family members, relatives and friends (Appendix 2: a, b, and d in # 53 through #56). The Cronbach Alpha for this group is 0.818. Bridging social capital includes 16 questions that measure social ties that are less personal such as neighbors, community members, volunteer groups, trade unions, religious groups, recreational groups and leisure groups (Appendix 2: c and f in # 53 through #56; a and b in #58 through #61). Coworkers are included in the questionnaire but not in this variable because there are too many missing variables and when included it significantly decreases the Cronbach Alpha compromising internal validity. The Cronbach Alpha for the questions selected to measure bridging social capital is 0.893. Linking social capital is measured through 10 questions (Appendix 2 questions # 57 a through f; 62 a through d). These questions are expected to measure if participants have strong ties with people who may have more power and/or influence in their communities. The Cronbach Alpha for this group is 0.924.

Four control variables are included: educational level, health insurance, age and gender. Although these are treated as independent variables they are not part of the main focus in this study, but are included because they are expected to strengthen the model. Participants were asked for their specific level of education including 15 different levels (Appendix 2: included in #8’s table). However, the levels listed in the table do not constitute a scale. So, a scale was constructed using estimated years of schooling encompassed in each category listed including “no schooling completed” (0 years),

nursery school to 4th grade (4 years), 5th to 6th grade (5.5 years), 7th to 8th grade (7.5 years), 9th grade (9 years), 10th grade (10 years), 11th grade (11 years), 12th grade but no diploma (11.5 years), HS diploma (12 years), 1 or more years of college but no degree (13 years), Associate's degree (14 years), Bachelor's degree (16 years), Master's degree (18 years), Professional's degree (19 years), doctorate's degree (20 years).

A dummy variable was created to measure healthcare insurance where 0 stands for not having insurance and 1 for those who do have any type of insurance serving as the reference group. Age was simply included as reported constituting a scale. For the gender question participants were given the option of male and female.

Finally, the interaction variable was created by multiplying the acculturation and insurance variables. The interaction variable serves as a moderator in the model since it is assumed that no matter how acculturated someone is to the American way of life, if that person is undocumented, legal restrictions will inhibit that person from having health insurance. By including such moderator in the model, the relationship between health insurance and the DV should be more accurate than if the moderator were not included. Therefore, the interaction is expected to strengthen the model overall.

D. Results

Descriptive Statistics

The dependent variable coded as a binary categorical variable has a frequency of 170 (69%) for those coded "0" (No) representing those with less access, and 68 (28%) for those coded "1" (Yes) representing those who have better access.

Table 5.9 depicts indexed results of the descriptive statistics for a sample N=245. The mean for respondents' acculturation level is 2.4 with a standard deviation of 0.59711 and a median of 2.0. The numbers for social capital are as follows: bonding social capital's mean is 3.89 with a standard deviation of 0.721 and a median of 4; bridging social capital has a mean of 2.68, a standard deviation of 0.989 and a median of 2.5 while; linking social capital has a mean of 2.29, a standard deviation of 0.932 and a median of 2.2. The mean for educational level is 9.81 years with a standard deviation of 4.174 and a median of 11.5 years. The control variable labeled health insurance has a frequency of 94 (38%) for those who have insurance and 148 (60%) for those who do not. In terms of age, the youngest corresponded to 18 years of age and oldest to 86 with a mean of 41.68, standard deviation of 13.754 and median of 40. Finally, there were 157 (64%) female participants and 88 (36%) male.

Results from Logistic Regression Model

Before running the logistic regression model, correlations were verified among the independent and control variables (Table 5.10). None of the variables show any significant correlation among each other, meaning none are significantly above a 0.70 correlation (Pearson). Collinearity statistics were also checked through the VIF values (Table 5.11). None of the VIF values are above 3, which means collinearity is not a concern for the model.

Table 5.9: Descriptive Statistics (N=245)

Items in Questionnaire	Minimum-Maximum (for scales)	Frequencies and Percentages of Responses	Mean (for scales	Stand Dev (for scales)	Median (for scales)
DEPENDENT VARIABLE					
Better Access: Participant reported to have been seen at a doctor's office in last 2 years	binary	NO: 170 (69%) YES: 68 (28%)			
INDEPENDENT VARIABLES					
IV 1: Acculturation	**1-4**	**1=Almost Never; 2=Sometimes; 3=Often; 4=Almost Always**	**2.28**	**0.945**	**2.1**
1. English Language Use	1-4	Almost Never: 79 (32%) Sometimes: 70 (29%) Often: 57 (23%) Almost Always 39 (16%)	2.25	1.01	2
2. English Linguistic Proficiency	1-4	Very Poorly: 63 (26%) Poorly: 92 (38%) Well: 42 (17%) Very Well: 48 (20%)	2.29	1.03	2
3. English Electronic Media Use	1-4	Almost Never: 70 (29%) Sometimes: 71 (29%) Often: 57 (23%) Almost Always: 47 (19%)	2.34	1.04	2.33
4. Spanish Language Use	1-4	Almost Never: 8 (3%) Sometimes: 17 (7%) Often: 48 (20%) Almost Always 172 (70%)	3.58	0.73	4
5. Spanish Linguistic Proficiency	1-4	Very Poorly: 7 (3%) Poorly: 7 (3%) Well: 62 (25%) Very Well: 162 (66%)	3.55	0.658	4
6. Spanish Electronic Media Use	1-4	Almost Never: 21 (9%) Sometimes: 53 (22%) Often: 85 (35%) Almost Always: 79 (32%)	2.92	0.924	3
IV2: Bonding Social Capital	**1-5**	**1=None; 2=A few; 3=Some; 4=Most; 5=All**	**3.89**	**0.721**	**4**
1. Frequency of interactions	1-5	None: 3 (1%) A few: 18 (7%) Some: 32 (13%) Most: 116 (47%) All: 74 (30%)	3.98	0.854	4
2. Keeps in contact	1-5	None: 2 (1%) A few: 21 (9%) Some: 35 (14%) Most:105 (43%) All: 76 (31%)	3.97	0.86	4
3. Are trusted	1-5	None: 3 (1%) A few: 22 (9%) Some: 56 (23%) Most:111 (45%) All: 50 (20%)	3.75	0.885	4
4. Can count upon request	1-5	None: 2 (1%) A few: 12 (5%) Some: 59 (24%) Most: 109 (45%) All: 60 (25%)	3.879	0.829	4

Table 5.9. Descriptive Statistics (N=245) (cont.)

Items in Questionnaire		Responses (codes/scales used)			
IV3: Bridging Social Capital	**1-5**	**1=None; 2=A few; 3=Some; 4=Most; 5=All**	**2.68**	**0.989**	**2.5**
1. Frequency of interactions (with individuals)	1-5	None: 17 (7%) A few: 60 (25%) Some:85 (35%) Most: 47 (19%) All: 34 (14%)	2.914	1.112	3
2. Keeps in contact (with individuals)	1-5	None: 17 (7%) A few: 66 (27%) Some: 77 (31%) Most: 51 (21%) All: 29 (12%)	2.85	1.12	3
3. Are trusted (with individuals)	1-5	None: 48 (20%) A few: 76 (31%) Some: 64 (26%) Most: 40 16%) All: 15 (6%)	2.41	1.124	2
4. Can count upon request (with individuals)	1-5	None: 25 (10%) A few: 83 (34%) Some: 68 (28%) Most: 44 (18%) All: 68 (28%)	2.631	1.111	2.5
5. Frequency of interactions with organizations	1-5	None: 41 (17%) A few: 76 (31%) Some: 82 (34%) Most: 37 (15%) All: 7 (3%)	2.38	0.99	2.5
6. Participation in activities with organizations	1-5	None: 54 (22%) A few: 82 (36%) Some: 66 (27%) Most: 29 (12%) All: 12 (5%)	2.25	1.062	2
7. Number of organizations that represent participant's rights and interests	1-5	None: 38 (16%) A few: 59 (24%) Some: 83 (34%) Most: 48 (20%) All: 12 (5%)	2.58	1.08	2.5
8. Organizations that will help upon request	1-5	None: 19 (8%) A few: 67 (27%) Some: 78 (32%) Most: 56 (23%) All: 19 (8%)	2.8	1.063	3
IV4: Linking Social Capital (1- 2 combined with Cronbach Alpha = 0.924)	**1-5**	**1=None; 2=A few; 3=Some; 4=Most; 5=All**	**2.4**	**0.915**	**2.33**
1. Connections to people with assets/resources	1-5	None: 80 (33) A few:80 (33%) Some:47 (19%) Most:28 (11%) All: 3 (1%)	2.09	1.012	1.83
2. Connections to organizations with assets/resources	1-5	None: 35 (14) A few: 62 (25%) Some: 72 (29%) Most: 52 (21%) All: 16 (7%)	2.71	1.089	2.75
CONTROL VARIABLES					
CV 1: Educational Level	**0-20**	**Scale constructed based on approximate years of schooling**	**9.81**	**4.174**	**11.5**
1. Received no schooling	0	8 (3%)			
2. Received schooling but no HS diploma obtained	1-11.5	117 (48%)			
3. HS Diploma	12	66 (27%)			
4. Above HS Education	13-20	49 (20%)			
CV2: Health Insurance (participant has health insurance)	binary	NO: 148 (60%) YES: 94 (38%)			
CV3: Age	18-86		41.68	13.754	40
CV4: Gender	binary	Male: 88 (36%) Female: 157 (64%)			

Notes: Numbers are rounded. Missing items not included.

Table 5.10. Correlations (Pearson)

		1	2	3	4	5	6	7	8
1	**Acculturation**	1							
2	**Bonding Social Capital**	.269**	1						
3	**Bridging Social Capital**	.135*	.572**	1					
4	**Linking Social Capital**	.326**	.345**	.277**	1				
5	**Education**	.469**	.152*	-.124	.226**	1			
6	**Have Insurance**	.189**	.108	.073	.135*	-.001	1		
7	**Age**	-.090	.023	.194**	-.054	-.290**	.237**	1	
8	**Gender**	-.008	-.137*	.022	0.017	-.134*	.057	.006	1

** *Correlation is significant at the 0.01 level (2-tailed).*

* *Correlation is significant at the 0.05 level (2-tailed).*

The logistic regression model was first run including the interaction. For this model, the Chi-square value is 48.021 ($p \leq .001$), the Nagelkerke R-square (a measure for pseudo-R-square) is 0.27 and the overall percentage predicted by the model is 78.8%. Since the interactional variable was not significant, it was eliminated from the final model. The final model without the interaction has a Chi-square value of 47.607 ($p \leq .001$), the pseudo-R-square value predicts that about 24% of the variation in the dependent variable is explained by the model. The overall percentage fit statistic of the reduced model estimates that about 78.4% of cases are correctly predicted by this model. The sample size used in the final model is N=231 after 14 missing cases were eliminated.

Table 5.11. Collinearity Statistics

	VIF
Acculturation	1.464
Bonding Social Capital	1.682
Bridging Social Capital	1.633
Linking Social Capital	1.258
Education	1.492
Have Insurance	1.162
Age	1.199
Gender	1.075

In terms of the odds ratio for the coefficients included in the model, the results show that three variables are not significant: linking social capital, educational level and gender (Table 5.12). As mentioned, the interaction variable was also not significant.

The final model used predicts that a one unit increase in acculturation (versus being one unit less acculturated) is associated with a 3.069 ($p \leq .001$) higher odds (a 0.75 probability) of reporting better access to health care when holding all other variables constant. Every unit increase in bridging social capital (as opposed to having a lower level of bridging social capital) is associated with a 1.581 ($p \leq .05$) higher odds (a 0.60 probability) of reporting better access when holding all other variables at fixed values.

