

**Gender In Context:
Immigrant Routes to Healthcare Access**

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Abstract

Gender In Context: Immigrant Routes to Healthcare Access

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It is well established that immigrant men are less likely to access healthcare than immigrant women. We cannot assume that immigrant men are just reluctant, and immigrant women are not, but that there are structural factors that facilitate and constrain gendered help-seeking. To better examine how gender structures immigrant access to healthcare, I develop a theoretical framework that integrates individual-level determinants with a contextual analysis of the immigrant household along multiple dimensions of gender relations. Employing the 2002-2003 National Latino and Asian American Study (NLAAS), I examine three outcomes related to healthcare access: having a usual provider for medical care, using a medical service within the last 12 months, and the number of medical visits within the last 12 months. First, I examine if gender interacts with migration decisions, incorporation and transnationalism to affect healthcare access. Second, I examine if gender interacts with socioeconomic-legal, institutional and social support resources to facilitate or hinder healthcare access. Third, I examine if gender interacts

with multiple dimensions of gender relations related to the household division of labor, composition, caregiving, and decision making to affect healthcare access. I find that responsibilities, strain and support networks related to the household and family are more likely to be associated with immigrant women's healthcare access. In contrast, community relations in the U.S. and abroad, friends, and institutions are more likely to be associated with immigrant men's healthcare access. Moreover, household gender relations along multiple dimensions are more egalitarian than expected. The findings demonstrate how healthcare is a gendered institution that occupies a key role between intermediate social factors and structural processes of health inequality. These analyses enrich the structural understanding of healthcare access to better inform policy and programs to alleviate immigrant and gender inequities in health.

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DEDICATION

To my parents, Wai-Chung Leung and Lai-Fei Lee,
for being a guiding example and supportive force for this curious immigrant kid

CHAPTER ONE

INTRODUCTION

How does gender structure the different opportunities and ways immigrants access healthcare?

Recent studies examining multiple health outcomes have found that access to healthcare is a significant mediator in the health gap between immigrants and non-immigrants, recent and established immigrants, and men and women (Gorman, Read, and Krueger 2010; Read and Reynolds 2012). This mediating effect across multiple population groups and multiple health outcomes contributes to a renewed focus on access to healthcare as an important structural mechanism of health inequities (Gorman et al. 2010; Kuhlmann and Annandale 2016; Pitkin Derose et al. 2009; Read and Reynolds 2012; Read and Smith 2017). It also places emphasis on the role of access to healthcare in dominant immigrant health patterns such as the “healthy immigrant effect,” the tendency for immigrants to be healthier than their U.S. born counterparts, and the “negative acculturation effect,” the decline in health with longer duration in the U.S. that have methodological, empirical and policy implications.

In the last decade, U.S. society has been focused on access to healthcare with substantial policies that have changed the structure of health insurance coverage and the healthcare safety net with the aim of ensuring affordable healthcare for the U.S. population. While policies such as the Affordable Health Care Act (ACA) have greatly contributed to decreasing the number of uninsured from 44 million in 2013 to less than 28 million as of the end of 2016 (Kaiser Family Foundation 2017b), immigrants continue to be disproportionately represented among the

uninsured and underinsured in the U.S. This reflects socioeconomic and legal barriers to affordable health insurance because immigrants are more likely to be employed in jobs and industries that often do not offer health insurance coverage, and are less likely to have access to healthcare safety net programs like Medicaid and the Children's Health Insurance Program (Kaiser Family Foundation 2017a). Despite the positive changes to healthcare under the Affordable Care act (ACA), much of the barriers that limit immigrant access to healthcare remain, and the factors that contribute to immigrant men being less likely to access healthcare less compared with immigrant women, also persist.

A growing body of literature has provided evidence that immigrant health patterns, including access to healthcare, differ for men and women. To date, much of the immigrant health literature that has explicitly focused on gender has progressed from examining gender differences by race and nativity (Erving 2011), to advancing more integrated approaches on examining the joint effects of gender and acculturation or immigration-related factors on health (Gorman et al. 2010; Hill et al. 2012; Kimbro 2009; Lopez-Gonzalez, Aravena, and Hummer 2005). A limited number of studies have started to examine the impact of gender within social contexts. These studies focus on some of the explanations for gender patterns in immigrant health and other social-environmental effects (Alcantara, Molina, and Kawachi 2015; Gorman et al. 2010; Leu, Walton, and Takeuchi 2011; Read and Reynolds 2012).

While there is a foundation of literature that has examined the extent of gender differences in access to healthcare, there are very few studies that have approached gender using a multi-dimensional and relational analysis to examine the differing pathways in which immigrant men and women access healthcare. These structural approaches to the examination of gender within immigrant health have only started. There is much opportunity to integrate

principles of gender and feminist theory such as gender as multi-dimensional and gender as relational into the analysis of immigrant health determinants. We already know that immigrant men are less likely to access healthcare than immigrant women. We cannot assume that immigrant men just are reluctant to access healthcare, and immigrant women are not, but that there are different structural factors that facilitate and constrain gendered help-seeking and access to healthcare. What we know less about is how gender structures the different opportunities and ways immigrant men and women access healthcare.

PERSPECTIVES IN UNDERSTANDING GENDER and IMMIGRANT HEALTH

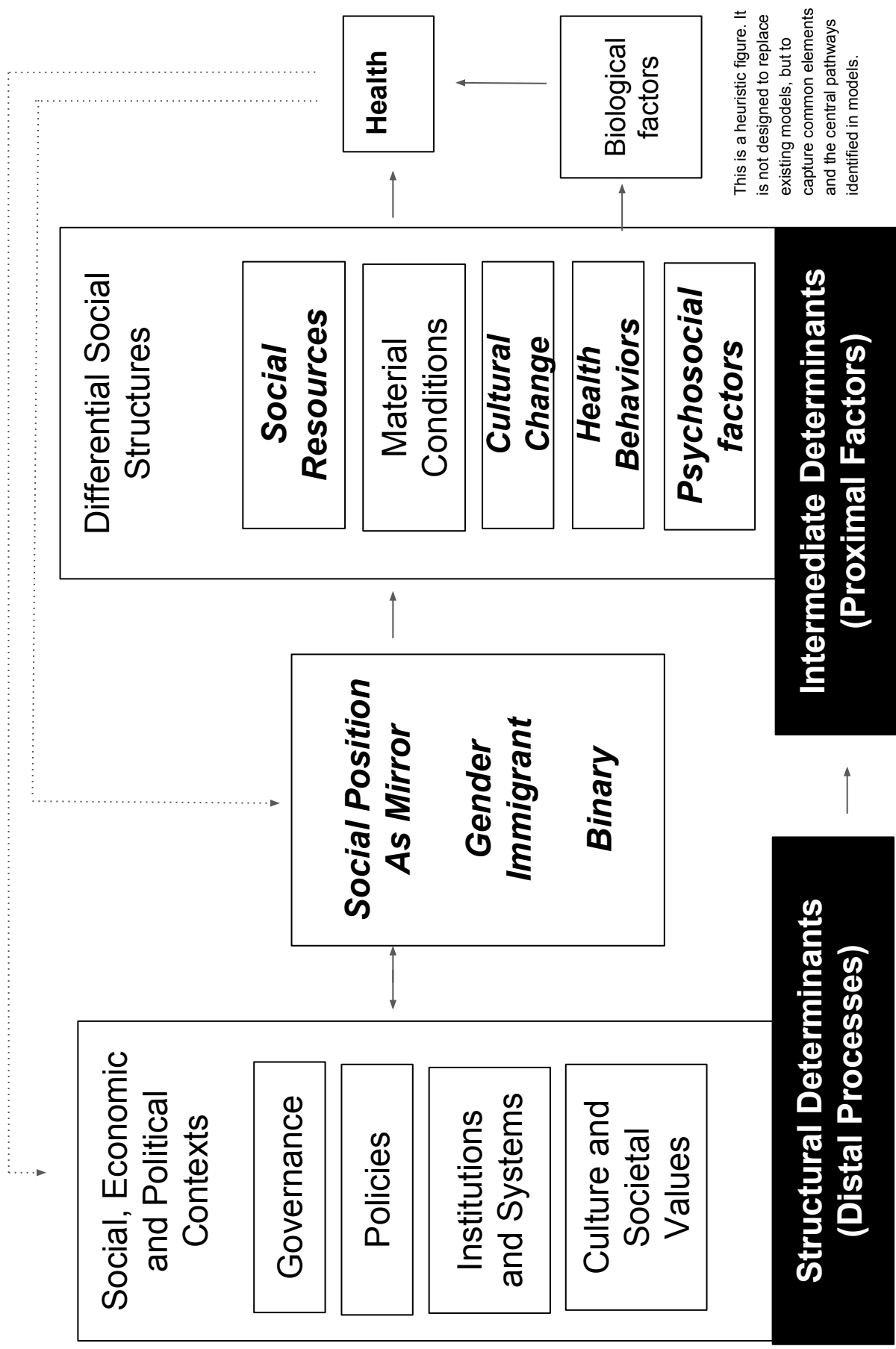
In the immigrant health literature, acculturation and structural approaches are two frameworks employed to examine and explain gender patterns in immigrant health. The acculturation approach mainly focuses on how gender traits, roles and position produce gender disparities in health behaviors and health outcomes. It emphasizes the role of cultural and social expectations on health behaviors and beliefs and mainly uses an individual-level analytical lens to measure the different health-related conditions and constraints. Acculturation approaches mainly adhere to a pathway model to the study of health inequalities, which is focused on examining the various types of mediating mechanisms. Pathway models highlight the effects of intermediate social factors even though distal factors are acknowledged and sometimes overlap (Diez Roux 2012). Figure 1.1 illustrates the main line of inquiry in the acculturation approach that largely examines how social positions, like gender, act as a mirror to reflect relative access to resources and how gender differences in health are affected by differences in immigrant men and women's adaptation and change to U.S. cultural norms, behaviors and beliefs.

The structural approach considers how gender disparities in immigrant health stem from dynamic social, economic and political structures and contexts that shape divergent gendered pathways of immigrant incorporation. This approach focuses on gender as a conduit that shapes social processes of inequality embedded in interactions within social and institutional structures. This means that gender organizes and shapes a variety of domains such as households and families, work, state policies and health-related institutions, and processes such as immigration decisions, social networks, and acculturation. These gendered social contexts and institutional practices that embed people in hierarchical relations are what constrain and segment immigrant men's and women's incorporation pathways, not just their individual behaviors and cultural beliefs. This approach acknowledges that immigration and settlement processes are disruptive to everyday life, entailing significant stress and upheaval, but also offer opportunities to recreate, reinvent and negotiate established gender relations that affect the health and well-being of immigrant men and women in complex ways. Figure 1.2 illustrates the main line of inquiry in this approach which largely focuses on how structural contexts and institutional practices produce and reproduce gender inequality and how these dynamic processes affect the health of immigrant men and women.

Gender *in* Immigrant Health - Acculturation Approach

Acculturation is the most widely used approach to understanding gender in immigrant health. In this approach, the gender differences in health stem from men and women differing in their pace and flexibility in adopting or shedding cultural norms and behaviors. I refer to this approach as gender *in* immigrant health as it mainly understands gender as a mirror that reflects

FIGURE 1.1
Acculturation Approach (bold italics)



relative access to resources in which men and women differ in position, traits and roles. More importantly, this approach conceptualizes gender as a fixed state, and health-related processes, like acculturation, are constraining conditions that contribute to health inequality.

Broadly, acculturation is a social change process that refers to individual-level changes in beliefs and behaviors that result of contact with dissimilar people in a new society. Commonly used in U.S. health research, acculturation refers to individual-level social change processes in which immigrants adopt behaviors, values, and beliefs prevalent in the destination society (Lopez-Class, Castro, and Ramirez 2011; Schwartz et al. 2011). Acculturation is a cross-disciplinary concept that remains highly contested with ongoing efforts to re-conceptualize and advance measurement to better understand its effect on health. Assimilation is strongly associated and refers to an outcome of acculturation or long-term interaction with the country of destination. Criticisms of acculturation include the assumptions of Anglo-conformity and ethnic stereotyping when interpreting the complex social processes that occur when immigrants settle in the U.S. (Hunt, Schneider, and Comer 2004; Lara et al. 2005; Salant and Lauderdale 2003). The ongoing debate of acculturation has resulted in both refinement of the concept that takes the form of ethnic specific scales (Chun, Organista, and Marin 2003) and expansion of the concept to include a wide range of proxy measures such as nativity, duration in the U.S., English language proficiency, citizenship status, social contacts or network composition, values and adaption of a “mainstream lifestyle”. While many acculturation measures have been found to be associated with health, each measure initiates a wide range of health mechanisms that, often times, run contradictory to each other.

Acculturation was originally conceptualized, and still commonly applied, as a uni-directional process in which an immigrant sheds their original culture while adopting new values

and practices. The ongoing debate and lack of consensus of acculturation has resulted in broader conceptualizations that include multi-dimensional processes. Multi-directional acculturation processes recognize the importance of migration decisions, incorporation into the destination country, and the maintenance of transnational ties (Abraído-Lanza, Chao, and Flórez 2005; Lara et al. 2005). In addition to identifying independent dimensions between the country of origin and destination, conceptualizations of multi-dimensional acculturation have further delineated distinct psychological areas and sociological contexts at the structural level (Portes and Zhou 1993; Ro 2011; Schwartz et al. 2010). This emphasizes that the process and pace of acculturation can differ across dimensions, with each dimension having distinct mechanisms, and potentially having different effects on health or other social outcomes.

The dominant gender assumption of acculturation is that that gendered constraints on health behaviors and beliefs will relax and “modernize” with increased years in the U.S. and more exposure to U.S. norms and gender ideologies. The traditional-modern gender paradigm assumes immigrant women of color arrive from experiences of being disadvantaged from asymmetrical gender structures from their country of origin that advantage men’s higher position and status. Therefore, the “modest gains in independence and decision-making ability reflect an improvement in status vis-à-vis gender relation [in their country of origin]” (Gorman et al. 2010; p. 442) that stem from increased exposure to U.S. based gender norms that are considered more “modern”, therefore less rigid, behavioral norms for women (Blau 2015; Erving 2011; Gorman, Lariscy, and Kaushik 2014; Read and Gorman 2010; Read and Reynolds 2012). This affects women’s status through increased access to employment, education and financial resources. On the other hand, men are more likely to lose social power and face more status loss in the larger

society, especially faced with hostile contexts of reception (Donato et al. 2008; Montes 2013; Walter, Bourgois, and Margarita Loinaz 2004).

Despite the persistent assumption of female mobility increasing with acculturation, socioeconomic and social mobility measures related to acculturation have been found to have very different effects on health across gender, race and ethnicity. While changes in gender roles and status can improve immigrant Mexican women's lives (Parrado and Flippen 2005), studies have also shown these changes to have very different gendered health effects. For example, immigrant women adopting more deleterious health behaviors with increased duration in the U.S. (Abraído-Lanza et al. 2005; Antecol and Bedard 2006; Hong et al. 2014; Lopez-Gonzalez et al. 2005; Markides et al. 1990; Pérez-Stable et al. 2001), or English proficiency having little effect on mental health among Asians (Takeuchi et al. 2007) and having deleterious effects to mental health for some Latinos (Alegría et al. 2007). According to some critics of acculturation, it is unclear whether these mixed results are a function of poor measurement and conceptualization as it pertains to gender, race and ethnicity (Hunt et al. 2004), or an empirical pattern meriting further investigation into the intersection of gender, race, ethnicity and immigration on health.

Since the retention of behaviors and social connections from the country of origin is often found to be protective of health, bi-directional concepts of acculturation have also measured language retention from the country of origin in tandem with English proficiency to highlight an important mechanism of the "healthy immigrant effect" or "immigrant health paradox". A bi-directional acculturation process allows for immigrants to have several strategies in which to incorporate into their new society without relinquishing of their culture from the country of origin. However, this also has mixed results across ethnicity and gender. In studies of health

behaviors, some found maintaining language of origin lessened the odds of drinking among Latinos (Kimbrow 2009) and smoking among Asians, but increased the odds of smoking among Latinos, with lower odds among women and higher odds among men (Gorman et al. 2014).

This traditional-modern gender paradigm is often used and rarely challenged. When examined more directly, the paradigm is often not supported. Kimbro's (2009) study on smoking and binge drinking among Latinos directly addressed the traditional-modern acculturation gender paradigm and the effects of neighborhood ethnicity and nativity. To measure acculturation, the study used English proficiency and a traditional values scale that assessed the approval or disapproval on issues such as unmarried childbearing and cohabitation. The findings highlighted some important gender-acculturation-health differences, and more importantly, many similarities. For the differences, women who were less proficient in English were less likely to smoke, but the opposite was found for men. There were no differences for binge drinking. Among immigrant women, the older they immigrated, the less likely they would drink or smoke. This pattern was more mixed for men. For the similarities, findings on traditional values were contrary to expectations. There were no nativity differences in holding traditional values. With gender, there were only small gender differences with holding traditional values and binge drinking, and no gender differences with holding traditional values and smoking. Gender also did not moderate the relationship between traditional values and the outcomes.

In a study on characteristics of immigrant Latino men and utilization of healthcare found that adherence to traditional notions of masculinity such as "strength", "asking for help", "being responsible" and "sticking to one's beliefs" had a positive effect on healthcare utilization (Rhodes et al. 2008). It is important to highlight that these notions of masculinity that were

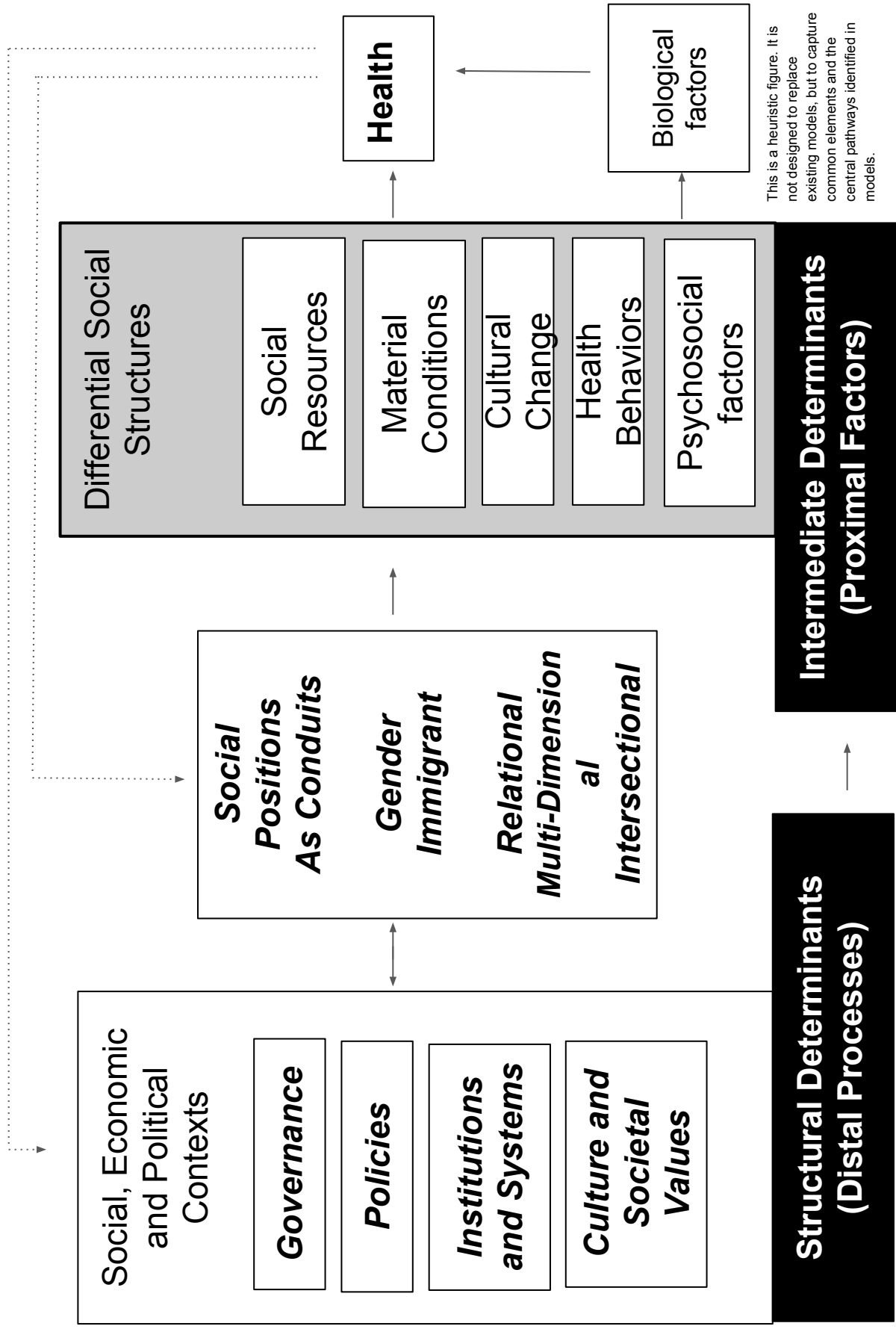
defined as traditional among immigrant Latino men contrasts with the more individualist notions of hegemonic masculinity and what is deemed as traditional in the acculturation literature

The effectiveness of intervention change using the acculturation approach is uncertain given the underlying traditional-to-modern gender paradigm remains strong. The endurance of the paradigm is especially revealing in the discussion and explanations of findings of gender differences across a wide range of studies using the acculturation approach and those attempting to address structural processes. For example, multi-dimensional conceptualizations of acculturation acknowledge the importance of maintaining pre-migration practices and beliefs, the immigrant health literature largely ignores the significant amount of social and cultural change regarding gender, family, work and education that has occurred in countries of origin in the past five decades. While these global changes have clearly attributed to demographic shifts and migration motivations for immigrants, these changes are less acknowledged when discussing the effects of immigration and settlement on the health of immigrant men and women. This underscores that this approach continues to limit the conceptualization of gender even when other associated concepts, like acculturation, are being advanced. Moreover, this approach reproduces colonial assumptions of global development, race and class and highlights why debates and critiques of acculturation approaches to gender, race, ethnicity and health remain.

Gendering Immigrant Health – Structural Approach

The structural approach posits that gender inequities in health stems from a multi-dimensional social system of stratification that occurs at the individual, group and structural level (Phillips 2005; Risman 2004b; Risman and Davis 2013). Gender is not only an individual-level

FIGURE 1.2
Structural Approach (*bold italic/shade*)



This is a heuristic figure. It is not designed to replace existing models, but to capture common elements and the central pathways identified in models.

attribute that is congruent with sex, but a composite of multiple dimensions that organizes production, power, emotional relations and culture (Connell 1987). This broader conceptualization of gender does not disregard individual level approaches, but emphasizes the multi-dimensional and interactional processes between individuals and social structures. Alternative to the pathway model seeing the social position of gender being a mirror that reflects relative access to resources, the structural approach sees social positions, like gender and immigration, as conduits that reveal the process and pathways of health inequities. I refer to this approach as *gendering* immigrant health because it conceptualizes gender as a relational process which focuses on questions of how gender inequities are produced and maintained, and to what effect (Geronimus and Thompson 2004; Knaak 2004).

Stemming from feminist and critical gender theory (Connell 1987, 2009; Lorber 1994; Martin 2004; Risman 2004a; Risman and Davis 2013), intersectional theories of inequality (Collins 1990; Crenshaw 1991; Glenn 2003; Hondagneu-Sotelo 1994, 2003; Pessar and Mahler 2006); and structural theories of health (Bird and Rieker 2008; Krieger 1994, 2008; Link and Phelan 1995; Williams 1997), the structural approach to gender emphasizes the importance of addressing distal factors and processes of inequality along axes of power, social positions and contexts. This approach does not dismiss individual level or proximal factors, but places an important spotlight on how the unequal distribution of power and access is generated and reproduced to affect multiple health outcomes via multiple mechanisms (Diez Roux 2012).

Gender and health scholars emphasize gender, as a fundamental cause of health, has unique qualities that need to be considered given persistent gender-health paradoxes, and the interaction with biological factors. To capture the complexity of gender, theoretical models should address biological processes and the interaction with social processes (Bird and Rieker

2008; Krieger 2003). Gender inequalities are primarily generated through interactions emphasizing relational dynamics of power, and not segregation and isolation as applied to models addressing socioeconomic or racial inequities (Annandale and Hunt 2000; Ridgeway 1997; Ridgeway and Smith-Lovin 1999). These unique qualities of gender suggest addressing the relationship between gender and health using more contextual and intersectional models that capture the gender-specific processes and pathways that lead to health outcomes (Bird and Rieker 2008).