On the other hand, every unit increase in bonding social capital (versus a lower level of bonding social capital) is associated with a 0.528 ($p \leq .05$) lower odds (a 0.35 probability) of reporting better access when holding all other variables constant. Bonding social capital is therefore showing a different result than hypothesized. The health insurance coefficient predicts that having insurance has a positive impact on access, with an odds ratio of 2.411 ($p \leq .01$). Hence, people who have insurance have a 0.71 higher probability of accessing health care as compared to those who do not have insurance when holding all other variables at fixed values.

Table 5.12. Odds Ratio and Probabilities (N=231)

Variables	Model Including Interacton		Reduced Model (w/out Interaction)	
	Odds Ratio	Probability	Odds Ratio	Probability
Acculturation	3.763**	0.79	3.069***	0.75
Bonding Social Capital	0.519*	0.34	0.528*	0.34
Bridging Social Capital	1.610*	0.62	1.581*	0.61
Linking Social Capital	1.219	0.55	1.215	0.55
Educational Level	1.044	0.51	1.041	0.51
Health Insurance	6.078	0.86	2.411**	0.71
Interaction (Acculturation and H. Insurance)	1.216	0.55	N/A	N/A

*$p \leq .05$; **$p \leq .01$; $p \leq .001$ (two-tailed tests)*

Going back to the five hypotheses:

H_1: Higher levels of acculturation to the American way of life among Hispanics are associated with higher chances of accessing health care.

H_2: There is an interactional effect between acculturation and health insurance status that derives from legal status that impacts access to health care.

H_3: Higher levels of bonding social capital are associated with higher levels of access to health care.

H_4: Higher levels of bridging social capital are associated with higher levels of access to health care.

H_5: Higher levels of linking social capital are associated with higher levels of access to health care.

The results lead to the conclusion that we fail to reject H_1 and H_4 and reject H_2, H_3, and H_5. However, with respect to bonding social capital, results show that, as bonding social capital increases, access is worsened, which is showing significance on the opposite directions as to what was hypothesized. This result has important implications for how different types of social capital may impact immigrant groups, which will be discussed more in the next section. Among the control variables tested, it is found that age (being older) and having health insurance impact access to health care for this group, but educational level and gender are not showing significance.

E. Final Remarks

The statistical analysis applied corroborates that Hispanics in Missouri have low access to health care and that there are several factors, both structural and social, that cause this situation. Seven main conclusions can be drawn from the quantitative analysis study in this chapter. First, as is the case in so many other studies previously analyzed in the meta-analysis, lack of insurance is proven to be a significant barrier for this group in Missouri. In addition, age (older) increases chances of access.

I found that 61 percent of Latinos in the state are uninsured. As Chapter 2 explains, insurance represents a structural barrier in American society. In other words, the system

dictates that having insurance is the first requirement needed to access the healthcare system. This requirement was not just instituted by law (i.e. formally) when the Affordable Care Act made it mandatory, but has also been an informal one stemming from a strong neoliberal worldview governing the healthcare system in the US. As (North, 1990) points out, informal institutions can be as authoritative as formal ones, particularly when a country is found in a path dependency situation as is the case with health care here. In the US, path dependency in health care means that practices applied today are based on historical preferences instituted over time.

The challenging issue in the system's path dependency situation is not just that insurance is required to enter the system, but also how individuals can access and use insurance in a neoliberal guided structure (Coburn, 2004). If insurance is the first thing required to access the system and if, at the same time, the system imposes too many barriers for certain groups to obtain insurance (i.e. the poor, minorities, etc.), then the system should be questioned. If we question the system, we would be adopting another approach to the traditional one that has obstinately focused primarily on the individual's responsibility while ignoring how the structure affects individuals' choices.

Furthermore, the responsibility imposed on individuals is not restricted to insurance requirement, but extends to how individuals are expected to use their insurance. A simple illustration serves to prove this point. Insurance companies negotiate prices for patients. Prices in the same hospital therefore vary by patient depending on which company insures the patient and the type of plan chosen. The result of this arrangement is a lack of transparency of prices in the same hospital. How can individuals be expected to be responsible with their out of pocket payments if, in the first place, they cannot even plan

ahead in a system that offers no transparency of prices for its services? More on this conundrum is examined in the last chapter.

Second, although educational levels are generally low - over half (53%) have less than a high school diploma – this factor is not significant in this study. This finding must be interpreted with caution and further tests and/or perhaps a larger sample with greater variation in the levels of education are needed to make broader conclusions. There are other impacts of educational level on healthcare access that were not tested here, such as the availability of effective services that can enhance navigation of this complex system (i.e. *promotoras de salud)*.

Third, linking social capital is not significant in this study. Yet, it must be pointed out that interviewers complained about sometimes struggling to convey the meaning of these questions. These were among the toughest questions to translate because in Spanish, the scale did not apply equally across all questions as it did in English (i.e. same scale was used for all social capital questions, which works well in English, but does not work well for all questions when translated into Spanish). So, the problem was not in the translation per se, but the fact that we were dealing with the same scale across all questions in the social capital portion of the questionnaire. The other issue is that this group had low levels of linking social capital overall, so we may lack enough data and face a limited range to prove this link. Finally, the association between linking social capital and access is harder to make the case for here because the structural barriers in access are imposed primarily at the federal rather than the community level. In other words, a person having connections, say to someone with local political power, is not going to have an impact on that person's rights determined at the federal level. Connections to local political power

could however impact the existence of community clinics for instance. Such clinics offer some forms of medical services, but they are limited when it comes to specialty care and more advanced screenings.

Fourth, bonding social capital is found to be significant, but the effect is opposite to what was predicted. The contradicting finding is very important because it sheds light on how we should approach immigrant/newcomer groups when it comes to addressing the issue of uneven development as observed by (Harvey, 2006). Bonding social capital stems from close relationships, such as family members, friends and relatives (Woolcock, 2001). For the general population, support coming from this kind of relationships may prove to be effective in enhancing healthcare access. In the specific literature on Hispanics' access to healthcare analyzed in the meta-study, the impact found from bonding social capital (although most studies label with other terms) is mixed. So, I predicted bonding social capital would be an enhancer, but acknowledge the hypotheses could have been in the opposite direction. In the case of immigrants, there are two main factors that must be considered: the residing location of individuals in these tight relationships offering support, as well as their level of integration into American society. The social capital scale used, unfortunately does not specify where these family members, friends or relatives reside. If any of them reside, say in Mexico, then my results from bonding social capital make a lot of sense. They are not enhancing, and may actually be detrimental to access health care for this group, as the statistical results prove. The unfavorable impact from these relationships can, for instance, come from the fact that these people are not connected to the American healthcare system and they may in turn provide recommendations that do not apply in the US. Another perspective is that, if

participants are restricting their more intimate relationships to individuals that mainly reside in highly concentrated Spanish-speaking communities, they may also be restricting themselves from being more integrated to American society. This lack of integration indirectly imposes barriers to better access healthcare services. This finding relates to the study by (Katz et al., 2012) who find that bonding social capital (authors used "informal health communication ecologies") can be detrimental to access healthcare services among Hispanics of lower socio-economic status.

Fifth, bridging social capital is also a significant factor in healthcare access and resulted as predicted. Bridging social capital comes from networks that are not close relationships, such as neighbors and community members (Woolcock, 2001). Being connected to individuals that are assumed to be well integrated in American society and, as a result, expected to also be better connected to and have a better understanding of the healthcare system, can aid in access for Latinos. Findings support this hypothesis. With respect to public policy and other forms of initiative that aim at enhancing access, this finding has important implications for policy making. A good example of a bridging social capital created through policy are the *promotoras de salud*. The *promotoras* are people in the community that are hired and then trained to help Spanish speaking communities navigate the healthcare system including how to buy insurance, educating about the importance of having a primary healthcare provider, offering healthy eating educational activities, and so on.

Sixth, acculturation was proven to be relevant in accessing health care for this group. I hypothesized that if they were more acculturated to the American way of life, they would also be more acculturated to the healthcare system and have better access. I relied

on the bi-dimensional classification proposed by Berry (1980; 2003, 2005) which includes marginalized, separated, integrated and assimilated. In this group, both marginalized and separated would be individuals that are not acculturated to the Anglo-American way of life, while both integrated (also bicultural) and assimilated (those who have lost their connections to the Latino culture) would be the ones that are acculturated.

The acculturation hypothesis is confirmed but should be interpreted from two perspectives: from the Latino immigrant lacking an understanding of the system, as well as from the American society that continues to support the growing complexity of its healthcare system. In the short-term it is important to help Hispanic immigrants understand and navigate the complex system if the aim is to enhance their access. In fact, many people are getting sick and dying due to lack of access (Hadley, 2003). This help, however, cannot be restricted to just offering translated materials or translators among services themselves. As the study done in Massachusetts (Maxwell et al., 2011) proves, and the three dimensions included in the acculturation scale tested corroborate, translation alone will not do the job. Latinos must be aided in getting acculturated to the healthcare system.

Health care navigators are being used across the US to help Hispanics access insurance and other services (Perez-Escamilla, 2010). Nonetheless, in order for these services to be truly effective, follow ups are essential because insurance status often changes when employment status changes (Schoen & DesRoches, 2000). In a system that primarily relies on employment for insurance, this has strong implications for those in lower paid jobs where most of the structural problems are found (Doty & Holmgren, 2006; Fronstin, 2013; Graves & Long, 2006; Schur et al., 2001).

Furthermore, there are various aspects that are simply not part of Latinos' "cultural capital", as Bourdieu (Bourdieu, 2011) would call it, that go beyond just making sure people get insurance. Hispanics who do not possess the cultural capital that applies to health care will constantly struggle in access even after they get insurance. If the navigators succeed in enrolling them in an insurance plan, and then they don't understand how to use that insurance, the cost of paying for that insurance may actually hurt them more than help them (Sanger-Katz, 2016). So, mechanisms to increase their cultural capital must be identified and applied.

As pointed out in the analysis on findings regarding insurance, in the long-term, society needs to reflect on the urgency of simplifying the system. This study merely adds to the overwhelming amount of research that show how such complexity is impacting not just Hispanics, but Americans overall. Hispanics serve as the most extreme group illustrating the crucial importance of making significant changes if the US were to seriously move toward better access for society as a whole. For over half a century the strategy has been one that (Waitzkin, 1978) has labeled as "patching," but no serious steps have been taken to focus on the root of the issues that are causing the malfunctioning of the system.

In sum, these results corroborate that structural barriers are present. Nonetheless, they also add to the literature by saying that efforts to help Hispanics acculturate to the healthcare system, particularly through adding bridging social capital mechanisms, could increase access for this population to overcome some of the structural barriers. These findings do not however imply that programs targeting acculturation and bridging social

capital could potentially eliminate the structural problems. In other words, structural barriers should also be addressed in the long-term.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

A. Conclusions

Although access to health care does not fully determine all outcomes in people's health, inequalities observed in healthcare access can impact inequalities in health outcomes across groups. The first study of health outcome inequalities can be credited to Engel, titled *The condition of the working class in England* in 1845 (Waitzkin, 1978). Engel traced diseases such as tuberculosis, typhoid, and typhus to malnutrition, inadequate housing, contaminated water supplies and overcrowding which became common among the working class during the Industrial Revolution in England. Influenced by Engel, Virchow, a German physician, pioneered studies on infectious diseases, epidemiology and social medicine. Virchow surprised people by offering no medical solutions from the studies he conducted, his recommendations to treat diseases, were to "increase employment, better wages, local autonomy in government, agricultural cooperatives, and more progressive taxation structure" (Waitzkin, 1978, p. 264).

The ideas from Engel and Virchow were dismissed after the 1840s. The Germ Theory Model that emerged in the 19th century took over the medical field and with this, a "unifactorial model" (p. 265) of disease began. The 1910 Flexner Report[25] later completed the transition that began with the Germ Theory Model. Since then, medicine treats people more as the sum of organs, as opposed to a whole organism that resides in a

[25] The Flexner Report is a study of medical education in the United States and Canada, written by Abraham Flexner and published in 1910 and sponsored by the Carnegie Foundation. Many aspects of the present-day American medical profession stem from this report and its aftermath.

society that impacts the health of the organism. This unifactorial mentality is not just applied to health, but today also extends to health care.

Health inequalities as a result of healthcare access was not a huge issue prior to 1750 when there were no major technological advances in medicine. Outcomes among the rich were not differentiated substantially from those among the poor before then. As soon as technological advances (primarily with vaccinations) began to bring significant impacts on health we start observing more divergences in health between rich and poor. Health inequalities first appeared within countries like Britain, and then among countries. At the same time that technological advances brought positive trends in medicine, the Industrial Revolution and increased urbanization brought bad living and working conditions for the working class and the poor. As Engles and Virchow noted, these conditions also had a negative impact on people's health.

More current research on health inequalities, show that they are not caused by poverty per se, but by bad or unfair policies. Take for instance China, a country in which health improvements were more successful before its recent impressive economic growth. There have been no major improvements in health in China since the mid-seventies when the country began implementing more capitalist policies. Hence, as China increased its GDP per capita, the health of its population has actually deteriorated (Deaton, 2007, 2013a, 2013b).

To treat health inequalities, Deaton (2007) argues against traditional economists' recommendations that focus largely on income growth. Instead, he proposes to shift focus on better education and towards the treatment of population health as a human right through political priority. Another example he gives to prove his point is the case of

India. In the 90s, India experienced rapid economic growth. During this same period, infant and child mortality rates, which had been declining, became more stagnant. When the government stopped focusing on things such as bringing vaccinations to the people, opening more public health centers, etc., and started putting effort on income growth, health outcomes suffered. The cases of China and India are different when analyzed in detail, but they both serve to demonstrate that for the working class and the poor, too much emphasis on *economism* could be harmful if not complemented with policies that also emphasize social aspects that are not centered on income growth.

There are two main flaws with the approach of governments focusing too much on GDP growth. First, resources are cut or shifted from other areas under the assumption that increased incomes will bring about improvements in health. Second, increasing the average real GDP per capita (which is what policies tend to focus on) does not guarantee an even distribution of such growth across the population. In other words, you can have an average that is growing but one in which most of that growth is concentrated among the top earners, hence resulting in higher inequalities. So even if increases in income were to have real impact on health, if the growth is not distributed evenly, gains in health would not be seen.

There are many factors that influence the health of individuals. Access to health care is one of them. Universal access to health care is included as a key component of "Good Health and Well-Being," among the 17 sustainable development goals recently listed by the United Nations. In discussing that goal, the UN states: "The aim is to achieve universal health coverage, and provide access to safe and affordable medicines and vaccines for all" (United Nations Development Programme, 2017). More specifically,

the target goals state: “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all” (United Nations Development Programme, 2017). In the US, the most commonly used definition is: “Access to health care refers to the degree to which people are able to obtain appropriate care from the health care system in a timely manner” (Escarce & Kapur, 2006, p. 411).

Potential access and realized access are further differentiated. Potential access “refers to the presence or absence of financial and non-financial barriers to obtaining appropriate and timely care,” while realized access “refers to the quantity of health care actually received” (Escarce & Kapur, 2006, p. 412). The meta-analysis conducted in Chapter 4 shows that potential access is primarily dependent on having insurance in the US. Actual access, is measured mainly through realized visits to a doctor, usually a primary care physician or a specialist. In the last fifty years, the Hispanic population has been recurrently found to have the lowest potential and realized access to health care in the country. This dissertation focuses on Hispanics’ access to healthcare with an emphasis in the state of Missouri.

In order to understand the broader context in which access to health care for Hispanics in Missouri takes place, **Chapter 2** first provides an overview of the state of the US healthcare system. The American healthcare system is considered the most privatized among developed countries and also the most complex, most inefficient and most expensive in the OECD. In addition, it is the country that leaves the most number of people without or with low access (OECD, 2015b; C. Schoen et al., 2009, 2013; Squires

& Anderson, 2015). As Sanger-Katz (2016) notes, the US is "the most expensive place in the world to get sick" (Refer to Table 1.1).

Remarkably, health care is also one of the most profitable sectors in the US economy encompassing almost $3 trillion in GDP, larger than the whole economy of France or the UK, or if counted as a country, it would be the fifth largest in the world (Blumenthal, 2014; The Economist, 2016a). There is clearly a misalignment between what the healthcare system is intended to offer society and what is happening in reality. The current crisis is not new, however, in the late 70s Waitzkin (1978) asserted that society has been "patching" (p. 273) the system as the size of the crisis continues to grow. The problem is that the crisis has escalated to such a high level that there is no longer a simple way out.

On the one hand, a portion of society is being excluded from access at the same time that access keeps getting more limited for the majority of the overall population. The constraints in access for the overall population can be observed through: increased costs for consumers through higher premiums, deductibles and copayments (Pear, 2015, 2016a, 2016a, 2016b); increased costs of insurance paid by employers at the expense of higher wages over time (Gaynor, 2011); decrease quality in services as measured by trends such as the substitution of doctors for nurses (Gaynor, 2011; Trish & Herring, 2015); increased scarcity of basic medications that have recovered R&D costs in hospitals because they bring less profits for distributors (Fink, 2016); increased costs of certain medications due to monopolistic strategies applied in the US but not seen in other countries (Paton & Kresge, 2016; The Economist, 2016b; Woodyard & Layton, 2016); mislead R&D costs among pharmaceuticals that impact price of treatments (DiMasi,

Grabowski, & Hansen, 2016; Kolata, 2017a; Kolata, 2017b; Thomas & Ornstein, 2017b; Workman, Draetta, Schellens, & Bernards, 2017); the restriction of more costly but less addictive medications among insurers which seemed to be impacting an opium addiction epidemic (Thomas & Ornstein, 2017), and so on. On the other hand, there is a significant number of people whose jobs depend on such a dysfunctional system. As the system grew in complexity through its patching mechanism, so did number of jobs.

Eckersley (2001) analyzes the American healthcare system from an anthropological perspective. By observing the American healthcare system from the outside, Eckersley shows how there is a culture that rules over this system. Insiders usually are not conscious or are incapable of perceiving this culture because they themselves are also being governed by it. In Chapter 2, I followed Eckersley's approach in my analysis of the healthcare crisis by further expanding it through Gramsci's (1948/2014) theoretical framework from his *Prison Notebooks* on cultural hegemony. Both Eckersley (2001) and Gramsci (1948/2014) allowed me to analyze the American healthcare system through the worldview a general sociologist and a political economist would assume, one in which I try to look at the root of the *disease*, as opposed to just the *symptoms*.

I first take into account economic data, primarily from the hospital and insurance markets, that illustrate the severity of the healthcare crisis. Both the hospital and insurance markets operate at local levels, but researchers observe clear national trends when we compound such markets. Various studies show the majority of these markets are highly concentrated all across the US today. Moreover, at the national level, a small number of large firms dominate most insurance and pharmaceutical markets. As consolidation increased, the efficiency gains, used as the primary justification for

mergers, have not been passed on to consumers. On the contrary, overall prices have been rising, quality of services has been declining, and over time individuals have been recurrently cut on breadth of coverage. As things have gotten worse for most Americans, hospitals, insurance and pharmaceutical companies continue to use the rise in cost as further justification to merge. This creates a vicious cycle in which the end result has been cuts in access to health care for the overall population. Although the rise in costs is not fully due to consolidation, there is consensus today that increased market concentration has indeed had a significant impact (L. Dafny, 2009; L. Dafny et al., 2012; L. S. Dafny, 2010, 2015; Gaynor, 2011; The Economist, 2016a, 2016b).

Since the 1980s healthcare has been compromised by policies that have in fact worsened access for most Americans, while concurrently expanding profits for some companies servicing the sector.[26] In 1987, the national mean HHI[27] for hospital markets was 2,340 and by 2006 the HHI was 3,440. Already by 1992, the HHI for hospitals (=2,440) was just below the cut-off point for being considered highly-concentrated. In 1998, the national mean HHI for large employer insurance markets was 2,984 and by 2009 the HHI went up to 4,126 (L. Dafny, 2009; L. Dafny et al., 2012; L. S. Dafny, 2010, 2015). Trish and Herring (2015) show that less than 3% of the markets in which employers purchase fully-insured coverage are not concentrated today and about 50% are

[26] This is primarily referring to insurance and pharmaceutical companies. Hospitals are usually not-for-profit, but they operate as if being for profit since they operate within expectations from insurances and pharmaceuticals (Gaynor, 2011).

[27] The HHI goes from 0 to 10,000. The higher the number, the closer a market is to a monopoly, where 0=perfect competition and 10,000= 1 firm in the market. In general, the US Department of Justice considers less than 1,500 to be a competitive marketplace, 1,500-2,500 to be moderately concentrated, and above 2,500 to be highly concentrated. Anytime a merger or acquisition case raises the HHI by at least 200 points, they may be blocked based on anti-trust concerns, but this rule has an exception. Mergers may be justified based on efficiency gains, which is precisely what companies have become good at demonstrating when requesting approval.

highly concentrated, meaning we're getting close to the point where horizontal integration will be saturated among insurers. Most of this consolidation has so far taken place at the horizontal level. While vertical integration has happened less so, it is starting to pick up (Gaynor, 2011). I predict that as horizontal integration saturates, companies will be more aggressive in vertical undertakings.

The end result of consolidation has been that as hospitals increased prices and cut on quality of services, insurance companies passed those costs on to consumers. The increased costs to consumers are observed through the fact that employers have passed these to their employees via lower wages (i.e. no wage increases, or smaller increases, particularly when adjusted to inflation) or simply reduced benefits (i.e. higher premiums, less coverage, and in some cases loss of coverage) (Gaynor, 2011). These trends are critical when we consider that about 56% of the non-elderly population receives health insurance coverage through employment. Most are worse off in this system , although there seems to be one notable exception: the very wealthy. Schwartz (2017) displays how specific services that target the very wealthy are popping up offering VIP medical access that seems like a fantasy in a system, where the majority of the population struggles to even set an appointment in a timely manner.

The problem with access worsens when we consider those not covered by employment-based insurance. In the 1960s, when Medicare[28] and Medicaid were passed, they were expected to cover the population that the private sector was leaving behind through dependence on employment based insurance. Medicaid covers those that are

[28] I did not analyze much on Medicare because the majority of Hispanics excluded from healthcare access currently fall among the young population. Also, Medicare would require a whole other analysis since it has a major critical exogenous factor that falls beyond the focus of this dissertation: the fact that people live longer.

considered below the federal poverty level through a poverty threshold measurement developed in 1963 (US Census Bureau, 2016). The poverty threshold methodology has never been updated. Employment-based insurance kept covering less people, especially those at lower-paid jobs, either because employers stopped offering for that group or because the employee's contribution was too high relative to their incomes. Private insurance options outside employment were expensive. As a result of these factors, before the ACA was passed, a group of individuals without coverage emerged: those who did not make it below the poverty threshold but were still not earning enough to afford insurance. The ACA allowed states to expand Medicaid by raising the level of income higher than the federal poverty threshold. This expansion was voluntary, so some states (like Missouri) did not apply. The new law also provided subsidies for those of lower incomes who still did not qualify for Medicaid. These trends briefly show how the rise in healthcare access inequality took place through the years. The main concern has become the lack of insurance, as insurance came to largely determine if people had potential access to the healthcare system.