This multi-dimensional and interdisciplinary conceptualization of gender acknowledges that change in one dimension of gender may happen at a different pace, or even in a different direction, from change in another (Annandale 2009; Connell 2012). To extend this to immigrants and their health, gender-related gains or losses are not uniform across immigration status, racial and ethnic groups, and modes of immigrant incorporation. For example, there may be gains in employment among women, being tempered by little change or losses in other dimensions such as emotional relations (Menjívar 1997, 2000; Parrado and Flippen 2005; Zhou 1992). These changes across multiple dimensions contribute to the increasing variation in health effects as well as illuminate the persistence of inequities to manifest in different types of gender-health mechanisms.

Studies using the structural approach have found that gender inequities among immigrants stem from interactions of power and status within social contexts and institutions, such as the household, community and society, transformed by the dynamic and complex immigration and settlement process. As immigrants rebuild and renegotiate a life imposed by new environments, they reconstruct social relations, including gender relations. This approach aims to emphasize how structural vulnerability is embedded in immigrant men and women's

relative position in specific contexts and networks, how contextual interactions are gendered, and how specific institutions of immigrant incorporation are organized along gendered dimensions (Hondagneu-Sotelo 1994; Itzigsohn and Giorguli-Saucedo 2005; Pessar 1999; Pessar and Mahler 2006; Tienda and Booth 1991).

Many gender and health scholars posit that men and women routinely make different health decisions because they are given different choices that are constrained by contexts. Even when health is a priority, individual decisions are informed by gendered environmental and contextual norms, expectations and opportunities that have different implications for health (Bird and Rieker 2008). The social contexts of immigrant incorporation have been found to contribute to the varying trajectories of social mobility, including health, among immigrants. Individual level factors alone cannot advance immigrant health and mobility because contextual constraints may exacerbate or buffer their effect and lead to divergent outcomes (Portes and Zhou 1993)., Bird and Rieker (2008) posit a contextual analysis is central the relationship between gender and health because of the unique features of gender stratification being interactions within contexts that merit extending beyond existing models of differences and inequality to address the processes and pathways that lead to health behaviors and outcomes.

The immigrant health literature has made some developments in both approaches to gender, and more importantly, the gaps that remain point to important directions for future research. To be able to pivot from the common assumption of the traditional-modern gender paradigm to a structural approach that examines gender as a multi-dimensional and constitutive element in the production of health inequities and divergent immigrant incorporation trajectories. This framework attempts to go beyond current approaches to gender and immigrant health that limits gender to an individual-level variable and evokes racial and ethnic stereotypes. It also aims

to respond to a consistent call among scholars for more studies examining health contexts and employing theories such as segmented assimilation (Portes and Rumbaut 2006; Portes and Zhou 1993) and constrained choice (Bird and Rieker 2008) that address the divergent immigrant and gender, respectively, processes and pathways of health outcomes.

RESEARCH QUESTIONS

The overall question I ask in this dissertation is how gender structures the different ways immigrant men and women access healthcare. I argue that access to healthcare occupies a key role between intermediate social factors and structural processes of health inequality because healthcare is more than a flexible resource for improving health. Healthcare is a vital institution in society and an unrecognized domain of immigrant incorporation. Moreover, healthcare is a deeply gendered institution that differentially distributes health-related resources, knowledge and power in complex ways. I aim for this dissertation to address the structural contexts of gender and its interaction with immigrant factors to put forth policy and intervention recommendations to alleviating immigrant and gender inequities in access to healthcare.

In Chapter Two, I develop an intersectional framework using contextual analysis to explain gendered pathways to healthcare access among immigrants. I build upon a dominant model used in the healthcare field, the Behavioral Model of Health Services Use that is commonly referred to as the Andersen model (1968, 1995), by integrating a contextual analysis of immigrant incorporation with a focus on the immigrant household (Bird and Rieker 2008; Portes and Rumbaut 2006; Portes and Zhou 1993). To address the intersection of gender and

immigration, I use gender theory to identify three dimensions of gender relations within the immigrant household (Connell 2009).

The empirical studies in this dissertation investigate three questions about the gendered effects on immigrant access to healthcare. Given the lower rates of access to healthcare among immigrants compared to the U.S. born, I am interested in how gendered structures and contexts affect immigrant help-seeking via the healthcare system. In each study, I use three outcomes of potential and realized access to healthcare that measure a distinct type of interaction with the healthcare system. The three outcomes include having a usual provider for medical care, having used a medical service within the last 12 months, and the number of medical visits within the last 12 months.

The outcome of having a usual provider for medical care measures a key enabling factor that reflects a level of awareness of the healthcare system. Because of additional barriers to healthcare access faced by immigrants, such as availability of interpretation services and levels of cultural competency, immigrants who may have insurance to pay for services still may not have a usual place to go to for healthcare.

The realized access outcomes, having used a medical service within the last 12 months, and the number of medical visits within the last 12 months, measure the level and frequency of engagement with the healthcare system.

Because my model includes multiple dimensions of household gender relations, my sample includes individuals, born outside the U.S. in Latin America or Asia, who are married/cohabitating with a spouse/partner of a different sex.

Question One:

How does gender interact with acculturation to effect access to healthcare?

Recent literature has conceptualized acculturation as multi-dimensional to recognize that an individual's context in their home country and decision to migrate can affect long term health and social mobility outcomes, and that having cultural acquisition in the country of destination can occur independently of the retention of behaviors and cultural beliefs from the country of origin, such as bilingualism. This acknowledges that some beliefs from and maintaining ties with the country of origin and immigrant co-ethnic enclaves have been found to have a protective effect on health (Abraído-Lanza et al. 2005), and other factors such as racial discrimination can affect different trajectories of social mobility despite robust human capital attributes (Portes and Rumbaut 2006; Portes and Zhou 1993).

It is also widely found that acculturation-related processes of migration, incorporation and transnationalism are highly gendered, where men and women perceive, live and respond differently to leaving their home country, being in the country of destination, and being part of both countries (Hondagneu-Sotelo 1994; Itzigsohn and Giorguli-Saucedo 2005).

In the first empirical study, I examine the effect of three dimensions of acculturation – reason for migration, incorporation to the U.S., and maintenance on transnational ties using the contextual model of access to healthcare that includes indicators of immigrant household gender relations.

Question Two:

How does gender interact with enabling factors to differentially facilitate or hinder immigrant men's and women's help seeking behaviors via the healthcare system?

Financial, legal, social, emotional or environmental factors that enable or impede access to healthcare play an important role in understanding the causes of health inequalities, but there remains limited research examining the gender and immigrant-specific enabling factors that may differentially shape healthcare access.

A considerable amount of literature has focused on socioeconomic and financial factors, especially in the U.S. when healthcare coverage is not universal, and the cost of coverage and medical care continues to increase. The importance of socioeconomic factors is also supported by theories of health inequalities, which posit that a social group's relative position in society determines their access to and capacity to purposefully use flexible resources that decrease health vulnerability and minimize negative health consequences.

While there is strong theoretical and empirical support for socioeconomic enabling resources like health insurance, few studies on immigrants have focused on examining other immigrant and gender-related enabling factors such as support networks and past barriers to healthcare that may produce differing responses among immigrant men and women.

In the second empirical study, I examine the interaction of gender and three types of enabling factors on access to healthcare: socioeconomic-legal resources, institutional barriers, and social network support.

Question Three:

How do power, production and emotional dimensions of household gender relations differentially effect immigrant men's and women's access to healthcare?

Households are primary social contexts where illness occurs, health-seeking decisions are made, and enabling resources for healthcare access are pooled and redistributed. People in the same household share similar physical, economic and social environments leading to common health vulnerabilities and exposures. Household members also share financial access to important enabling resources such as health insurance and social support. Pooled financial resources usually pay for family-based health insurance plans. Household members are also more likely to share similar beliefs and behaviors related to illness, help-seeking and health. These commonalities lead to assumptions that household members would mutually influence health behaviors. However, as evidence in the literature of gender and health shows, men and women within the same household can greatly differ in health beliefs, behavioral and emotional responses to stressors, and their health-seeking behaviors.

For immigrants and people of color, the household is more than just a context where men and women negotiate work and family decisions. The immigration household is both a site of resistance against societal discrimination and a site of intense negotiation in gender, generational and cultural relations. This places the immigrant household within the contexts of immigrant incorporation as well as the social changes associated with acculturation. Emerging evidence shows contexts of immigrant incorporation at the household, neighborhood and national level does matter for health across nativity, immigrant status, and race and ethnicity (Choi 2009; Lasser, Himmelstein, and Woolhandler 2006; Siddiqi et al. 2013; Siddiqi, Zuberi, and Nguyen

2009), but still little is known about how gender operates within these immigrant contexts of incorporation when it comes to accessing healthcare.

In the third empirical study, I examine how multiple dimensions of household gender relations differentially affect immigrant men and women's access to healthcare. I measure the context of household gender relations along three dimensions of power, production and emotion.

IMPORTANCE OF THE RESEARCH

Why Gender and Immigrant Access to Healthcare?

Recent studies have found that access to healthcare is a significant mediator in the health gap between immigrants and non-immigrants, recent and established immigrants, and men and women (Gorman et al. 2010; Read and Reynolds 2012). These findings across multiple U.S. population groups partially attribute the better health found among immigrants, particularly immigrant men and recent immigrants, to less access to and use of U.S. based medical care services. Read and Reynolds (2012) and Gorman, Read and Kreuger (2010) interpreted these findings among immigrants, notably men and recent immigrant arrivals, are more likely to report better health because they have less knowledge about their health status, resulting in a more positive view. This is reflected in subjective measures such as self-rated health. They posit that the decline in health among these groups with longer duration in the U.S. may be better explained by their likelihood of accessing healthcare and gaining more clinical knowledge of their health, than more commonly found acculturation-related factors such as adopting poorer health habits and losing protective social factors.

These findings across multiple populations highlight access to healthcare as an important issue for further examination, especially as it pertains to immigrant and gender health. I summarize that methodological, policy and theoretical implications that emerge from these studies. First, these studies found that immigrants, independent of selectivity effects, are more likely to report more positive health status if they had not accessed medical services. For immigrant subgroups with higher selectivity for health such as recent immigrants and men, some of their better health may be reflected in their lower rates of accessing healthcare. Gorman, Read and Kreuger (2010) urge for more cautious interpretations in immigrant health studies that only use self-rated health. This issue can be addressed by using different types of medical conditions that are more likely to come from a medical provider (e.g. hypertension, heart disease, diabetes) along with subjective measures of self-rated physical or mental health. Another approach could be to re-examine how illness or wellness is constructed to focus on other less subjective measures such as days off work, the number of physical limitations, medication use or number of hospital days.

Second, the findings point to the need for renewed policy focus on access to healthcare where resources and interventions can be targeted to improve health and reduce inequities between and among groups. In the U.S, immigrants have lower levels of access and use of healthcare in comparison to non-immigrants (Pitkin Derose and Varda 2009). The additional findings on gender and national origin in healthcare utilization among immigrants affirm the need for increased resources to improve healthcare access for sub-populations within cultural and linguistic groups (Read and Smith 2017). However, there has been limited discussion on more precise policy details such as what type of resources and when interventions should be implemented that will lead to improved immigrant healthcare access and decreased inequality.

Third, the recent findings across multiple populations highlights the need to re-examine the role of access to healthcare as structural factor in shaping health inequities instead of just an intermediate factor or flexible resource. The consistent patterns of low levels of healthcare access among immigrants regardless of time spent in the U.S., and low levels among men regardless of immigration or nativity status, points to intersecting immigrant and gender barriers.

Why Gender as Social Structure?

Gender has unique qualities as a fundamental cause of health that does not simply follow models of socioeconomic status and race. Gender and sex must be addressed as distinct factors that affect health and access to healthcare. Gender inequities cannot be solely characterized by material and social segregation or isolation, but rely on a broader analysis of interactional power and contexts that produce relative advantage/disadvantage to health-related resources.

Both gender and immigration are most commonly measured and conceptualized as individual level demographic variables. Gender theorists posit the importance of analyzing gender as an individual, group and structural measurement.

Gender substantially differs from other social positions, like socioeconomic status and race, because the beliefs and practices that produce gender-health inequities are sustained in a context of social interaction, instead of social isolation or segregation (Bird and Rieker 2008; Kuhlmann and Annandale 2016; Weber 1998). The dynamics of interaction is core to the gender relations approach which encompasses the recursive relationship between structures and individuals, and the power relations embedded in interpersonal relationships, institutions and contexts. For example, men and women interact extensively within the context of families,

households and communities, and unlike race and socioeconomic status, men and women are not socially segregated in different neighborhoods or social classes, although they may individually embody differences like education (Ridgeway and Smith-Lovin 1999) or work in segregated occupations. Therefore, a gender analysis of contextual effects on access to health resources cannot be solely characterized by material and social segregation or isolation, but relies on a broader analysis that addresses how interactional power and gendered contexts produce relative disadvantage/disadvantage to health-related resources.