The rise of inequality in access to health care is not an isolated trend. There has been an overall rise of socio-economic inequality in the last 30 years, not just in the US, but in all developed economies (OECD, 2015a, 2017b, 2017a; Piketty, 2014). However, the US has experienced the most pronounced rise (Lindert & Williamson, 2016; Piketty, 2014). If we look just at wealth, the top 0.1% of households in 1978 owned about 7% of wealth and by 2012 this share rose to 22% (Stanford Center on Poverty and Inequality, 2016). Researchers don't always agree on how to measure the changes in inequalities, but they all agree on the fact that there has been a significant rise in the US since the 1980s. They

also agree that this trend is primarily due to neoliberal policies that have recurrently cut on taxes for the wealthiest, while simultaneously cutting on safety-nets for the working class and the poor.

In health care specifically, policies since the Reagan administration have been transferring the responsibility of access from the government to the private sector, allowing profit-seeking organizations to take over a social issue. Although the idea of free markets with large number of firms in perfect competition was used to validate this transition, the result has actually been substantial market concentration (i.e. the opposite of perfect competition). Today, a small number of large companies continue to gain political power through lobbying and by worrisomely becoming *too big to fail* in oligopolistic markets that, if continued, can lead to more local monopolies.[29] More importantly is that this is not a typical market. Access to health care, which should be treated as a human right by policymakers, has instead become a sector that prioritizes profits over people's health.

As mentioned, among those left out, the Hispanic population is the largest group with the lowest access to health care in the US. Publications included in the meta-analysis illustrate that this has been a recurring problem since the 1960s, but with the strengthening of neoliberal policies since the 80s, it has gotten worse. In addition to the structural barriers that are in place today, Latinos face other needs that are linked to acculturation and social capital**. Chapter 3** discusses the role of capital, particularly

[29] Hospital and insurance companies operate in local markets, and monopolies are already a reality in some of these markets. What complicates things is that even though these are local markets, at the national level, many of these companies, particularly in the insurance business, are owned by a few large companies. So, there is concentration at both, the local and national level when data is compounded. Though this concentration seems to be leading to more local monopolies, while maintaining a stronger oligopoly at the national level (Cooper, Craig, Gaynor, & Van Reenen, 2015; Havighurst & Richman, 2010).

cultural and social capital, as they apply to Latinos navigating the American healthcare system.

The Hispanic population in the US is considered today the largest ethnic group, but within this group there is significant heterogeneity. In the analysis of access to healthcare, heterogeneity is based primarily on cultural differences that are rooted in the countries of origin, as well as immigration statuses. The cultural and institutional contexts in which each immigrant or immigrant descendant grew up as a child has a significant impact on the worldviews that different individuals carry with them when they face the American healthcare system. Because this system was created with different cultural values than those in an immigrant's country of origin, immigrants find themselves required (informally) to acculturate. Acculturation in this specific case involves the acquiring of cultural capital required to comprehend and be capable of effectively accessing the American health system.

Additionally, social capital, in particular the types that belong to networks of people that are already well acculturated to the system, can serve as a means to speeding up the acculturation process and/or enhancing access in the short-term. In particular, the literature on social capital that has evolved in the fields of sociology (Bourdieu, 2011; J. S. Coleman, 1988; J. L. Flora, 1998; M. Granovetter, 1985; Lin, 2001a; O'Brien, Phillips, & Patsiorkovsky, 2005; Portes, 1998), political science (Helliwell & Putnam, 1995; R.D. Putnam, 1995; Robert D. Putnam, 1993) and economics (Fukuyama, 1999; Woolcock, 1998, 2001) stresses the importance of separating social capital by type to measure and be able to compare among them. In the case of Hispanics, where a large portion are

immigrants or immediate descendants of immigrants, this separation is even more critical (Portes, 1995, 1998; Portes & Sensenbrenner, 1993).

Through a meta-analysis, **Chapter 4** is able to identify and quantify variables from 83 studies that have measured both the structural barriers imposed by federal healthcare and immigration legislation, and the role of acculturation and social capital among Hispanics' access to health care. It is clear from the literature that structural barriers imposed through the intersection of healthcare and immigration legislation are strong for this group. In addition, Hispanics still face the need to acculturate to a system that differs from their acquired worldviews of health care from their countries of origin. Although with less frequency and severe inconsistencies in how they define and operationalize them, the reviewed studies also analyze the impact of acculturation and the role of social capital.

In general, the literature reviewed recognizes the importance of acculturation, but it does a poor job defining the term and explaining why and how researchers choose to operationalize this variable. With respect to social capital, scholars include the importance of social networks as enablers to access. The literature identified, however, does not adopt the term social capital and researchers insufficiently operationalize the multiple dimensions of social capital. In other words, there is no consensus in how social capital is being labeled or applied as a variable impacting access. Incorporating the term social capital and measuring the different forms of social capital separately may prove to be an important step when addressing Hispanics' access to health care. Overall, the meta-study shows that acculturation to the American way of life and possessing social networks that are well acculturated with respect to the American healthcare system can

enhance access for Hispanics. Nonetheless, Chapter 4 also points to the need for more research on these two factors.

In **Chapter 5**, I apply logistic regression to measure the impact of acculturation and three types of social capital, plus test for structural barriers through an interaction between insurance and acculturation as well as insurance. In addition, age, education and gender are used as control variables in the model. The data used is primary, collected in 2014 and 2015 through a survey study done in Missouri in seven communities that have the highest concentrations of the Latino population in the state. Results show having insurance, age (being older), higher levels of acculturation to the American way of life, and higher levels of bridging social capital (from weak ties) enhance access for Latinos. On the other hand, bonding social capital (from strong ties) has a negative effect on access, while linking social capital was not proven to have any impact. In addition, two of the control variables, gender and education, were not proven to be significant.

To measure acculturation I used a bi-dimensional scale developed by (Marin & Gamba, 1996), which is based on Berry's four types of acculturation including: assimilation, integration, separation and marginalization. My research seeks to understand how acculturated someone is to the American way of life so that it leads to better access, which can be either someone who is assimilated or integrated in Berry's four categories. My findings suggest that both assimilated and integrated individuals are better off with respect to access.

The fact that bridging social capital has a positive effect on access, while bonding has the opposite effect, supports the idea proposed by many social capital scholars in political science, economics and sociology: it is important to measure social capital by types

separately. This finding also signals that what matters is to have social networks that first understand the system and/or are connected to the proper resources that enable access. In other words, weak ties which can create bridging social capital, like the *promotoras de salud,* are important since they possess the proper capabilities to help Latinos navigate the complex American healthcare system and can also help them acculturate to the system over time. On the other hand, strong ties that lead to bonding social capital may actually hinder access. For example, if an individual is strictly connected to just a Spanish speaking ties that non-integrated to the rest of the community the close relationshios may not enable access.. The results from social capital complement the ones from acculturation because they indicate that the most helpful social networks are those that are acculturated to the American way of life. Those that are more acculturated should in turn understand better how to navigate the complex healthcare system.

What is critical to understand about social capital, in the particular case of access to healthcare for Latinos, is that it is not just about being connected to networks, but rather being connected to the proper networks. As the chapter on the role of capital poses, networks alone do not represent capital, they must have resources that bring benefits in order to be considered capital. Furthermore, a specific network may turn into a useful form of social capital in one situation, but not be useful in another. Impact from different types may also change over time. So it is necessary for research into this topic to account for local context.

Bridging social capital stems from networks that are considered weak ties, in this case including neighbors, community members, volunteer groups, trade unions, religious groups, recreational groups and leisure groups. By enabling access, these ties seem to

possess the needed resources that help Latinos navigate the system. They also represent ties that show an individual may be more integrated beyond the Spanish-speaking radius in a particular community. On the other hand, bonding social capital stems from close social ties including family members, relatives and friends. My results indicate that these close ties are actually hindering access. These close relationships represent people who may not be necessarily integrated into the American way of life, like family and relatives who reside in Mexico, or friends who are not integrated beyond the Spanish speaking radius. Our survey did not ask for that level of detail, but the opposing results between bridging and bonding social capital lead me to infer that bonding social capital, in the case of Missouri at the present moment, may be linked to networks that are not integrated beyond the Hispanic cluster. Missouri is considered a state whose Hispanic population is still primarily composed of newcomers when compared to other states in the Midwest (Haverluk & Trautman, 2008; Kandel & Parrado, 2005; Valdivia et al., 2008; Valdivia & Dannerbeck, 2009). So, it makes sense to assume that most Latinos still lack integration to the Anglo culture and as a result, bonding social capital is not currently useful in accessing resources needed beyond the Hispanic community. These findings again stress on the importance of measuring social capital separately by type and may be a useful guide when doing research with other immigrant and refugee populations.

In sum, the analysis and findings from this dissertation confirm that Hispanics as a group, overall face significant structural barriers to access health care. In particular, lack of potential access measured through levels of non-insurance, is found to be high and significant for Latinos in both the meta-study as well as the statistical analysis from the survey study done in Missouri. Some of the structural barriers faced by this group in

Missouri could be overcome through increasing the levels of acculturation, specifically to the American healthcare system. Moreover, acculturation levels could be enhanced through bridging social capital, which include weak forms of social ties such as the *promotoras de salud*. On the other hand, bonding social capital, which represent strong social ties including family members, relatives, and friends, is inhibiting access for Latinos living in Missouri. What matters when it comes to social capital in terms of access is the level of acculturation to the healthcare system that is possessed by an individual's specific social ties.. Therefore, understanding better the sources of these ties and their particular levels of acculturation may prove useful in future research. The impact of these ties may vary by situation (i.e. depend on the research question being tested), by location (i.e. communities with higher percentages of Hispanics that have been established longer may vary from those with higher percentages of newcomers; locations that are closer to the border with Mexico may vary from those that are farther because proximity to the border may delay integration when lawfully residing Hispanics cross the border to obtain medical services and products), and over time in the same location (i.e. a particular location may change as its Hispanic population becomes more established and integrated to the rest of the community).

B. Recommendations

Before I provide three main general recommendations, I would like to recognize that offering specific steps of what to do next is not the primary purpose of this dissertation. The current healthcare crisis is extremely complex and the impact on Latinos is just one symptom of a larger problem. Hence, the task in this study was primarily to expose the

problem Hispanics face and tie that to the larger picture. I say this because I do not want to fall into the trap that I believe many sociologists usually fall. Because the sociologist's approach taken here forces the researcher to get to the root of the problem, the tendency is to provide unrealistic recommendations that tend to be overly simplistic. In other words, sociologists tend to offer a good understanding of the problem; that is the strength the general sociologist's worldview has to offer. I do not believe such approach necessarily helps when offering recommendations. Here, it is impossible to recommend to dismantle the whole capitalist system and re-start with a new socialist one, while ignoring the costs of radical transitions as well as cultural and political barriers. This tendency also assumes an alternative model in the other extreme of the political spectrum is going to solve for all the problems. The purpose of this dissertation has been to expose the problem. An analysis on how to make a proper transition considering the political and financial barriers, would require another dissertation or perhaps a very complex consulting project. Yet I provide some general recommendations with the acknowledgement that they will be limited.

My first recommendation involves the short-term. I believe the ACA does not solve all the problems needed to be solved, particularly because it offers solutions within a system that needs radical changes, another "patching" mechanism (Waitzkin, 1978), although a big one this time. Nonetheless, I also believe the ACA was a remarkable accomplishment in the right direction when we consider the cultural hegemony that has governed the US for several decades. Perhaps the passing of this law is one indication that the US is starting to lean a little to the left as a reaction to the damage neoliberal policies have caused.

So, in the short-term, I do think that when I consider my results from the meta-study and the statistical analysis, it is important to offer ways that accelerate the acculturation process of the healthcare system for Hispanics. Bridging social capital is a form of capital that can be created to serve as a bridge that links Latinos with the proper resources and accelerating the acculturation process. For example, the *promotoras de salud,* a type of bridging social capital, are healthcare navigators provided by local communities to help Hispanics navigate the system. First and foremost, it is important to recognize the need to acculturate in order to improve access for this group. If big changes continue to take place, they are not going to be immediate when we consider the political battles needed to be won in between. Furthermore, acculturation to this system should be considered in a sustainable manner. For instance, if efforts are just invested in getting Hispanics to acquire insurance but they do not understand other components of access that come after that first step, insurance could be useless and in some cases even harmful if low-income families are spending money on it but do not know how to use it.

My second recommendation is long-term in nature: to move the current healthcare system into a more social democratic one gradually. If not repealed, the ACA is only a starting point towards this transition. The law is far from treating health care as a human right. Even if fully implemented, it falls short from being universal, particularly in the case of Hispanics due to its intersection with immigration categories. Thus, the ACA still operates under profit-seeking behavior while trying to be more inclusive within the preexisting system. The first step should be to understand and acknowledge the flaws of this legislation, primarily the fact that it does not wean health care from profit-seeking behavior.

If the starting point were to be a new legislation (currently being considered by Republicans and another version was considered by Bernie Sanders), I strongly believe the risks are too high now to re-start a process that I view as irreversible. If the Bernie Sanders' idea of dismantling the ACA and re-enacting a new legislation more socialist in nature were to take place, the risk is that it will face even stronger political opposition from the right. If any of the Republican versions considered recently were to pass, I see it as a temporary win for the right. In other words, even if Republicans were to succeed in once more passing a neoliberal policy, I can foresee there will be harsh consequences, not just for the political candidates among their constituencies, but for society too because this would push the crisis even closer or into an abyss. After all, there are limits to the level which Americans can continue to tolerate no or low rise in their salaries due to escalating insurance costs, as well as higher deductibles and premiums with further cuts in overall coverage.

Accordingly, when considering the present political constraints in D.C., even though the current version of the ACA has serious pitfalls, it can be seen as a first step towards further changes needed to be done. Further steps should gradually add amendments to the ACA that specifically shift the profit-seeking behavior currently governing the system, to one where access to health care is treated as a human right and representing a more universal model. The comparisons to other countries indicate that this transition should also bring about a less expensive system if implemented wisely. In other words, after the thorough analysis in this dissertation, I don't think a capitalist system with some socialist components added to it is best for the US in terms of offering better access at a lower cost to society. The aim should be for a more social democratic system, implemented

gradually. There is simply a fundamental conflict of interests at the bottom of this crisis, the one between making profits and offering fair access to health care. There is a place for profits, but I don't think it should dominate a healthcare system as is currently the case in the US.

Moreover, the gradual transition should be fully transparent and involve the public through educational and informational workshops. Through active public participation, people are allowed to provide feedback, but also learn about the pros and cons analyzed as decisions are being made. Right now, the majority of Americans do not seem to truly understand the real nature of the crisis. Hence, this kind of participation can help provide a better bridge between the government and the public. In other words, participatory action research should be an important factor in this transition. After all, the users should be speaking up, not just passively following policies imposed from the top. A gradual participative transition would allow for a *learn as you go* mechanism that makes it easier to make adjustments when changes implemented are not functioning as expected. By having the participation of the public, the *learn as you go* strategy is also better validated by society.

When we consider the number of jobs that this system handles as part of the American economy, a gradual strategy also allows for losses to be less disruptive to the economy and avoid abrupt changes that make it hard to adjust.[30] As changes slowly take place and job losses are identified, there should be government support helping people to transition to new jobs. For example, when factories were closing across the US to move

[30] One example of a type of job that can be lost includes positions in hospitals and clinics that negotiate different prices of services with insurance companies. If prices were to be more transparent, more similar across plans as well as across insurance companies, and across locations, these jobs would eventually not be needed.

their operations to other countries, the communities were left with no transitional help from the government, even though the layoffs were a consequence of Free Trade Agreements (FTAs) signed by the US government. My purpose here is not to defend or attack the FTAs, but to point out that any policy that brings big changes to communities should be accompanied by temporary support from the government in its transition by offering options such as technical training for new jobs, scholarships to expand on education that can open new doors, orientation towards new job markets, financial help with re-allocations and so on.

My third general recommendation is more of a warning. The failure of communist economies may not necessarily be due to what theorists like Marx had recommended, but rather to human nature constraints that appear when theoretical ideas are put into practice. In a centralized economy, we get rid of big companies, but we also substitute them for one big government. Both models require large bureaucracies which produce inefficiencies and concentration of power. The concentration of power can be acquired by individuals either through top management positions in large companies in capitalist countries, or through top government officials in centralized governments. When abuse of power emerges as a consequence of concentration, social services suffer in both quality and quantity. Another main consequence is the increase of corruption. In a capitalist country like the US, I see healthcare lobbying specifically, as being a legalized corruption system for profit-seeking companies that were unethically handed the job to provide a large portion of healthcare services to its population. In other less capitalist models, like Brazil for instance, corruption like the one seen in the US is still existent and very strong, but not legal. Legal or illegal corruption schemes seem to grow when

concentration of power is allowed either within the private or public sectors. Instead, a good balance is necessary.

The purpose of this dissertation is not to propose a new model. Instead, I suggest that as the US moves to a more social democratic model, the *learn as you go* strategy should recurrently account for bureaucratic and concentration of power effects. Additionally, no model is going to be able control for exogenous factors that also impact the system. These should be taken into account by concurrently acknowledging the limitations of what can be changed and what cannot. After all, universal access to health care is a utopian idea, but one we should aim for in order to at least move closer to a fairer society. An example of a common exogenous factor that all healthcare systems around the world are facing is the expanded life-span or increase in the average mortality age. People are living longer, but also many people are living healthier past the retirement age. Longer life-spans costs more in health care, but this issue is also not going to be solved by simply patching the current model.

Moreover, there seems to be a bias towards the idea that more resources spent on health care will actually improve health. When we compare developing and developed economies' overall state of health, we clearly see that big changes are not necessarily due to more healthcare services being offered, although that has a role, but also to investments, like guaranteeing clean drinking water for the poor.[31] In the US, when we consider, for example, the issue of obesity, that exogenous factors causing this phenomenon can be changed through better policies in other areas, like agriculture or crime, must be recognized. For instance, an obese woman living in an unsafe

[31] The Flint River contamination in Michigan illustrates that access to clean water is not just a problem for developing countries.

neighborhood with high crimes, does not have the option to go out and exercise in her neighborhood. If she wants to increase her exercise perhaps she will be better served by policies that effectively target crime, as opposed to a doctor telling her she needs to exercise regularly. In general, we also have to move away from the mentality that resources to improve health have to be *overly* concentrated in health care. This idea is a myth or perhaps the result of political power among those who gain from these investments in a profit-seeking healthcare system. There are many investments that can help improve the lifestyles of individuals that could have far more potential benefits than many invested in health care today have. The bias towards more spending on health care, in my perspective is also linked to another cultural hegemony dominant in the US, the one of an enchantment with technology (i.e. believing technology can solve for everything). But that is the topic for another dissertation. :)

APPENDIX

APPENDIX 1: GLOSSARY

Access to health care: refers to the degree to which people are able to obtain appropriate care from the health care system in a timely manner. People with potential access would be considered to have access to health care on a timely manner. Realized access on the other hand, refers more to the quantity actually received. Potential access is usually measured by insurance coverage, while realized access can be measured by various variables, the most common one being having had a recent visit to a doctor's office.

Asylee: a person who is seeking or has been granted political asylum, which must be based on person facing some kind of threat in his/her country of origin. Asylees have a similar status as refugee in the US, but they are nonetheless two different forms of immigrant statuses.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (PPACA) – also known as the Affordable Care Act or ACA, and generally referred to as Obamacare – is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. Under the ACA, there is eligible immigration status for subsidies (See also Obamacare).

Citizenship: a person recognized under the custom or law as being a member of a state.

Citizen at birth (or native born citizen): must have been born in the US or certain territories or outlying possessions of the US, and subject to the jurisdiction of the US.

Coinsurance: (not the same as copayment) the percentage of costs of a covered healthcare service you pay after you've paid your deductible. Coinsurance are calculated on a percentage basis (as opposed to copayments which are flat rates).

Copayment: a payment made by the insured individual for services in addition to the amount paid by the insurance. Copayments are usually charged at the time of service when patient checks in.

Cost sharing: occurs when patients pay for a portion of healthcare costs not covered by health insurance. The "out-of-pocket" payment varies among healthcare plans and depends on whether or not the patient chooses to use a healthcare provider who is contracted with the healthcare plan's network.

Cultural capital: requires cultural competence or the ability to properly interpret codes within a class (Bourdieu, 1984, p. 2) and is "encountered in a class society" deriving "social value from the power of social discrimination" (Bourdieu, 1993, p. 128).

Deductible: The amount you owe for covered health care services before your health insurance plan begins to pay for services. For example, if your deductible is $1,000/year, your plan won't pay anything until you've paid $1,000 for covered services during that year. Some plans pay for certain healthcare services before you've met your deductible.

Deductibles are usually specified by plan on an annual basis. The value spent accumulates throughout the year, going back to zero at the beginning of each fiscal year.

Economic capital: "immediately and directly convertible into money and may be institutionalized in the form of property rights;" (Bourdieu, 2011, p. 84);

Eligible immigration status (from ACA): An immigration status that is considered eligible for getting health coverage through the Marketplace (i.e. person can buy insurance through the Marketplace). The rules for eligible immigration status may be different in each insurance affordability program.

Employment-based insurance (EBI): Coverage that is offered to an employee (and often his or her family) by an employer. The employer usually also covers part of the insurance for the employee, although not the family members. Also referred to as job-based insurance/coverage.

Foreign nationals: anyone residing in the US that was not born in the US. Among foreign nationals there are those lawfully residing and those not lawfully residing.

Health care: used as a noun.

Healthcare: used as an adjective.

Health insurance Marketplace (through ACA): A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Hispanics or Latinos: based on the U.S. Census Bureau (2015) are those people who classified themselves in one of the specific Spanish, Hispanic, or Latino categories listed on the Census 2010 questionnaire -"Mexican," "Puerto Rican", or "Cuban"-as well as those who indicate that they are "another Hispanic, Latino, or Spanish origin." People who do not identify with one of the specific origins listed on the questionnaire but indicate that they are "another Hispanic, Latino, or Spanish origin" are those whose origins are from Spain, the Spanish-speaking countries of Central or South America, or

the Dominican Republic. The terms "Hispanic," "Latino," and "Spanish" are used interchangeably.

Origin can be view as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States.

People who identify their origin as Spanish, Hispanic, or Latino may be of any race. Thus, the percent Hispanic should not be added to percentages for racial categories.

Immigrant: Any person who has permanently migrated to the US. The group includes both individuals that have entered the United States legally (legal aliens) and those that have entered the United States without inspection or have remained in the country after their visa (non-immigrant authorization to reside temporarily) expired.

Job-based health plan: see employer-based insurance.

Latino: see Hispanic

Lawful permanent resident (LPR): Any person not a citizen of the US who is residing the in the country under legally recognized and lawfully recorded permanent residence as an immigrant. Also known as "Permanent Resident Alien," "Resident Alien Permit Holder," and "Green Card Holder."