The framework of gender as social structure allows for analysis of how gender operates along different dimensions and is reproduced in domains of immigrant incorporation such as healthcare institutions. Connell (2009) posits that institutions or contexts are organized along four gendered dimensions: power; production; emotional; and cultural. Gender as social structure emphasizes the complexity and variability of gender and the need to go beyond individual level conceptualizations of relative advantage/disadvantage. It allows us to ask how do gendered institutions affect immigrant access to healthcare, and which gendered dimension is most salient? What are the individual, interactional and structural level constraints that affect immigrant men and women seeking help or accessing healthcare? This way of looking at how gender, and other social positions, structures multiple levels of social stratification give us opportunity to not just measure if there is inequality, but where and how inequality is maintained and reproduced.

Why now?

The implementation of the Affordable Care Act (ACA) and the continued public debate about its effectiveness has changed the U.S. healthcare system and how all populations in the U.S. access healthcare. The ACA policies increased, mainly through socioeconomic mechanisms related to health insurance and the expansion of the healthcare safety net, potential and realized access. However, the ACA did not change many of the legal restrictions placed on immigrant access to healthcare. Undocumented immigrants continue to be ineligible for any form of federal subsidy or program for health insurance coverage. They must continue to rely on the local and state based safety net that varies considerable by county and state. Moreover, recent documented immigrants must still wait for five years to receive any form of public assistance such as Medicaid. Eligible immigrants still risk being labeled a public charge that would jeopardize their eligibility for further services and their application for citizenship. These effects, even as ACA has alleviated some important barriers to access, still persist. Moreover, with increasing immigrant restrictions and stigmatizing public attitudes, immigrant access continues to have significant barriers that are not faced by the U.S. born. The data used in this dissertation was collected before the ACA. While the level of private health insurance will have increased after ACA, I argue that many of the structural determinants of gender and immigrant access to healthcare, and the relationships between gender and acculturation, resources and household gender relations found in this dissertation will not have changed very much under the implementation of the ACA. These three studies provide a baseline for future research using more updated data.

DISSERTATION OUTLINE

This dissertation is organized around the presentation of a theoretical framework and three empirical analysis that apply this theoretical framework to a 2002-2003 nationally representative sample of married/cohabitating immigrant men and women in the U.S. I use the same data, basic model and methods for all three analyses, adjusting modeling strategy on each study's specific area of focus. Because each paper is focused on a different set of factors and theoretical perspective, I embed further discussion of theory into each of the empirical chapters.

In Chapter Two, I propose my theoretical framework that builds upon the individual-level predisposing, enabling and needs factors of the Behavioral Model of Health Services Use, commonly referred to as the Andersen model (1968, 1995), by integrating a contextual analysis of the immigrant household along three dimensions of gender relations (Bird and Rieker 2008; Connell 2009; Portes and Rumbaut 2006; Portes and Zhou 1993).

In Chapter Three, "Gender and Immigrant Access to Healthcare: The Effects of Migration Decisions, Incorporation and Transnationalism" I present the first empirical analysis, exploring how dimensions of acculturation differently affect immigrant men and women's access to healthcare.

In Chapter Four, "Women Go to their Family, and Men Go to their Community: Gender and Immigrant Routes to Healthcare", I present how three types of enabling factors differentially facilitate or hinder immigrant men and women's access to healthcare.

Chapter Five, "Gender in Context: Household Gender Relations and Immigrant Access to Healthcare", I investigate how multiple dimensions of household gender relations affect

immigrant men and women's access to healthcare, and if gender acts as a moderator in this relationship.

I conclude the dissertation with Chapter Six which discusses the findings from each empirical analysis in relationship to one another and the implications for theoretical, empirical and policy aims of improving immigrant access to healthcare.

CHAPTER TWO

A GENDER and IMMIGRANT FRAMEWORK for HEALTHCARE ACCESS

This chapter provides a critical review of structural theories of health with the aim of proposing a theoretical framework to examine the immigrant and gender-related determinants of access to healthcare. I argue that access to healthcare occupies a key role between intermediate factors and structural processes of inequality because healthcare is more than a flexible or intermediate resource for improving health. Healthcare is a central societal institution that is unrecognized as a domain of immigrant incorporation. Moreover, healthcare is a deeply gendered institution that differentially distributes health-related resources, knowledge and power in complex ways. I aim for the theoretical framework to address the structural determinants of immigration and gender to put forth research, policy and program recommendations that illuminate the urgency of alleviating inequities in access to healthcare.

This chapter has four main parts. First, I argue that access to healthcare should be considered a structural determinant of health. I draw from the World Health Organization's Commission on the Social Determinants of Health framework (Solar and Irwin 2010) that delineates between the social determinants of health, which are referred to as intermediate factors, and the social determinants of health inequities, which are referred to as structural processes. Rarely acknowledged as either an intermediate or structural determinant of health, Solar and Irwin (2010) make a compelling argument to place the healthcare system (back) into the social determinants of health framework. I extend their argument and posit that for immigrants, healthcare access is a key structural determinant of health inequities, and not just an

intermediate factor because of the multifaceted and pivotal role that access to healthcare plays in trajectories of immigrant health and social mobility.

Second, I critically examine fundamental social cause theory (Link and Phelan 1995; Phelan, Link, and Tehranifar 2010), one of the main structural theories of health, and its relevance to gender and immigration health inequities. I discuss the limitations of fundamental social cause theory's conceptualization of access to healthcare as a flexible resource, and the strengths and challenges in addressing some of the complexities of gender and immigrant-related health paradoxes and puzzles.

Third, I detail how immigration and gender, separately and together, structurally shape health inequities in access to healthcare. Focusing on healthcare as an institution, my argument is twofold: healthcare functions as a vital, yet unrecognized, domain of immigrant incorporation; and healthcare is a deeply gendered institution that affects immigrant men's and women's health care access and treatment in varying and complex ways. To better discuss and emphasize how gender and immigration intersect to act as conduits to structural inequities, I discuss the importance of contextual analysis as an intersectional analytical strategy to comprehensively account for the systems of power, governance and values that constrain and facilitate immigrant and gendered access to healthcare.

Fourth, I outline my proposed theoretical framework which builds upon the individual-level predisposing, enabling and needs factors of the Behavioral Model of Health Services Use, commonly referred to as the Andersen model (1968, 1995) by integrating a contextual analysis of the immigrant household along three dimensions of gender relations (Bird and Rieker 2008; Connell 2009; Portes and Rumbaut 2006; Portes and Zhou 1993). I focus on the context of the immigrant household although the framework can be extended to contexts encompassing local

neighborhoods, county and state healthcare systems, public attitudes, and national policies. This framework aims to advance the analysis of gender as a social and structural determinant of health that has implications for healthcare access at the individual, group and institutional level.

MAKING a PLACE for GENDER and IMMIGRATION: EXTENDING STRUCTURAL THEORIES of HEALTH

With the complexity and persistence of health inequalities, it is important to clarify the relationship from the immediate factors that contribute to inequities in population health, and the structural processes that reproduce the unequal distribution of social factors that impact the magnitude of health inequities (Graham 2004; Solar and Irwin 2010). The hallmark of structural or ecological theories of health is the persistence of health inequalities despite pronounced changes in diseases, health risks, and medical treatments (Graham 2004; Krieger 1994, 2008; Link and Phelan 1995; Solar and Irwin 2010). Structural inequalities persist despite inequality decreasing in some intermediate factors. In other words, overall health can improve through medical, public health or social interventions, but inequities between or among groups can continue or even widen. Structural theories of health emphasize the need to improve health overall *and* decrease the magnitude of health inequities. Focusing on processes that affect the distribution of health resources and opportunities, structural approaches underscore that health inequities cannot be eliminated by solely addressing proximate or immediate risk factors. Many scholars use the analogy of an iceberg (Annandale 2009; Gee and Ford 2011) to remind us that when we are only focused on changes at the surface, we fail to recognize the stronger, complex and dynamic structural forces underneath.

Gender and health scholars emphasize that looking below the surface challenges our assumptions that decreasing gender gaps in mortality and morbidity can simply imply more gender equality and less discrimination. Rather, these changes imply “more complex patterns of similarity and difference, equality and inequality emerging from the ferment” (Annandale 2009, page 1) that should prod us to further examine the dynamic processes of inequality and how they affect health in different contexts and across different social positions.

This paper attempts to respond to Annandale’s point about the complexities that underlie immigrant and gender health inequities. The extensive research into intermediate health factors have found strong consistent patterns of inequality and health such as socioeconomic status, as well as some confounding paradoxes especially in gender and immigrant health. Examining structural processes is aimed at better understanding these seemingly disparate patterns to show how immigrant and gender inequities are reproduced in complex systems, and how inequities are reinforced despite significant improvements to social determinants.

In addressing structural determinants and analyzing differences, it is also important to address the overlapping terminology of health disparities, inequalities and inequities and how they apply in different analytical purposes. Disparity refers to differences between groups and is often used across multiple fields. It is considered more as a neutral term and encompasses differences based in inequality. Inequality also refers to differences between groups that reflect the presence of discrimination or injustice. Inequities imply a lack of fairness, acknowledging that there may be differing needs. Like the other terms, inequities also reflects the presence of an unjust and systematic difference that is preventable. Because of the presence of differing needs, equity in health is not the same as equality in health status (Arcaya, Arcaya, and Subramanian 2015). Consistently revisiting these terms, calls for more precision in our research and policy

goals, and thus, our analytical strategies. This allows us to make clearer distinctions with research and policy aims addressing health equality that focuses on the elimination of discrimination, and health equities that focuses on adequately and fairly meeting different needs (Hammarström et al. 2014).

Structural theories of health aim to address the persistence of health inequities despite significant policy and medical advances. Link and Phelan's (1995; 2015) fundamental cause theory, a dominant theory in the medical sociology, focuses on the processes and mechanisms that affect access to and capacity to use resources, which in turn affect health exposures, vulnerabilities and consequences. Link and Phelan outline four critical components of fundamental cause theory: 1) a fundamental cause is related to multiple disease outcomes; 2) the causes of illness operate through multiple risk-factor mechanisms; 3) a fundamental cause operates through the access to flexible resources that are used to minimize health risk or disease progression; and 4) the association between fundamental cause and health, assuming the cause has not shifted or been eradicated, is reproduced over time through the replacement of intervening mechanisms or intermediate determinants.

The first two components emphasize how broad and distal factors influence health as well as the importance of examining persistent health problems that are rooted in dynamic processes that are not just linked to a single linear process of cause, mechanism and health outcome. These are commonly held criteria across a number of structural theories of health (Graham 2004; Krieger 1994, 2008; Solar and Irwin 2010; Williams 1997).

The third component addresses the theory's main mechanism in which fundamental cause operates to drive inequality. Link and Phelan centralize the availability and capacity to access and use flexible resources in a timely manner are vital to protecting and promoting health. These

flexible resources can be social (education, beneficial social connection, power, prestige) and material (money, property). Even though fundamental social cause theory primarily addresses non-medical and non-health system resources, I assume access to healthcare would be conceptualized as a flexible resource. A social group's relative position in society determines their access to and capacity to purposefully use flexible resources that decrease vulnerability and minimize negative consequences operate at the individual, group and structural level. With a strong emphasis on socioeconomic status, the relationship between access to flexible resources and capacity to use them is what continues to drive inequities in health despite significant medical and social advances (Adler et al. 1994; Link and Phelan 1995; Wilkinson 1997).

The fourth component emphasizes how health inequities endure despite the elimination or emergence of specific intervening mechanisms. According to Link and Phelan (1995), "mechanisms come and go, but fundamental cause remains", therefore inequality persists. This is also a common component in many structural theories of health, which is why more inquiry into the processes that reproduce uneven distribution of resources throughout the population is needed.

Socioeconomic status dominates the field as "the" fundamental cause (Phelan et al. 2010) even though other structural theories focusing on race and other social positions developed at a similar time (Krieger 1994; Williams 1997), and Link, Phelan and colleagues have attempted to address racism (Phelan and Link 2015) and stigma (Hatzenbuehler, Phelan, and Link 2013) as fundamental causes independent of socioeconomic status. These complementary theories have had fewer empirical examinations or theoretical modifications in the field of sociology, hence my focus on fundamental cause theory. Additionally, the lack of theoretical or empirical development on other social positions, such as gender, may be because of specific limitations of

fundamental social cause theory instead of just time and effort needed for development beyond socioeconomic status.

Like socioeconomic status, immigration status and gender both operate as conduits of structural determinants, separately and together, to affect access to healthcare, which is a key resource for minimizing health risk and disease progression. Fundamental social cause theory provides a foundation in which to address structural processes in health inequities, however the persistence of immigrant health and gender health paradoxes point to unknown interactions between gender, immigration, and the healthcare system, as well as the uniqueness of health as a social mobility measure for immigrants. This compels us to consider additional ways that immigration and gender affect access to and capacity to use flexible resources as well as other mechanisms that have not been fully addressed by fundamental cause theory. In response to these issues, I pose the following research question: What are the immigration and gender-related structural determinants associated with access to healthcare?

In the next section, I provide a critical discussion of fundamental cause theory aimed at extending structural theories of health to better address gender and immigration, and begin to discuss the question posed.

Making a Place for Gender and Immigration Means Moving Some Things Around

In most structural theories of health, gender is often mentioned along with socioeconomic status and race (mainly Black-White disparities) as a key social position that affects access to health-related resources (Link and Phelan 1995; Solar and Irwin 2010). Only recently, immigration status has been incorporated into the theoretical literature (Castañeda et al. 2015;

Gee and Ford 2011; Viruell-Fuentes, Miranda, and Abdulrahim 2012). Despite there being a large body of literature from multiple fields that have argued on why and how gender and immigration, separately and together, structure social life and health, current structural theories of health addressing gender and immigration continue to be underdeveloped in the literature (Bottorff et al. 2011; Knaak 2004; Llácer et al. 2007; Phillips 2005).

Moreover, if considered at all within the social determinants of health framework, the healthcare system is more commonly conceptualized as an intermediate social determinant because medical services can directly address differences in health exposure and vulnerabilities, and function as the critical mediator in differential health consequences of illness. Often overlooked is the healthcare system as a structural determinant. The healthcare system strongly influences how people move in the social hierarchies of society by granting certain rights and privileges to access important enabling resources, and has the capacity and obligation to strengthen policies that reproduce contextual factors such as social capital that reduce the effects of poverty and marginalization, and protect against social and economic consequences of ill health (Solar and Irwin 2010).

In this next section, I will discuss how access to healthcare uniquely structures immigrant and gender inequities by addressing some of the missing elements of fundamental social cause theory and other structural theories of health.

Access to Healthcare: More than a Flexible Resource for Immigrants

People are waiting on a dock with suitcases. By the clothes, you can tell this black and white photo was taken a century ago. In multiple languages, the type reads, “We support the

United States' long history of welcoming refugees, immigrants and those seeking asylum." This poster went up in a community health clinic exam room in Kent, WA shortly after the 2016 travel ban. While there were no changes made to medical services in response to the change in law, much had changed outside the clinic. This meant that Muslims, immigrants and refugees had more questions about accessing healthcare. Would they be detained at the clinic? Would using services now put them in jeopardy for future services? Would they be treated poorly? A medical provider asked her patient, a Mexican man who was undocumented, how he felt about the most recent changes in immigration policy. He shook his head, then pointed at the poster and said, "But I'm okay in here."

The vignette above illustrates how access to healthcare for immigrants has multi-dimensional implications beyond being a flexible resource to improve health and health behaviors. Before and after a series of policy changes in immigration, medical services remained the same, but this clinic was compelled to put this poster up. What had significantly changed was how immigrants felt about accessing healthcare. They had more fear and questions about their options. Could they continue to trust their provider and local health clinic? Is the clinic still a safe place to go for support and resources beyond medical care? These legitimate questions underscores the close ties between healthcare, immigration status, and belonging throughout U.S. history.

The social stratification of immigrants to the U.S. is maintained by various mechanisms such as stigmatization, segregation, and discrimination. Immigrants have diverse experiences that have been mitigated by period, social class, national origin, race and ethnicity, gender and religion. Pathways of immigrant incorporation have also varied with changing contextual factors

at the government, societal and community level. Immigration as a fundamental social cause of health shares some of the logic of relative advantage and disadvantage like socioeconomic status and race, and is often discussed as an extension of racial stratification (Gee and Ford 2011).

At the same time, there are paradoxical health patterns that do not fully follow the logic of relative advantage and disadvantage to resources. The “healthy immigrant paradox”, with immigrants having better health despite lower social position compared with their U.S. born racial and ethnic counterparts may explain some, but not all, factors. This paradox is further complicated with the immigrant decline in health with longer duration in the U.S. which differs from other social mobility measures. Interestingly, this immigrant health decline is not mirrored with a similar increase of healthcare utilization, which may point to other challenges that have not been addressed in current models (Yang and Hwang 2016).

The structure of the U.S. healthcare system and access to health insurance closely mirrors class stratification. Those with regular employment and higher incomes having better access to quality healthcare than those with lower incomes and lacking full employment. This structure points to why socioeconomic status as a fundamental social cause of health is so significant and enduring. Independent of socioeconomic status, immigration status further marginalizes health-related stigmatization and exclusion for resources. Immigrant treatment under a class-stratified system can be better conceptualized as caste because of the categorical exclusion based on immigration status. This further entrenches the unequal relationship between immigration status, socioeconomic status, race and ethnicity, and healthcare access (Portes, Light, and Fernández-Kelly 2009).

Within the fundamental social cause theoretical framework, the relative position of nativity or immigration status determines access to flexible resources needed for health.

However, the conceptualization of access to healthcare as a flexible resource limits the unique and important ways that the healthcare system, currently and historically, shapes immigrant social and health trajectories.

Access to healthcare plays an important structural role in immigrant health inequities as a large-scale and contextual level force that impacts the distribution of resources, prestige and power to affect immigrant men and women's lives and health. Issues of access to healthcare impact many groups, however, for immigrants, access to healthcare, as a societal institution, has two unique implications for immigrant health beyond what is provided in medical care.

First, healthcare is a key domain of immigrant incorporation into society. Incorporation, measured in terms of social mobility or social citizenship is integral for optimizing health and wellness. Less recognized than the domains of employment, education, legal/political and housing, access to healthcare not only facilitates access to a health-promoting resources such as medical care, it also serves as an institutional mechanism that clears, delays or blocks a pathway for social citizenship manifested as belonging and engagement in the receiving society (Ager and Strang 2008).

Second, public and policy debates regarding immigrant access to healthcare and their impact on public health have been used as a longstanding source of immigrant stigma and stratification. Public attitudes and policies have frequently cast immigrants as exploiters of U.S. systems, like healthcare and welfare, and as threats to public health (i.e. scourges, contagions) as a reason for denying entry, residential and social segregation, denying of resources, and discrimination. These complex and conflicting mechanisms linking immigrants and access to healthcare reflect how multiple intervening mechanisms are reproduced to have a wide detrimental impact on immigrant health and social mobility.

Healthcare as a Key Domain of Immigrant Incorporation

Immigrant incorporation and other related terms of integration, assimilation and acculturation are often used to describe an immigrants' relationship to the receiving society. I use the term incorporation because it implies adaptation for both the immigrant and the receiving society, and focuses on the varying pathways that allow for increased engagement in society as full social or legal citizens. Immigrants are more likely to access healthcare when they are more incorporated into U.S. society, which enables them to better engage with other domains of incorporation (Ager and Strang 2008; Lasser et al. 2006).

Healthcare is one of the key domains of immigrant incorporation that is less frequently discussed compared with economic/jobs, housing, education, legal/political domains. For immigrants, access to healthcare is more than just seeing a medical provider. Whether in the physical form of a clinic or a social form of patient-provider interaction, healthcare is often overlooked as a key social institution in which immigrants rely on to ease their settlement process, to develop a sense of belonging, and to build trust with government supported systems. More importantly, healthcare, along with education, are seen as domains of incorporation with a mission to mitigate inequality.

Like most other populations, immigrants access healthcare when they are already vulnerable because of illness or injury, underscoring the need for affirming interactions that open up opportunities to build trust with societal institutions. These positive interactions also help to bridge potential access to healthcare (i.e. insurance, a regular place of care) and realized access (i.e. visits to a provider, having needs met) for acute, chronic and preventative health issues. When an immigrant gains access to healthcare, the interaction goes beyond individual level

medical provision between a patient and the medical provider, it marks a relationship with a key government-supported service that entails both risk and relief.

While health providers and local organizations often uphold a humanist and moral orientation with the aim to help and heal (re: Hippocratic oath), U.S. healthcare policies that regulate the healthcare system and insurance often limit and actively exclude some immigrants from affordable access to healthcare. This creates a tension, or institutional ambivalence, which can erode overall immigrant trust in healthcare systems, divide families and communities among those who are deserving and non-deserving of healthcare, and to delay or block full incorporation into U.S. society (Light 2012).

Healthcare as a Source of Immigrant Stigma and Stratification

There is growing evidence that stigma is a fundamental cause of population health inequities (Hatzenbuehler et al. 2013). Stigma is the co-occurrence of labeling, stereotyping, separation, status loss and discrimination in a context where power is exercised over a group. It incorporates multiple statuses (i.e. sexual orientation; race) and characteristics (i.e. HIV positive status; mental illness). A dominant groups' ability to keep people "down, in or away" (Hatzenbuehler et al. 2013) undermines or exacerbates health-related processes (i.e. stress, isolation, access to resources) that lead to adverse health outcomes. Stigmatizing mechanisms can occur, and often reinforced, at all levels of society.

As much as accessing healthcare is vital for forging a better pathway for immigrant incorporation and health, issues of access to healthcare have historically been used as a stigmatizing mechanism towards immigrants to block their full incorporation into society. From

as early as the first waves of immigrants to the U.S., policies and public attitudes on access to healthcare and other state supported services that regulate public health and medical services have played a significant role in generating, justifying and validating immigrant-related stigma through denied entry, deportation or exclusion from services (Fairchild 2004; Markel and Stern 2002). Historical examples include neighborhood segregation of Chinese immigration (Shah 2001), laws that blocked Haitian entry into the country (Sargent 2012) and deplorable working and living conditions among agricultural workers (Molina 2011). These are just a few historical examples that reinforce the hierarchal status of immigrants at the bottom of the social and health hierarchy. While increases in socioeconomic status can improve access to healthcare and health-related resources, the re-occurring stigma associated with immigrants and healthcare continues to solidify the stratification of immigrants as the least deserving of public services and rights to healthcare.

The rhetoric from policies of healthcare exclusion shapes and is shaped by public attitudes towards immigrants. Since healthcare in the U.S. is considered a commodity, and not a universal right, the motivation to stigmatize immigrants has remained strong and enduring over time. As a mediating mechanism, potential access and use of healthcare has consistently been used to create immigrant-related fear and stigma that reproduces health inequities by segregation, control or exclusion (Molina 2011; Shah 2001). More recent examples include the debates regarding immigrants and their eligibility for healthcare subsidies under the 1996 The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the 2010 Affordable Healthcare Act (ACA). These debates no longer cast immigrants as vectors of disease and contagion. Instead they are framed as “scamming resources”, “taking advantage of systems ” and

caste as “undeserving” of state supportive services (Derose, Escarce, and Lurie 2007a; Derose, Gresenz, and Ringel 2011).

This rhetoric and policies of exclusion are intended to mitigate further immigration, but the result has not been less immigration, but more marginalization and inequality. The stigmatization attached to these exclusions reproduces inequality by affecting the ability of immigrants to access the limited services that may be locally available to them, increasing stress levels and other psychological and behavioral responses, increasing social isolation, and blocking full incorporation into society.

Interaction, not Segregation: Gender, Power and Structure of Health and Healthcare

In most societies, it is rarely disputed that men have a higher social position compared to women, and that inequities in social position affect inequities on health status. However, many gender and health scholars argue that it is not that gender is just overlooked or deprioritized in structural theories of health, but that current structural models of inequality and health are insufficient to address unique facets of gender and the complexity of gender-health paradoxes (Bird and Rieker 2008).

The framework of fundamental cause theory (Link and Phelan 1995) does not address the observed paradoxical gender differences in mortality and morbidity, where men die earlier and women live with a higher burden of disease (i.e. women get sicker, but men die quicker). This gender-health paradox occurs with and independent of socioeconomic status. While socioeconomic health disparities contribute to, and interact with gender, many gender and health scholars argue that the unique complexity of gender effects on health extends beyond concepts of

relative advantage/disadvantage in access to resources. These models are based on the implicit hypothesis that the health effects produced by inequality, isolation and discrimination go in the same direction (Bird and Rieker 2008; Phillips 2005). In other words, unlike socioeconomic status which has a consistent positive health gradient, the variation in gender differences in morbidity and mortality, and the presence of biological sex factors, merits a model that accounts for additional factors other than inequities of access to resources through discrimination or other means of inequality. Bird and Rieker (2008) propose a contextual approach that prioritizes that examination of process and pathways that lead to health outcomes, and not just differences in health outcomes.