Lawfully present (based on ACA): The term “lawfully present” is used to describe immigrants who have:

- “Qualified non-citizen” immigration status without a waiting period
- Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)
- Valid non-immigrant visas
- Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals)

Lawfully residing: same as lawfully present

Marketplace: see Health Insurance Marketplace.

Medicaid: A joint federal and state program that helps low-income individuals or families pay for the costs associated with long-term medical and custodial care, provided they qualify. Although largely funded by the federal government, **Medicaid** is run by the state where coverage may vary.

Medicare: is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Native born citizen: see citizen at birth

Non-immigrant resident: foreign nationals residing lawfully temporarily in the US under a specific visa such as a student visa (F1 or J1), a work visa (H1), and so on.

Not lawfully residing/present: individuals residing in the US without a valid Visa or who have no valid immigration status. Among those not lawfully residing are two main categories: unauthorized and undocumented

Obamacare: An informal name sometimes used to refer to the health coverage plans available through the Health Insurance Marketplace. Obamacare often also refers to the Affordable Care Act (ACA).
Obamacare Summary:

- Signed into law March 23, 2010 by President Obama, which is where the term "Obamacare" comes from
- The 2016 Open Enrollment period started on November 1, 2015 and runs through January 31, 2016
- The Health Insurance Marketplace helps you find and enroll in a plan

Out-of-pocket-costs: patient's expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Potential Access: refer to **access to health care.**

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Primary care provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Realized access: refer to **access to health care.**

Refugee: a person who has been forced to leave their country in order to escape war, persecution, or natural disaster.

Social capital: which is built on connections that are "made up of social obligations" (Bourdieu, 2011, p. 124).

Symbolic capital: Bourdieu refers to cultural capital as being institutionalized in society through symbolic capital, which is made up of codes that people unconsciously use within a social class. Although he does not specifically state that social capital can also be symbolic, it can be argued that social capital can, in some ways, also be expressed through symbolic capital.

Unauthorized resident: individuals who are residing in the U.S. without a valid Visa or immigration status.

Underinsured: People who have health benefits that don't adequately cover their medical expenses. Often, consumers discover they're underinsured the hard way when they need to access medical services and then their medical bills exceed their benefits enough that it is difficult for them to pay.

Undocumented resident: individuals who entered the U.S. without valid documents to enter and/or reside in the country.

APPENDIX 2: SURVEY QUESTIONNAIRE

University of Missouri Columbia

Center for Health Policy

Missouri Health Equity Collaborative

Missouri Hispanic Health Survey

2013-2014

Surveyor's name _____

City/county _____

Date _____

Place/event _____

This project is funded by the Missouri Foundation for Health

By answering this questionnaire, you are helping to improve healthcare access and services provided by health institutions for Latinos in Missouri.

[ENUMERATOR: HAND A COPY OF THE ORAL CONSENT STATEMENT WITH ALL THE CONTACT INFORMATION TO THE INTERVIEWEE. PLEASE INFORM THE INTERVIEWEE OF THE FOLLOWING: "PLEASE NOTE THAT IT IS NOT POSSIBLE TO COVER ALL THE ISSUES THAT AFFECT HISPANICS IN THIS COMMUNITY; IF YOU WOULD LIKE TO COMMENT ON ISSUES NOT IN THE QUESTIONNAIRE, PLEASE WAIT UNTIL WE COMPLETE THE SURVEY." SPACE FOR COMMENTS IS ALSO PROVIDED THROUGHOUT THE QUESTIONNAIRE IN CASE THEY HAVE SPECIFIC COMMENTS ABOUT A QUESTION, PLEASE INCLUDE THE QUESTION NUMBER WHEN YOU ADD COMMENTS]

ORIGIN/BACKGROUND (Information about Latino homes in MO and household profiles)
We will begin by asking a set of questions about yourself and the members of your household.

1. **What is your gender?**

Gender [CIRCLE ONE] | **M** | **F** |

2. **How old are you?**

| | Years | OR | Your year of birth | |

3. **What is your marital status?**

Married		Widowed	
Partnered		Separated	
Divorced		Single	

4. [SHOW CARD] **What is your race(s)?**

Mark ALL that apply	
	White
	Black or African American
	Indigenous, American Indian, or Alaska Native
	Asian Indian
	Chinese
	Filipino
	Japanese
	Korean
	Vietnamese
	Native Hawaiian
	Other_____ (please specify)

5. **Where were you born? (Other country than U.S., include state; for example Country = Mexico; State = Monterrey)**

In the US		→	Which state:	
Outside US		→	Which country, state:	

6. How long have you been living in the US?

- ☐ Less than a year
- ☐ 1 to 3 years
- ☐ 4 to 7 years
- ☐ More than 8 years
- ☐ All of your life

7. How long have you been living in Missouri?

- ☐ Less than a year
- ☐ 1 to 3 years
- ☐ 4 to 7 years
- ☐ More than 8 years
- ☐ All of your life

Now we are going to ask you some questions about your household. The definition of household for this interview consists of the family members who live with you and share income, expenses, food and purchases, and investment decisions. Also included are your children, dependents, and other immediate relatives you are financially responsible for, who live with you or at another location. (This does NOT include people who share rent costs and are not part of your family). [REFER TO CODES BELOW TO FILL THE CHART]

8. How many people belong to your household based on this definition?

Member	Code of HH Member	Living in house		Gender		Age	Languages English/Spanish/Other [SHOW CODES FOR LANGUAGE]						Educ.	Occupation
		Yes	No	M	F		Speak		Write		Read			
YOURSELF														
Adult members														

Total Children	C	Living # that Yes	in House # that No	# M	# F
Preschool (0-4)	C				
Elementary (5-12 years old)	C				
Secondary (13-18 years old)	C				
Post Secondary (19+)	C				

Code for language					
English	Very well	E1	Spanish (S)	Very well	S1
	Well	E2	Other (0):	Well	S2
	Not well	E3	_____	Not well	S3
	Not at all	E4	O1, O2, O3, O4	Not at all	S4

Other Language: _____

Codes for house members				
Husband	H	Sibling	S	
Wife	W	Grandparents	GP	
Partner	P	Nephew/Niece	N	
Own child	C	Mother/Father in Law	IL	
Parent	D			
Grandchild	G			
Friend	F			
Other	O			

Code for education	
No schooling completed	(1)
Nursery school to 4th grade	(2)
5th grade to 6th grade	(3)
7th grade to 8th grade	(4)
9th grade	(5)
10th grade	(6)
11th grade	(7)
12th grade, NO DIPLOMA	(8)
High school graduate /equivalent (e.g. GED)	[9]
1 or more years of college, no degree	(10)
Associate's degree	(11)
Bachelor's degree	(12)
Master's degree	(13)
Professional's degree	(14)
Doctorate's degree	(15)

9. Which describes your current employment situation?

- ☐ Full-time (more than 30 hours in one job)
- ☐ Part-time/casual job
- ☐ Retired
- ☐ Self-employed
- ☐ Not currently employed [IF NOT CURRENTLY EMPLOYED GO TO QUESTION (11)]

10. How much do you earn from all your jobs?
_____(amount) This amount is earned (circle one): weekly monthly other_____

11. In the home you currently reside, what type of ownership status applies to you?

- ☐ Owner without mortgage
- ☐ Owner with mortgage
- ☐ Renting
- ☐ Occupying (not paying rent)
- ☐ Other_____

12. What is your immigration status?

- ☐ U.S. citizen born in the U.S.
- ☐ U.S. citizen born outside the U.S. (naturalized citizen)
- ☐ Permanent legal resident (have a Green Card)
- ☐ Temporary legal resident (have a temporary Visa)
- ☐ Other_____

13. Below are a number of statements that evaluate changes that occur when people interact with others of different cultures or ethnic groups. [PLEASE SHOW CARDS WITH CODES FOR EACH SECTION SEPARATELY/REMIND INTERVIEWEE ABOUT THE SCALE IN EACH SECTION AND ASK TO SELECT ONE ONLY]

1 ALMOST NEVER	2 SOMETIMES	3 OFTEN	4 ALMOST ALWAYS

Dimension:	Language use	
a.	How often do you speak English?	
b.	How often do you speak in English with your friends?	
c.	How often do you think in English?	

d.	How often do you speak Spanish?	
e.	How often do you speak in Spanish with your friends?	
f.	How often do you think in Spanish?	

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____
_____

[SHOW NEW CARD]

1 VERY POORLY	2 POORLY	3 WELL	4 VERY WELL

Dimension:	Linguistic proficiency	
g.	How well do you speak English?	
h.	How well do you read in English?	
i.	How well do you understand television programs in English?	
j.	How well do you understand radio programs in English?	
k.	How well do you write in English?	
l.	How well do you understand music in English?	
m.	How well do you speak Spanish?	
n.	How well do you read in Spanish?	
o.	How well do you understand television programs in Spanish?	
p.	How well do you understand radio programs in Spanish?	
q.	How well do you write in Spanish?	
r.	How well do you understand music in Spanish?	

[SHOW NEW CARD]

1 ALMOST NEVER	2 SOMETIMES	3 OFTEN	4 ALMOST ALWAYS

Dimension:	Electronic media	
s.	How often do you watch television programs in English?	
t.	How often do you listen to radio programs in English?	
u.	How often do you listen to music in English?	
v.	How often do you watch television programs in Spanish?	
w.	How often do you listen to radio programs in Spanish?	
x.	How often do you listen to music in Spanish?	

HEALTH PROFILE

14. Would you say in general your health is?

Excellent ___ Very good ___ Good___ Fair___ Poor____ Don‘t know___ No answer___

15. From the list below, what illnesses have you ever had? (Check ALL that apply)

- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Asthma
- ☐ Oral health
- ☐ Mental health (depression, others)
- ☐ Cardiovascular disease and stroke
- ☐ Venereal diseases (HIV/AIDS)
- ☐ None of these
- ☐ Other _____

16. Currently, do you have any illnesses or health concerns?

- ☐ Yes Please specify_____
- ☐ No
- ☐ Don’t know/ Not sure
- ☐ Prefer not to answer

17. Do you feel that it is important to see a doctor when you aren’t feeling ill? (For example, for checkups.)

- ☐ Yes
- ☐ No
- ☐ Don’t know/ Not sure
- ☐ Prefer not to answer

18. Do you know where to go to receive preventative healthcare services?

- ☐ Yes
- ☐ No
- ☐ Don’t know/ not sure
- ☐ Prefer not to answer

19. When visiting your healthcare provider, do you understand the options and protocols led by the nursing staff? [IF THEY ANSWER SOMETIMES, MARK YES]

- ☐ Yes
- ☐ No
- ☐ Don't know/ Not sure
- ☐ Prefer not to answer

DENTAL CARE

20. Please tell me how important each action is below. [PLEASE SHOW CARD WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE ONLY. MARK N/A FOR b IF NO CHILDREN]

1 VERY IMPORTANT	2 IMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 NOT IMPORTANT

a. How important is it for you to have dental cleaning and checkups?	**a.** ____
b. How important is it for children to have dental cleanings and checkups?	**b.** ____
c. How important is your dental health?	**c.** ____

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____
_____
_____

21. Please answer the questions in the following table for yourself and then for your children (if you have any). [IF ANSWER (a) is NO, SKIP TO QUESTION (25) , BUT MAKE SURE BOTH, THE RESPONDENT'S AND THE CHILDREN'S SECTION, ARE ANSWERED FIRST]

	ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a. Have you ever been to a dentist?	YES	NO	YES	NO
b. In the past 2 years, have you ever seen a dentist in the U.S.? [IF NO SKIP TO 22]	YES	NO	YES	NO

c.	**Where do your dental visits in the U.S. usually take place? (SELECT ONE)**	Dental Clinic	Emergency Room	Dental Clinic	Emergency Room
		Private Dentist	Other_____	Private Dentist	Other_____
d.	**Are interpreters provided at the dental facilities you have visited in the U.S.? (this does not include children or friends you bring with you)**	Never	Often	Never	Often
		Sometimes	Don't know	Sometimes	Don't know
e.	**How do you pay for your dental care? (Check ALL that apply)**	Full amount in cash	Payment plan offered at location of services	Full amount in cash	Payment plan offered at location of services
		Dental insurance with copayment	Other_____	Dental insurance with copayment	Other_____

22. Did you ever feel you were being discriminated against by your dental care provider in the U.S.?

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Not applicable

23. If you have not seen a dentist in the U.S. in the past two years, what is the reason? (Check ALL that apply)

- ☐ I can't afford a dentist
- ☐ I don't trust dentists
- ☐ I don't speak English
- ☐ I can't get time off work
- ☐ I am afraid it will be painful
- ☐ I can't find someone to take care of my children while I visit a dentist
- ☐ I have problems getting transportation to see a dentist
- ☐ There is no dentist available near my residence or place of employment
- ☐ I don't think it's necessary to see a dentist
- ☐ I am unable to make an appointment because I have no insurance
- ☐ I have seen a dentist, but not in the U.S.
- ☐ Other _____

24. Please answer the questions on dental insurance in the following table for yourself and then for your children (if you have any). [SKIP b if a IS NO. SKIP c IF NO CHILDREN]

		ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a.	**Do you have dental insurance?**	YES	NO	YES	NO
b.	**Is your dental insurance offered through your job?**	YES	NO	YES	NO
c.	**Is your children's dental insurance offered through Medicaid?**	N/A	N/A	YES	NO

HEALTH CARE ACCESS/SYSTEM PROCESS

25. Please rate the following statements related to preventative healthcare. [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE ONLY]

[CARD IS SAME AS #20, LAST ONE USED]

1 VERY IMPORTANT	2 IMPORTANT	3 NEUTRAL	4 SOMEWHAT IMPORTANT	5 NOT IMPORTANT

a. How important is it for you to have an annual physical check-up with a doctor?	**a.** ____
b. How important is it for children to have an annual physical check-up with a doctor?	**b.** ____
c. How important is your overall health?	**c.** ____

26. When was your last visit to a healthcare provider in the US? (Please check ONE)

	ANSWER FOR YOURSELF	ANSWER FOR YOUR CHILDREN
a. Less than a year ago		
b. Between 1 and 2 years ago		
c. More than 2 years ago but less than 3 years ago.		
d. More than 3 years ago		
e. Never		

27. Please answer the questions in the following table for yourself and then for your children (if you have any). [IF ANSWER (a) is NO, DO NOT ASK (c) and (d), BUT MAKE SURE BOTH, THE RESPONDENT'S AND THE CHILDREN'S SECTION, ARE ANSWERED FIRST]

		ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a.	**Have you ever been to a doctor in the US?**	YES	NO	YES	NO
b.	**Have you seen a doctor outside the U.S.?**	YES	NO	YES	NO
c.	**Are interpreters provided at the medical facilities you have visited in the U.S.? (this does not include children or friends you bring with you)**	Never	Often	Never	Often
		Sometimes	Don't know	Sometimes	Don't know
d.	**How do you pay for your medical care? (Check all that apply)**	Full amount in cash	Payment plan offered at location of services	Full amount in cash	Payment plan offered at location of services
		Medical insurance* with copayment	Other_____	Medical insurance with copayment	Other_____

**Medical insurance includes all types of insurance (i.e. private, Medicare, Medicaid, etc.)*

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____
_____

28. How do you find information that helps you decide where to go for healthcare services? (Check ALL that apply)

- ☐ Family members
- ☐ Friends
- ☐ Internet/Social Media
- ☐ Radio and TV
- ☐ Newspaper/magazines
- ☐ Health care provider
- ☐ Church
- ☐ School
- ☐ Other_____

29. Once you decide you need medical care, what would be your first choice? (Please select ONE)

- ☐ Community health clinic (family health)
- ☐ Doctor's office
- ☐ Emergency room
- ☐ Urgent care (different from emergency room)
- ☐ Hospital (other than emergency room or urgent care)
- ☐ Other _____

30. (a) In the past two years, if you or someone in the family have seen a doctor or a nurse practitioner, please use the following table to mark where each have been seen at (Check ALL that apply). [SKIP TO QUESTION (31) IF THE RESPONDENT HAS NEVER SEEN A DOCTOR OR NURSE PRACTITIONER IN THE U.S.]

	Commu. health clinic	**Doctor's Office**	**Emergency room**	**Urgent care (different than emergency**	**Hospital (other than emergency room or**	**Other _____ _____ _____**
You						
Spouse						
Children						
Parents						
Other						

30. (b) Did an individual or organization help you access the health services?

- ☐ Yes. Please specify_____
- ☐ No

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____
_____

INSURANCE COVERAGE (Data will inform on healthcare insurance coverage among Latinos)

31. Please use the following table to identify what kind of insurance (if any) the people living in your household currently have (check ALL boxes that apply) [IF RESPONDENT HAS NO INSURANCE **SKIP TO QUESTION (34)]**

*CHIP=Children's Health Insurance Program (Children's Medicaid)

	No Insur.	Medi caid	Medi care	Health Insurance Marketplace	V A	CHIP *	Through the job	Self-Paid	Other (please specify) _____
You									
Spouse									
Children									
Parents									
Other (please specify)									

32. If anybody in the family has "insurance through the job" please specify whose job provides the insurance for the following:

You_____
Spouse_____
Children_____
Parents_____

33. Did you ever feel you were being discriminated due to the type of insurance you hold (such as Medicaid)?

☐ Yes
☐ No

34. Did you ever feel you were being discriminated against because you did not have insurance?

☐ Yes
☐ No

35. Have you ever had the feeling of being discriminated against by your healthcare provider?

☐ Yes
☐ No

36. Was there a time in the past 12 months when you needed a doctor but you did not make an appointment because you did not have enough money?

	ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
YES				
NO				

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____
_____

37. Was there a time in the past 12 months when you needed a doctor but you didn't make an appointment because you have no insurance?

	ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
YES				
NO				

38. Would you indicate how much you agree or disagree with the following statements [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE FOR EACH STATEMENT]

1 STRONGLY AGREE	2 AGREE	3 NEITHER AGREE NOR DISAGREE	4 DISAGREE	5 STRONGLY DISAGREE

a.	It needs to be a very serious illness before I schedule a visit to a healthcare provider.	**a**. ____
b.	Visiting a healthcare provider when a non-serious illness exists, is not more important than covering the basic needs (food, shelter, utilities) in my household.	**b**. ____ **c.** ____
c.	Trying traditional healing systems like home remedies first is better than trying to visit a conventional healthcare provider.	**d**. ____
d.	Buying healthcare insurance is not as important as covering my other household needs such as food, roofing and utilities.	**e.** ____
e.	When I feel sick, I prefer to seek healthcare advice from relatives, friends or by using traditional practices such as home remedies.	**f.** ____
f.	At this point in my life, health concerns are irrelevant for me.	**g.** ____
g.	I cannot think of any circumstances where I would visit a healthcare provider at this point in my life.	

EXPERIENCE AT THE HEALTHCARE PROVIDER

[ALL QUESTIONS IN THIS SECTION, (39) THROUGH (46) SHOULD BE BASED ON THE RESPONDENT'S MOST RECENT VISIT TO THE DOCTOR'S OFFICE, WHICH CAN BE A CLINIC, A HOSPITAL OR A DOCTOR THEY USUALLY GO TO. IF THE RESPONDENT DOES NOT VISIT A PROVIDER ON A REGULAR BASIS, ASK HIM/HER TO REFER TO A RECENT VISIT (PAST 2 YEARS)]

Answer all questions in this section from (#39 to #45) based on your experience at the doctor's office. Please use the clinic, hospital or doctor you attend most often. If you do not visit a provider on a regular basis, refer to a recent doctor's visit you recall well.

[COMMENTS. USE BACK IF NEEDED]

_____

_____

39. Please answer the following based on **HOW OFTEN** this takes place at a doctor/clinic/hospital you usually attend or from a recent visit you recall. **[**PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE ONLY FOR EACH STATEMENT]

1	*2*	*3*	*4*	*5*
NEVER	***NOT VERY OFTEN***	***SOMETIMES***	***VERY OFTEN***	***ALWAYS***

a.	I need an interpreter when going to the doctor	
b.	I use family members as interpreters when I go to the doctor	
c.	I use friends as interpreters when I go to the doctor	
d.	I am able to understand the medical information through the use of an interpreter	
e.	The forms or signs in the doctor's office are written in Spanish	
f.	Someone explains the purpose of a form before I sign it	
g.	I was offered help in filling out a form at this doctor's office	
h.	The forms that I get at this doctor's office are easy to fill out	
i.	The doctor uses medical words I do not understand	
j.	The doctor talks too fast when addressing me	
k.	The doctor ignores what I tell him/her	
l.	The doctor interrupts me when I am talking	
m.	The doctor shows interest in my questions and concerns	
n.	The doctor answers all my questions to my satisfaction	
o.	The doctor gives me all the information I want about my health	
p.	The doctor gives me easy to understand instructions about how to take care of my condition	
q.	The doctor uses a condescending, sarcastic, or rude tone or manner with me	
r.	The doctor really cares about me as a person	
s.	I feel the doctor does a thorough examination	
t.	The written information I was given was easy to understand	
u.	I feel judged by my appearance, my background or my accent by the employees at the doctor's office	
v.	I feel there is a lack of communication between me and the health providers	
w.	I trust my doctor's recommendations to be correct	

40. At your health care provider what type of interpretation services have you used? (Check ALL that apply). [THIS TABLE HAS TWO SIDES TO ANSWER, IF ANY OF THE STATEMENTS ARE MARKED ON THE LEFT HAND COLUMN (MARK IF USED), THEN ASK THE RESPONDENT TO ALSO RATE THAT SERVICE AND MARK RESPONSE ON THE RIGHT HAND COLUMN USING THE SCALE PROVIDED IN TABLE. SHOW CARDS]

Mark if used	Type of interpreter	RATE your satisfaction of services used on a scale from 1 to 5 (1 =completely uncomfortable;
	a. In-person interpreter provided by the clinic/hospital	
	b. Non-medical staff (other than interpreter)	
	c. Medical staff (doctor and/or nurse spoke my language)	
	d. Spouse	
	e. Children	
	f. Other family members	
	g. Friends	
	h. Phone interpreter	
	i. Video interpreter	
	j. Not applicable	
	k. Don't know	
	l. No answer	

41. Please check ALL statements that apply for you and for your children.

	ANSWER FOR YOURSELF	ANSWER FOR YOUR CHILDREN
a. Location was too far from my home		
b. Transportation services were offered		
c. Interpretation services were offered		
d. The doctor/nurse gave me brochures that helped better explain my condition		
e. The doctor/nurse gave me a webpage where I could find more information about my condition		
f. The educational material I was given with information about my condition (if any) were in my first language		
g. The educational material I was given was useful		
h. Someone explained the billing process to me.		

42. If someone explained the medical follow-up procedures needed after this visit, please respond yes or no to the following statements (Check ALL that apply for you and/or your children):

		ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a.	Follow-up appointment with same doctor/nurse was recommended				
b.	Another doctor/specialist was recommended				
c.	No follow-up was recommended				
d.	I thought a follow-up was necessary although they did not recommend one				
e.	Some tests were ordered after this visit (blood tests, X-Rays, MRI, etc.)				
f.	My follow-up appointments were scheduled for me by the clinic/hospital				
g.	I had to make my follow-up appointments after I left				

43.

a. Did you (and/or your children) return to the same clinic/hospital for a follow-up?