Earlier structural theories of health acknowledge gender as a “fundamental cause”, but few theories have adequately incorporated the unique facets of gender as well as the theoretical advancements from the field of gender theory. In order to better incorporate gender as a fundamental cause, existing theories and models should address the relationship between the social and biological, power relations and the constraints of social interaction, and the multi-dimensional structure of gender. Below, I discuss three ways gender as a fundamental cause differs from other social positions, like socioeconomic status, and the implications of using a structural analysis of gender and access to healthcare.

Gender and Sex

Gender merits additional consideration in health models because of the interaction between social factors of gender and the biological factors of sex. Sex-linked biology plays a distinct role in the study of gender and health. Gender and sex matter separately, and together,

but not for every health outcome, which calls for a closer attention to modeling both health processes and outcomes. There is often confusion between the use of sex and gender in health research, Krieger (2003) outlines numerous examples that highlight where and at what point of the causal chain does social processes, biological processes or both matter to generate inequalities. For example, gender differences in exposure to the HIV virus among health care workers has a social component because of gender segregation in occupations, but there is no sex-linked component because, given exposure through a needle-stick, men and women seroconvert at similar rates. On the other hand, gender disparities in exposure and vulnerabilities to the HIV virus among heterosexuals has both a social and a sex-linked component with higher rates among women associated with women having more exposure to risk and vulnerability because of their lesser ability to negotiate safer sex and act on information obtained from health providers or family planning programs, and a greater biological efficiency in male-to-female transmission. Krieger stresses gender and sex-linked biology can be both, neither, or sole determinants of health, and that empirical relevance on health outcomes stems from clarity on the concepts of gender and sex and their respective roles along the causal chain of health exposure, vulnerability and consequences.

While the focus on biological sex is important for specific structural factors and health conditions, it is important to remember that women are not more or less determined by their biology than men (Annandale 2009). There may be important biological differences that affect potential and realized access to healthcare, but this means biology matters for both men and women in differing ways in which some interactions and contexts favor men and others favor women. For example, women's relative lower social position compared to men may lessen their access to health-promoting flexible resources such education and money, but they are more

likely to be eligible for health services if they have reproductive needs, regardless of immigration or socioeconomic status.

Another way of analyzing the interaction of the social and biological at the theoretical level is to clarify whether the focus is on gender equality which concerns the absence of discrimination or equal rights to resources, or gender equity which focuses on meeting women's and men's needs, which can vary depending on social and biological reasons (Hammarström et al. 2014). When much of health disparities research assumes a goal of equality across groups when examining sameness and differences, gender equity addresses more complex patterns based on needs of men and women, which may differ because of biology, age, health condition, social contexts, etc. that are not necessarily based on unfair treatment. In this debate over gender equality and equity in health, access to healthcare and other health promoting resources have been proposed as a priority goal over of gross outcomes of morbidity and mortality given complex biological and social interactions throughout the life course (Annandale et al. 2007; Doyal 2000). This does not mean that more comprehensive gender comparative studies are not needed (Galdas, Cheater, and Marshall 2005; Hunt, Adamson, and Galdas 2016), but that additional outcomes and processes should be considered in light of gender and sex interactions (Krieger 2003).

Gender: Interaction and Power Relations

Gender substantially differs from other social positions because the beliefs and practices that produce gender-health inequities are sustained in a context of social interaction, instead of social isolation or segregation (Bird and Rieker 2008; Kuhlmann and Annandale 2016; Weber

1998). The dynamics of interaction is core to the gender relations approach which encompasses the recursive relationship between structures and individuals, and the power relations embedded in interpersonal relationships, institutions and contexts. For example, men and women interact extensively within the context of families, households and communities, and unlike race and socioeconomic status, men and women are not socially segregated in different neighborhoods or social classes, although they may individually embody differences like education (Ridgeway and Smith-Lovin 1999) or work in segregated occupations. Therefore, a gender analysis of contextual effects on access to health resources cannot be solely characterized by material and social segregation or isolation, but relies on a broader analysis that addresses how interactional power and gendered contexts produce relative disadvantage/disadvantage to health-related resources.

Using a relational approach, structural relations of inequality are emphasized. This does not simply imply differences between men and women, but also hierarchies of power between and within groups (Annandale 2009). While fundamental cause theory acknowledges power as one of many types of health-related flexible resources (Link and Phelan 1995), the focus is on interaction in gender relations. Power is considered a central mechanism in which gender is organized, not just an embodied capacity to use resources. Gender structures the multi-level contextual influences on health suggesting a continuum of experiences between and among men and women.

With the focus of gender being embedded in evolving forms of social relations and recognizing that there is increasing complexity and cross-cutting axis of inequality that favor men in some contexts, and women in other contexts, health should to be understood in the context of men's and women's interaction within and across individual, community and

institutional levels and not just their individual status or identity (Annandale and Hunt 2000). As an example, Connell's theory of gender and power (Connell 2009) conceptualizes gender relations as interconnected and recursive social structures that shape daily interactions and practices. Connell posits four structures that characterize gender relations: power; production and consumption; emotional; and symbolism and discourse. These overlapping but distinct structures are enacted at the individual and interpersonal level and are reinforced and maintained at the institutional and societal level.

The gender relations approach incorporates and contributes to analysis from other fields such as critical race theory and intersectionality that strives to anchor relations within context-specific influences. Gender relations focuses on how specific social structures condition behaviors and constrain choices by producing gender-based inequities in economic and social potential, control of and access to resources, and expectations in the family, community and society. This multi-dimensional conceptualization of gender is important for integrating gender relations, and the importance of interaction and power, with race and ethnicity, socioeconomic status, sexual orientation other social positions. This calls for an intersectional analysis that focused on how gender is shaped by contexts and in turn stratifies people and groups in relative advantage and disadvantage to resources and power.

Much of the literature on gender and access to healthcare has focused on help-seeking behaviors and how family and gender roles affect realized access to healthcare. The literature has found that help-seeking is gendered in many diverse ways with a strong pattern of men being less likely to seek help than women. This suggests a number of relational factors such as gender norms informing a sense of need for healthcare or interpretation of symptoms, gender performance or display of masculinity and femininity, caregiving roles in the family, and the

gender compositional differences in social support networks (Berkman 2000; Pitkin Derose and Varda 2009; Ridgeway 2009; Ridgeway and Smith-Lovin 1999).

However, more recent research on racially diverse populations using gender comparative methods indicates that these assumptions of gender and help-seeking may not apply to all groups (Galdas, Cheater, and Marshall 2007; Hunt et al. 2016). In addition to more research needed on diverse racial and immigrant groups, the literature has only begun to adequately address the institutional factors and contexts that constrain or enable men and women to access healthcare such as health insurance limits (re: deductibles), temporal or liminal eligibility and immigration status (Kuhlmann and Annandale 2016). Bird and Rieker (2008) posit a compelling contextual model on gender and health that addresses the gendered constraints on “choosing” health. However, they do not address how “choice” is conditioned when health services are severely limited to a stigmatized group, like immigrants. There is a need to approach how immigrant access to healthcare is associated with gender in a structural and mutually constitutive way because we cannot assume that general patterns of gender and access to healthcare can apply to immigrants who face additional and unique systematic and societal barriers.

Gender as Social Structure

Gender theory has long posited that gender is not just differences between men and women; limited to a dichotomous variable of individual embodiment. Gender structures social interaction and institutional practices that differentiates opportunities and constraints across different domains (Connell 2009; Glenn 2003; Lorber 1994; Risman 2004b). As a conduit for social inequities, gender shapes interactional expectations and is embedded in organizations,

systems and institutions that determine the distribution of resources and power. This can be at the institutional level where gender structures organizational practices, regulations and policies, and at the societal level where gender structures ideology and public attitudes (Glenn 2003; Risman 2004b).

The framework of gender as social structure allows for analysis of how gender operates along different dimensions and is reproduced in domains of immigrant incorporation such as healthcare institutions. Connell (2009) posits that institutions or contexts are organized along four gendered dimensions: power; production; emotional; and cultural. Gender as social structure emphasizes the complexity and variability of gender and the need to go beyond individual level conceptualizations of relative advantage/disadvantage. It allows us to ask how do gendered institutions affect immigrant access to healthcare, and which gendered dimension is most salient? What are the individual, interactional and structural level constraints that affect immigrant men and women seeking help or accessing healthcare? This way of looking at how gender, and other social positions, structures multi-levels of social stratification give us opportunity to not just measure if there is inequality, but where and how inequality is maintained and reproduced.

A prevailing assumption is that the gender has an effect on realized access or use of healthcare (i.e. help-seeking), and not in the potential access to healthcare (i.e. insurance, geographic proximity, usual source of care) where other structural factors such as socioeconomic status have a stronger effect. This has led to most studies on gender and access to healthcare to focus on how gender norms, family roles and household interactions affect realized access of healthcare, and less emphasis on how gendered social structures, like the family and household, affect both potential and realized access.

Healthcare is a deeply gendered institution at each point of healthcare access, utilization and treatment. This often affects men and women in very different ways along the dimensions of power, production, emotion and culture (Connell 2009). Healthcare occupations are often highly sex-segregated with men occupying more prestigious and better-paid positions. For potential access, the U.S. employer-based healthcare insurance market favors men because of their higher likelihood of full time employment and greater incomes, yet for the poor and uninsured, more safety net programs and insurance eligibility are available for women, especially those in their reproductive years.

The prevailing discourse is that women access healthcare more frequently than men, especially during peak reproductive years, but there is little robust research using gender comparative studies and very limited evidence on immigrant and diverse racial groups (Hunt et al. 2016). Paradoxically, women's higher level of use of healthcare does not result into receiving quality care. Women are more likely to be to receive poor care, experience discrimination or other forms of unequal treatment in medical care (Annandale et al. 2007; Kuhlmann and Annandale 2016).

Intersection between Gender, Immigration and Access to Healthcare: The Importance of Contexts and Institutions

To extend from past studies that told an “immigrant story and a gender story” (Read and Reynolds 2012; p. 119), I propose an integrated story of gender, immigration and healthcare access by employing a contextual approach to interpret immigrant and gendered-related institutional effects on access healthcare. I centralize context and interaction effects to emphasize

explicit comparisons, dynamic structural processes that organize power, and variation between and among groups. A contextual approach addresses how and whether immigrant-related processes of inequality affect opportunities and incentives to access healthcare, and the distribution of healthcare-related resources, rights and protections.

I complement the contextual analysis by also addressing healthcare as a gendered institution or domain of incorporation that has broad implications on daily life, wellbeing and societal belonging. Gender and immigration inequities have concrete institutional locations where they are fully embedded in, working through, and determining healthcare access, treatment and quality (Choo and Ferree 2010; Collins 1990). This institutional view of healthcare acknowledges the recursive and dynamic relationship between the gender, healthcare and policies regimes that determine rights and protections, economic policies that regulate the health insurance-labor market, and social policies that determine the scope of the safety net and eligibility for public programs.

To address the intersection of gender and immigration in the association with access to healthcare, I propose a framework that utilizes a contextual analysis of immigration incorporation. I focus on the immigrant household as a detailed example, but the contexts can also include federal government policies, public attitudes, and local communities. Within each context, I analyze the gendered dimensions (Connell 2009) to examine the different ways immigrant and gendered inequities are associated with access to healthcare. This approach aims to address how institutional arrangements create divisions and similarities among and between groups when accessing resources, and not just focus on hierarchies of power.

This intersectional strategy acknowledges and is challenged by the complexity of systems and how processes of inequality are co-constructed to become deeply embedded. I operationalize

this approach by using Connell's (2009) institutional analysis of gender to examine how and if gendered dimensions of power, production, emotion and culture operate within the contexts of immigrant incorporation. This use of institutional analysis and intersectionality aims to understand how power operates within institutional practices, norms and arrangements and how intersecting axes of inequality create and sustain inequalities.