- ☐ Yes [IF YES GO TO QUESTION 44]
- ☐ No

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____
_____
_____
_____
_____

43. (b) I did not return to the SAME clinic/hospital for a follow-up because (Check ALL that apply for you and/or your children):

		ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a.	My doctor/nurse said I did not need a follow-up				
b.	My doctor/nurse recommended I see someone at a different location				
c.	My doctor/nurse recommended a follow-up but I did not agree it was necessary				
d.	After receiving my bills I decided not to go back for my follow-up				
e.	I did not understand the plan/steps for my follow-up				

f.	I did not have insurance*				
g.	It was too expensive				
h.	No interpretation services offered				
i.	No transportation services offered				
j.	The location is too far from where I live				
k.	I cannot miss work				
l.	I do not trust the people at that place				
m.	I felt discriminated				
n.	I did not have time to return				

**Includes all types of insurance (private, Medicaid, Medicare, etc.)*

44. The statements below are intended to assess your sense of how you were treated at the hospitals/clinic when you were there for a visit for yourself or your children. [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT A CODE FOR EACH STATEMENT FIRST FOR THE RESPONDENT, AND THEN FOR CHILDREN IF ANY]

1 STRONGLY AGREE	2 AGREE	3 NEITHER AGREE NOR DISAGREE	4 DISAGREE	5 STRONGLY DISAGREE

		ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a.	People at the hospital are always in a hurry				
b.	Doctors do not spend enough time with the patient				
c.	Too many tests are ordered				
d.	Doctors take the time to understand my concerns				
e.	There is always a long wait to see the doctor after you see the nurse				
f.	The non-medical staff discriminate against Hispanics				
g.	Education on how to handle paperwork is needed				
h.	If you do not speak English they try to send you somewhere else				
i.	People overall try to do their best to help if you are Hispanic				
j.	I need someone to contact me me after a visit to see how I'm doing				

[COMMENTS. USE BACK IF NEEDED]

_____

_____

45. The following questions relate to how you were billed for your last/recent medical visit and that of your children.

Please respond:	YES	NO	N/A*

		ANSWER FOR YOURSELF		ANSWER FOR YOUR CHILDREN	
a.	I owed an out-of-pocket payment				
b.	I was offered a payment plan				
c.	The staff explained the payment plan that was offered				
d.	I understood the payment plan they offered me				
e.	I received a bill before I left the hospital/clinic.				
f.	I received the bill in the mail after my visit				
g.	I received the bill by e-mail after my visit				
h.	The staff was flexible and understanding				
i.	The staff tried to accommodate my needs				

[*N/A = NOT APPLICABLE]

EDUCATIONAL PROGRAMS

[READ FIRST WHAT WE MEAN BY EDUCATIONAL PROGRAMS IN ORDER FOR THE RESPONDENT TO UNDERSTAND HOW TO ANSWER QUESTIONS IN THIS SECTION]

Educational programs are usually offered through local schools, worksites, healthcare facilities or others through the community. They involve support groups, workshops, *promotoras de salud*, or any others that help you better understand your condition and/or help you navigate through the system. Please answer the following questions regarding educational services.

46. The following statements relate to any educational programs offered to help you better understand your medical condition.

Please respond:	YES	NO	N/A*

a.	My provider informed me of educational programs	
b.	Educational programs are available in Spanish	
c.	I have attended at least one educational program	
d.	I did not attend any educational programs but I am interested in attending	
e.	I prefer to attend educational programs in Spanish	
f.	I prefer to attend educational programs in English	

[*N/A = NOT APPLICABLE]

[COMMENTS. USE BACK IF NEEDED]

_____

_____

_____

RESILIENCE SCALE (CD-RISC):

47. Resilience embodies the personal qualities that enable one to thrive in the face of adversity. Please choose a code that indicates to what extent you feel for each statement below is true. [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE FOR EACH STATEMENT]

1 NOT TRUE AT ALL	2 RARELY TRUE	3 SOMETIMES TRUE	4 OFTEN TRUE	5 TRUE NEARLY ALL OF THE TIME

a.	Able to adapt to change	
b.	Close and secure relationships	
c.	Sometime fate or God can help	
d.	Can deal with whatever comes	
e.	Past success gives confidence for new challenge	
f.	See the humorous side of things	
g.	Coping with stress strengthens a person	
h.	Tend to bounce back after illness or hardship	
i.	Things happen for a reason	
j.	Best effort no matter what	
k.	Achieving goals is possible	
l.	When things look hopeless, don't give up	
m.	Know where to turn for help	
n.	Under pressure, focus and think clearly	
o.	Prefer to take the lead in problem solving	
p.	Not easily discouraged by failure	
q.	Think of self as a strong person	
r.	Make unpopular or difficult decisions	
s.	Can handle unpleasant feelings	
t.	Have to act on a hunch	
u.	Strong sense of purpose	

TRANSPORTATION

48. When you need healthcare services, what type of transportation do you usually use?

- ☐ My own car
- ☐ Take the bus
- ☐ Ask for a ride to a family or friend
- ☐ Request a taxi service
- ☐ Transportation provided by the healthcare provider, the community or insurance
- ☐ Other _____

49. How long would it take you to travel for using this service?
hours and minutes _____

TRUST

50. At which of the following healthcare providers would you feel more comfortable receiving health care?

- ☐ Community health clinic (family health)
- ☐ Doctor's office
- ☐ Emergency room
- ☐ Urgent care (different than emergency)
- ☐ Hospital (other than emergency room or urgent care)
- ☐ Other _____

51. In the past two years, to what extent have the following factors influenced your trust in your healthcare provider? [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE FOR EACH STATEMENT]

Codes>	1 NONE	2 A FEW	3 SOME	4 MOST	5 ALL

a.	Appointment waiting time	
b.	Waiting room time	
c.	Actual processing time	
d.	Number of specialized personal in the clinic	
e.	Availability of primary care physicians	
f	Gender (sex) of the individual medical care provider	
g	Provider fee scale	
h.	Geographic accessibility	
i.	Diversity (of race/gender) of health care providers	

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____
_____

PATIENT-PROVIDER TRUST

52. When having a face-to-face visit with your doctor, how often do you feel the following thoughts or events during your visit? [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE FOR EACH STATEMENT]

1	2	3	4	5
NONE OF THE TIME	**SOME OR LITTLE OF THE TIME**	**OCCASSIONALLY or A MODERATE AMOUNT OF TIME**	**MOST OF THE TIME**	**ALL OF THE TIME**

a.	Health care provider discusses options and choices with you before decisions about your health are made?	
b.	Healthcare provider is committed to providing the best care possible.	
c.	Healthcare provider is sincerely interested in me as a person.	
d.	Healthcare provider is an excellent listener.	
e.	Healthcare provider accepts me for who I am.	
f.	Healthcare provider tells me the complete truth about my health-related problems.	
g.	Healthcare provider treats me as an individual.	
h.	Healthcare provider makes me feel that I am worthy of his/her time and effort.	
i.	Healthcare provider takes the time to listen to me during each appointment.	
j.	I feel comfortable talking to my healthcare provider about my personal issues.	
k.	I feel better after seeing my healthcare provider.	
l.	How often do you think about changing to a new healthcare provider?	
m.	How often does your healthcare provider consider your need for privacy?	

SOCIAL CAPITAL SCALE

Now we are going to ask you about your personal and social interactions.

53. Please indicate frequency/ number of interactions you have with other people [PLEASE SHOW CARDS WITH CODES /REMIND INTERVIEWEE ABOUT THE SCALE AND ASK TO SELECT ONE FOR EACH STATEMENT]

[USE SAME CODES FOR Qs # 53-62]

1	2	3	4	5
NONE	**A FEW**	**SOME**	**MOST**	**ALL**

a.	Family members	
b.	Relatives	
c.	Neighbors	
d.	Friends	
e.	Coworkers [USE N/A IF NOT WORKING]	
f.	Community members	

[COMMENTS. USE BACK IF NEEDED]

_____
_____
_____

54. With how many people in each of the following categories do you keep in contact? [USE SAME CODES AS 53]

a.	Family members	
b.	Relatives	
c.	Neighbors	
d.	Friends	
e.	Coworkers	
f.	Community members	

55. Among these people, how many can you trust? [USE SAME CODES AS 53]

a.	Family members	
b.	Relatives	
c.	Neighbors	
d.	Friends	
e.	Coworkers	
f.	Community members	

56. How many will help you upon your request? [USE SAME CODES AS 53]

a.	Family members	
b.	Relatives	
c.	Neighbors	
d.	Friends	
e.	Coworkers	
f.	Community members	

57. How many possess the following assets/resources? [USE SAME CODES AS 53]

a.	Certain political power	
b.	Wealth or owner of a large business	
c.	Broad connections with others	
d.	High reputation/influential	
e.	Connected to educational resources	
f.	With professional job	

58. Please indicate frequency number of interactions you have with other people [[USE SAME CODES AS 53]]

a.	Government, political, social, economic groups/organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.)	
b.	Cultural, recreational, leisure groups (religion, music, sports, dances, etc)	

59. Do you participate in activities for how many of each of these two types of groups and organizations? [USE SAME CODES AS 53]

a.	Government, political, social, economic group organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.)	
b.	Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	

60. Among each type of group and organization, how many represent your rights and interests? [USE SAME CODES AS 53]

a.	Government, political, social, economic group organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.)	
b.	Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	

61. How many will help you upon request? [USE SAME CODES AS 53]

a.	Government, political, social, economic group organizations (volunteer groups, coops, trade unions, neighborhood committees, etc.)	
b.	Cultural, recreational, leisure groups (religion, music, sports, dances, etc.)	

62. When all groups and organizations are considered, how many possess the following assets/resources? [USE SAME CODES AS 53]

a.	Significant power for decision making	
b.	Solid financial basis	
c.	Broad social connections	
d.	Great social influence	

Thank you for answering this questionnaire!

[COMMENTS. USE BACK IF NEEDED]

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VITA

Maria Elba Rodriguez Alcalá Trapani was born January 17, 1972 in Asunción, Paraguay. She is the daughter of Miguel Rodriguez Alcalá (R.I.P.) and Maria Raquel Trapani Ocampo. She attended the American School of Asuncion K4 through 12th grade. She obtained her B.S. degree in Agricultural Economics at Texas A&M University in College Station, Texas. Upon graduation, she married Fabio Ribas Chaddad (R.I.P.), from Brazil, and pursued her M.S. in Agriculture and Applied Economics at University of Missouri in Columbia, Missouri. Her son, Rodrigo Chaddad, was born as she was finishing her masters. The family moved to Pullman, Washington where she assumed the role of academic coordinator in the Department of Agricultural and Natural Resources Economics at Washington State University. Following, she moved to São Paulo, Brazil, where she worked as a researcher at the Institute for International Trade Negotiations (ICONE). At ICONE she later assumed the role of Regional MERCOSUR and National (Brazil) Project Coordinator in partnership with the Inter-American Development Bank, as well as got involved in several projects with international organizations such as the World Bank, the Swiss Agency for Development Cooperation, the William and Flora Hewlett Foundation, and the Woodrow Wilson International Center. She was then hired as the assistant director for the undergraduate program in the Department of Agriculture and Applied Economics at University of Missouri in Columbia, where she later pursued her PhD in Sustainable Development in the Rural Sociology Department. She worked with several projects involving Hispanics in the state of Missouri as a graduate research assistant during her PhD program, first with the Center for Health Policy in the School of Medicine, and then with the Cambio Center. Her husband, Fabio, passed away in 2016.