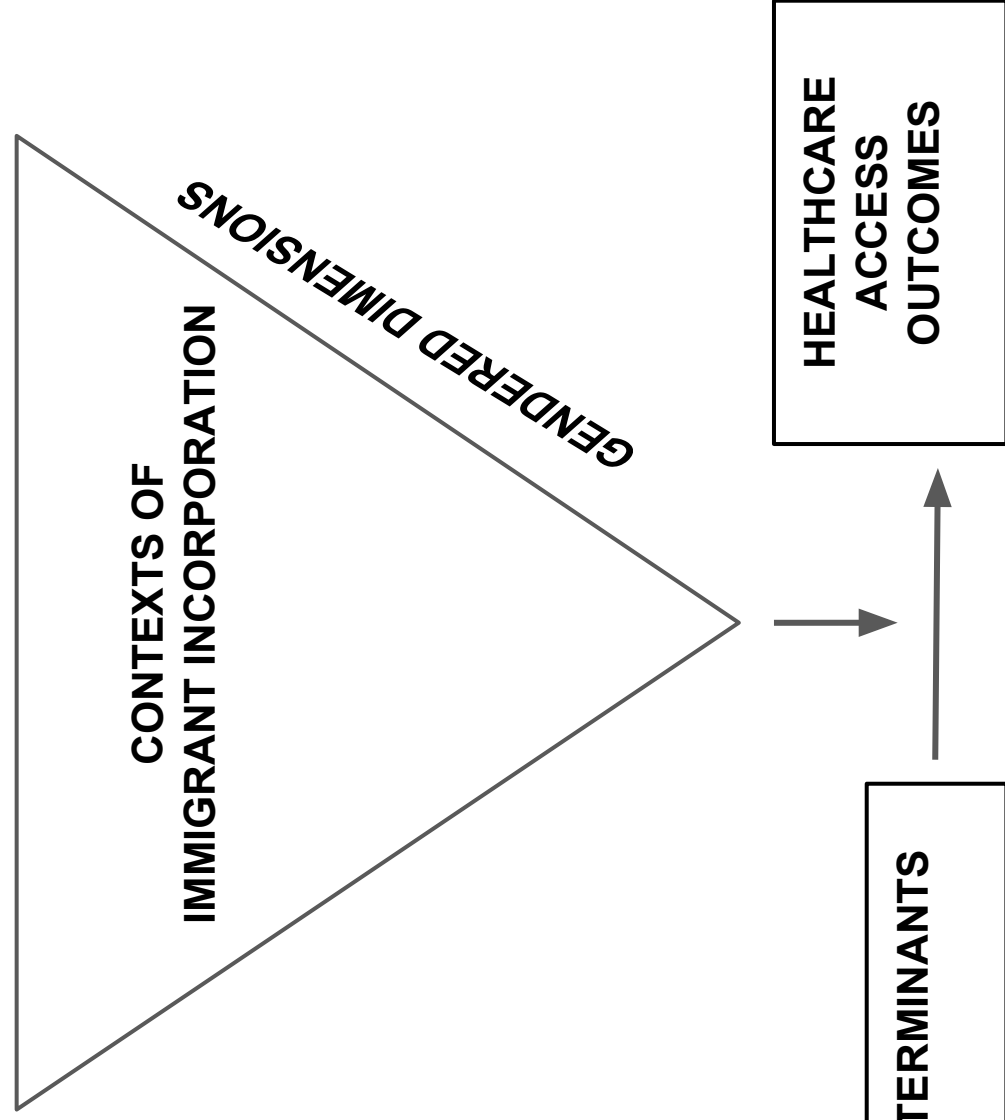
A GENDER and IMMIGRANT FRAMEWORK for HEALTHCARE ACCESS

I propose a framework to healthcare that builds upon the Behavioral Model of Health Services Use, commonly referred to as the Andersen model (1968, 1995). I integrate the Andersen model with a contextual analysis of immigrant incorporation (Bird and Rieker 2008; Portes and Rumbaut 2006; Portes and Zhou 1993). To address the intersection of gender and immigration, I identify significant gendered dimensions within each context of immigrant incorporation (Bird and Rieker 2008; Connell 2009).

Figure 2.1 presents the generalized framework that consists of three broad domains. Individual level human capital features categorized as predisposing, enabling and need factors addressed in the Andersen model. Contextual variables capture modes of immigrant incorporation such government policies, public attitudes, local and community services and networks, and households that are further delineated along dimensions of gender relations. Healthcare access outcomes measure potential and realized access to healthcare.

My aim is to highlight how the different and complex ways immigrant contexts, using the example of the immigrant household, are gendered to facilitate or constrain the distribution of health resources that exert influence on immigrant men and women's individual choices and

FIGURE 2.1.
FRAMEWORK FOR
IMMIGRANT and
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behaviors on accessing healthcare. In the next section, I summarize the three theoretical models that I draw from, and describe their relationship and purpose in my model.

The Andersen Model

The Andersen model is the dominant model in the field of healthcare access and utilization. The Andersen model was designed with three goals: 1) to better understand the social and behavioral determinants of health service utilization; 2) to define and measure equitable access and use to healthcare; and 3) to assist in developing policies to promote equitable access to healthcare (Andersen 1968, 1995).

In the initial formulation, the Andersen model (1968) was an individual-level behavioral model that explained healthcare utilization with three sequential factors, predisposing, enabling and need. Predisposing factors refer to socio-demographic characteristics that influence preferences or inclination to access healthcare such as demographics, social structure (education, occupation, ethnicity) and health beliefs. Enabling factors refer to personal, family or community resources that facilitate or hinder the ability to access healthcare such as family income, health insurance coverage, English language, availability of providers and facilities. The outcome variable of potential access can overlap with some enabling factors such as health insurance and availability of local providers. Need factors refer to perceived or clinically evaluated health conditions or illnesses and age- and sex-related preventative needs (e.g. mammograms).

Later developments of the Andersen model expand to include the healthcare system such as health policy, resources and organizations (Aday and Andersen 1974), external physical and economic environments as new categories of determinants (Andersen 1995) and contextual

factors (Davidson et al. 2004; Pescosolido and Kronenfeld 1995). In some of these later models, the measurement of healthcare utilization broadened to include customer satisfaction and health practices such as diet, exercise and self-care, and the causal position of healthcare utilization changes from an outcome to an intervening variable (Andersen 1995).

Developed as a model for the general population, Andersen's model has been extended and adapted to address specific sub-populations such as African-American women (Copeland and Butler 2007), immigrants (Akresh 2009b; Kao 2009; Leclere and Jensen 2009; Read and Smith 2017; Vargas Bustamante et al. 2012). Recent empirical studies on healthcare access using the Andersen model have examined immigrants, ethnicity and contextual affects (Choi 2009). Yang and Hwang (2016) based their proposed theoretical framework explaining immigrant health service utilization on the Andersen model. They discuss the general and immigrant-related predisposing, enabling and need for care as well as contextual and structural level factors addressing the effects of the contexts of migration, contexts of reception and health service utilization in the country of origin. While there is very large and extensive body of literature on gender and healthcare access that use the Andersen model (Annandale et al. 2007; Dixon-Woods et al. 2006; Kuhlmann and Annandale 2016), there are a limited number of models or studies that comprehensively address gender, immigration and access to healthcare.

I utilize the Andersen model (1968; 1995) to outline the overall relationship between individual level determinants, structural determinants, and outcomes. I also draw heavily from Yang and Hwang's (2016) critique and adaptation of the Andersen model to better address immigrant-related factors and empirical studies on healthcare utilization of immigrants in the U.S. (Akresh 2009b; Choi 2009; Derose, Escarce, and Lurie 2007b; Kao 2009; Leclere and Jensen 2009; Pitkin Derose et al. 2009; Read and Smith 2017).

Gendered Contexts of Immigrant Health Incorporation

Theories of immigrant incorporation address how societal contexts and stratification shape distinct social mobility pathways among immigrants and their children. Segmented assimilation theory, one of the central theories of immigrant incorporation, posits that divergent trajectories of social mobility stem from the interactions along three dimensions: individual features of human capital (age, education, skills, wealth, knowledge of English); the level of social capital and social support (family and ethnic communities); and the societal context of reception (immigrant-related policies, racial and immigrant attitudes of U.S. born population, the presence and size of co-ethnic community) (Portes and Rumbaut 2006).

Contexts of reception, a core tenet of segmented assimilation theory, addresses how features of the receiving society are determinants of immigrant incorporation, and not just characteristics of immigrants themselves. Social contexts are also central to gender and health patterns. Similar to contexts of reception, Bird and Rieker (2008) in their theory of constrained choice posit that gendered interactions within national, community, and work and family contexts differentially constrain and facilitate men and women's health choices and behaviors. Both theories posit that human capital features alone cannot advance social or health status because numerous contextual factors shape whether assimilation pathways are upward, downward or selective (Portes and Zhou 1993) or determine the dynamics of gender interaction (Bird and Rieker 2008).

Contexts of reception shape opportunities structures, the degree of welcoming versus hostile environments, level of acceptance, and their interaction with individual level characteristics. Four contextual features are considered significant: existing co-ethnic

communities or enclaves; variation in labor markets and related institutions; the influence of government policies and programs; and the changing nature of globalization and migration (Reitz 2002). Positive contexts foster immigrants' ability to engage and pursue goals, resulting in an upward pathway towards assimilation. Negative contexts marginalize immigrants, making them more vulnerable to discrimination, stigmatization and other challenges. This results in a downward pathway towards assimilation.

Incorporation, integration, assimilation and acculturation are used to describe an immigrants' relationship to the receiving society. There continues to be much debate and discussion of the definition and usage of the terms with the scholarship varying in terminology depending on time period, academic field, and place of study. Segmented assimilation theory stems from a critique of "straight-line" assimilation theory with contexts of reception being referred to as mode of immigrant incorporation, and outcomes as assimilation pathways (upward, downward, selective) (Portes and Rumbaut 2006; Portes and Zhou 1993).

Broadly, acculturation and assimilation refers to individual level processes and outcomes with a focus on the convergence or divergence of behaviors and attitudes with the population of the receiving country or culture. Incorporation refers to the operation of institutions and the relationship between individual and groups with the institutions of the receiving country. Acculturation and assimilation does acknowledge the importance of institutions, but the policies and practices of institutions are treated broadly and less subject to analysis. Assimilation also carries the historical baggage of one-way change theories, whereas incorporation implies a two-way change with more emphasis on whether institutions provide a welcoming, neutral or hostile environment for change, and less on the adaptability of the individual (Ramakrishnan and Espenshade 2006). Incorporation is also associated with citizenship. For the study of

immigration, legal citizenship does indicate a form of engagement. Moreover, incorporation as full social citizenship, regardless of legal status or nativity, is vital to ensuring equality and inclusion in society (Nakano-Glenn 2002).

When referring directly to segmented assimilation theory, I use the terms assimilation and incorporation as used by Portes and Rumbaut (2006) and Portes and Zhou (1993). In my proposed model, I use incorporation to highlight the central role of institutional and contextual interactions with individuals. I also use “contexts of incorporation” instead of the more commonly used “contexts of reception” to remove the distinction between the receiving society and the immigrant household. This usage does not stray far from usage in segmented assimilation theory, and incorporates the household framework in constrained choice theory (Bird and Rieker 2008).

Dimensions of Gender Structure

The literature has established that gender matters in modes of immigrant incorporation. Women and men have different experiences with the receiving society, and interactions with and reactions to race and socioeconomic stratification, two of the key variables that differentiate paths of incorporation. A consistent finding is that immigrant men experience a loss in social status, privileges and public recognition, especially in the first years of immigration when they are most likely to experience lower occupation, socioeconomic and racial status that challenge their power, agency and identity (Alcantara et al. 2015; Espiritu 1999; Guruge et al. 2010; Hondagneu-Sotelo 1994). Immigrant women also have lower social status, but relative to immigrant men, their status mobility is more complex with increases in areas of employment, but

decreases in racial status. Immigrant women also benefit from more protective institutions external to their family networks including the healthcare safety net, unemployment compensation, social security, domestic violence and shelter services (Hondagneu-Sotelo 1994, 2003, Menjívar 1997, 2000; Pessar 1999). These factors may explain why immigrant men and women have differing reactions to similar exposures to racial and socioeconomic discrimination (Itzigsohn and Giorguli-Saucedo 2005).

In the seminal work on gender, social structure and immigration, Hondagneu-Sotelo (1994) found that it was not just individual immigrant men and women changing from their interactions to the receiving society, the structure of the immigrant household also changed to affect the behaviors and beliefs of immigrant men and women. This recursive and reiterative relationship between gender, incorporation and social structure is where my model attempts to address the intersection of immigration and gender.

Expanding on Hondagneu-Sotelo's (1994) findings on the gender structure of the immigrant household, I offer a systematic intersectional approach to gender and immigration that does not associate a specific social status to an specific institution such as the family with gender, the economy to class or the nation to ethnicity (Choo and Ferree 2010). Instead, I attempt to model the processes how immigrant incorporation across multiple contexts is gendered.

To illustrate and operationalize how gender organizes contexts of immigrant incorporation, I draw from two theories of gender structure, Risman's (2004; Risman and Davis 2013) conceptualization of gender as stratification structure, and Connell's (1987, 2009) theory of Gender and Power. Risman (2004) identifies three categories of social processes that organize social life: individual, interactional and institutional. I focus on where gender is present in

institutional processes, practices, ideologies, and distribution of resources. I interpret Risman's use of institutions in two ways. First, healthcare is key domain of immigrant incorporation that parallels labor, legal/political, education and housing. Second, healthcare is a system that structures organizations and norms regarding who is deserving and entitled to services (Ager and Strang 2004, 2008; Allard and Small 2013).

Connell's theory of Gender and Power (1987; 2009) conceptualizes gender as interconnected social structures that constrain or facilitate daily interactions, behaviors and beliefs. Connell posits four dimensions that organize gender structure: power; production; emotional; and culture. Power refers to authority and control. Production refers to the division of labor. Emotion refers to emotional and sexual attachments. Cultural refers to symbolic meanings and representation. These overlapping but distinct processes are enacted at the individual and interpersonal level and are reinforced and maintained at the institutional and societal level. Connell (1987) emphasizes that each gendered dimension cannot fully be independent of the others because gender is a process of institutionalization. However, one dimension may be more salient than others within a specific context or institution. Gender regimes across institutions or contexts can be complementary, in conflict, or run parallel to each other.

I utilize the theories of gender structure to examine if and how gendered dimensions organize contexts of immigrant incorporation. I use Connell's (1987; 2009) dimensions of gender structure to operationalize gender and immigrant contexts of incorporation, and Risman (2004) to analyze and conceptualize the healthcare system as a gendered institution.

FRAMEWORK DETAILS

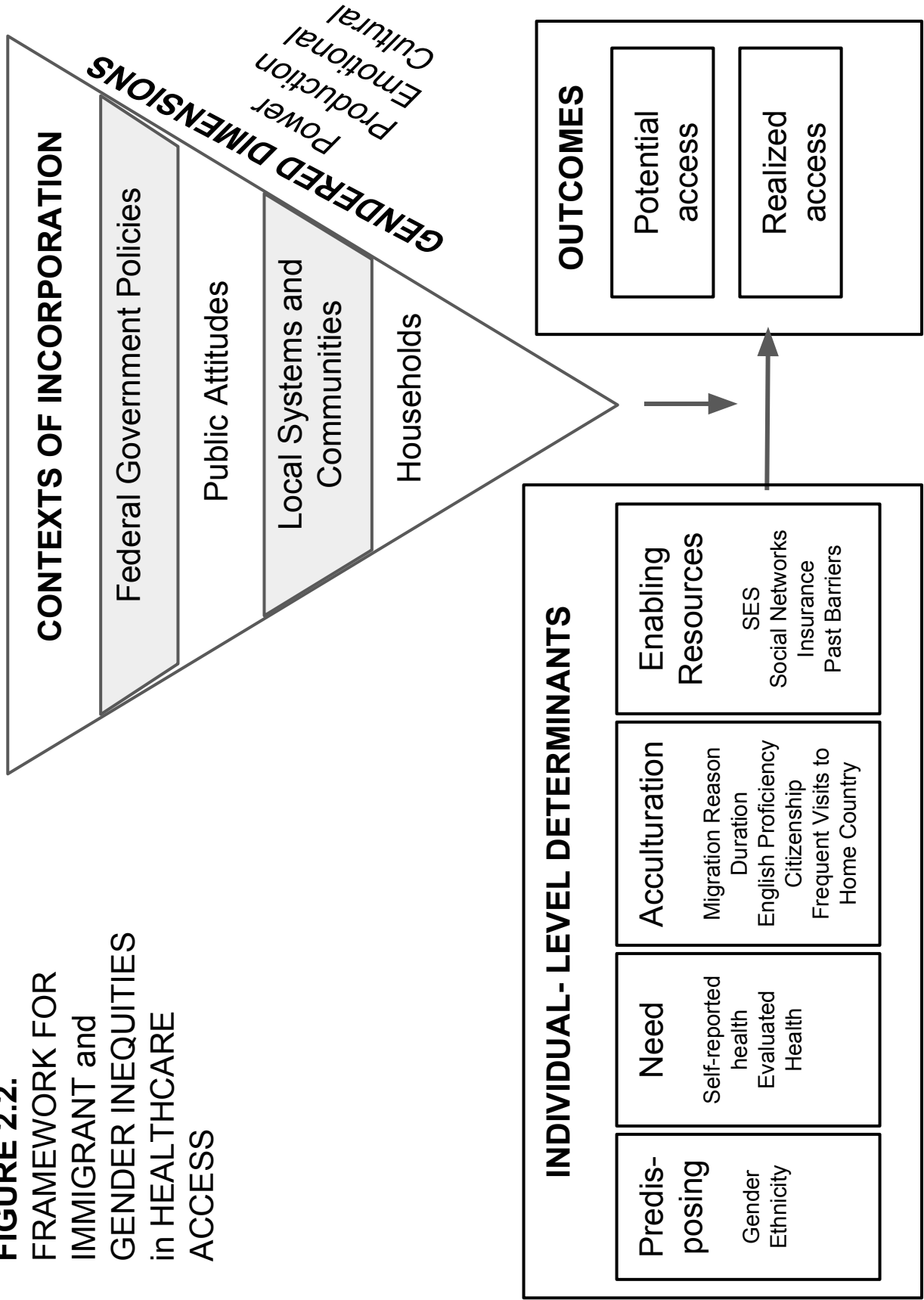
Figure 2.2 illustrates the detailed components of the proposed theoretical framework detailed below.

Individual-Level Determinants of Healthcare Access

Individual-level factors include predisposing, enabling and need variables. Andersen (1968, 1995) posited that the use of healthcare is a function of individual-level predisposing characteristics to use or not use healthcare; enabling conditions that facilitate or impede the use of services; and condition recognized in need of healthcare services. Most models, including the Andersen model, measure gender and immigrant status as predisposing demographic variables. This model attempts to expand the conceptualization and measurement of gender and immigration to include as a contextual or structural factor.

Predisposing factors indicate a propensity to access healthcare, although not directly responsible for use. They include commonly used demographic, socioeconomic, health beliefs and genetic factors. The literature on predisposing characteristics indicates that decreased access to healthcare occurs among those with lower socioeconomic status and education, people of color, recent immigrants who have limited English language skills, non-married, youth, and men (Andersen 1995; Andersen et al. 2002; Pitkin Derose et al. 2009). Yang and Hwang (2016) argue immigrant-specific predisposing factors should also be included such as immigrant status, assimilation level, and ethnic culture.

FIGURE 2.2.
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Enabling factors are resources that facilitate an individual to access healthcare. They include household financial and employment resources for obtaining health insurance or services, social resources through family, friends and community contacts, and physical resources such as the local availability of medical services. Some enabling factors overlap with potential access outcomes such as health insurance or having a regular source of care. Enabling factors that are associated with the under-utilization of healthcare including lower household socioeconomic status, not having a regular source of medical care, not having health insurance coverage, and being part of a social disadvantaged or stigmatized group. Perceptions of discrimination or poor treatment from medical systems or whether they trust their medical providers can also measure whether local resources are facilitating or deterring access.

Yang and Hwang (2016) argue immigrant-specific enabling factors should also be included such as homeland-based or transnational financial and social resources, and transnational access to healthcare services. Having health insurance is more consistently associated with realized use of healthcare among immigrants than income given resident duration and other restrictions on immigrants accessing healthcare. This pattern may have changed slightly after the passing of the Affordable Healthcare Act in 2012 where documented immigrants who did not already have employer or government supported health insurance have more options to buy affordable individual plans. However, for undocumented immigrants including people in mixed status families, have no insurance options under ACA. This experience of concentrated inequality widens the gap between people who have access and those who do not within the immigrant community.

Gender interacts with enabling factors such as the ability to obtain health insurance because of the strong association between gender, socioeconomic status, employment status and

potential access to healthcare. Men are often advantaged for employer-based private health insurance because of their higher likelihood for having more skills and work in formal professional industries, more full-time employment, and higher wages. This gives them more access to health insurance options like employer-based healthcare, whereas many women obtain private health insurance as a dependent from their spouses' insurance plan. In terms of social capital resources, women may have more informed friend networks to assist them in navigating the healthcare system, but this may not be enough to overcome barriers of gaining affordable health insurance.

Need factors include measures of perceived health, such as self-rated health, and clinically-evaluated or diagnosed conditions from a medical provider. The need for healthcare has been found to be the strongest predictor of realized use of healthcare out of the three individual-level factors (Andersen 1995). However, need factors have been found to be expressed differently across gender, immigration status and ethnicity.

Recent immigrants may have very different needs related to specific health conditions that are more prevalent in the country of origin such as higher rates of tuberculosis, asthma, hepatitis, and lower rates of child immunization. They may also not have access to regular professional medical services in their home country to validate their self-rated health status. This increases the likelihood of under-estimating their health needs and under-utilizing health services. This may partially explain why recent immigrants have higher self-rated health and lower healthcare utilization compared with more established immigrants. This underscores the importance of using both measures of self-rated health and a clinically-evaluated diagnosis (Gorman et al. 2014; Read and Reynolds 2012; Yang and Hwang 2016).

The healthy immigrant effect also presents differences in self-rated and clinically evaluated needs compared to non-immigrant populations. Recent immigrants are usually healthier than more established immigrant and non-immigrant because of health selectivity and other factors. This means, controlling for other factors, recent immigrants are less likely to access healthcare. However, the decline in health status with longer duration in the receiving country can lead to an increase in need for care and an increase in healthcare utilization. This is an important relationship between duration, need and access to healthcare among immigrant populations.

It is a common assumption that men and women express their level of self-rated health needs differently, but this has not been fully validated in rigorous gender comparative studies and among diverse populations (Annandale 2009; Hunt et al. 2016). The mainstream literature has found that women are more likely to self-report poorer health status, which increases their likelihood of accessing healthcare. On the other hand, men tend to self-report better health, tolerate pain and discomfort more and under-utilize healthcare services. Moreover, women generally have higher demands for healthcare than men because of reproductive needs. This includes more use of preventive services for contraceptives, cervical screening, and other diagnostic tests.

Need based on diagnosis type also affects pace and willingness to adapt to health practices, beliefs and ideologies in the destination country. In a quantitative study of Mexican immigrants, Reichman (2006) found immigrants diagnosed with chronic diseases more rapidly adopted U.S. health beliefs and practices than those with acute diseases. Diagnosis type was more relevant for change in health beliefs and practices than type of sending community (rural or urban), degree of religiosity, level of education and age. Immigrants with acute diseases were

also more likely to perceive the U.S. based medical providers as racist, negligent and incompetent, and more likely to continue accessing alternative or traditional medicine. Sending community (rural or urban), degree of religiosity, level of education and age were also significant factors. This study also found immigrant women more flexible and quicker to adopt U.S. based health beliefs and practices including accessing healthcare than men (Reichman 2006).

The Andersen model has been tested and validated for many decades, but there remains few studies on immigrant populations. This provides an opportunity to continue modifying and validating the model on diverse populations. The individual determinants have been found to account for an estimated 20-25% of the variance explained (Davidson et al. 2004). This points to a large proportion of unexplained variance and an opportunity to address healthcare access among immigrants in a more comprehensive model using contextual analysis. Contextual analysis has been tested using the Andersen model, but has not taken into consideration immigrant and gender-related contexts. The social conditions and contexts in which immigrants live often produce different healthcare needs, demands and enabling factors.

Contextual-Level Determinants of Healthcare Access: Immigrant Households and

Dimensions of Gender Relations

A contextual framework emphasizes how multiple social environments shape opportunities and constraints in accessing healthcare for immigrant men and women. My proposed model examines the household level, but it can be applied for other contextual levels like national policies, public attitudes and state and local communities. I discuss how some

household structures facilitate healthcare access better than others, and differentially affect men and women's help-seeking behaviors. The household is not commonly addressed as a context of incorporation in the immigration literature, but is a central context in the gender literature. I argue that the structural changes that occur as immigrant families migrate and settle into the receiving society are important structural factors to examine, especially as it affects immigrant gender relations and access to healthcare.

The immigrant household is an important, but often overlooked, contextual determinant of immigrant incorporation and health. There is considerable scholarship on the effects of the immigrant household and family structure on children's health and social outcomes (Huang, Yu, and Ledsky 2006; Kao 2009; Portes and Rumbaut 2006; Waters et al. 2010; Waters and Pineau 2015), but much less on immigrant men and women's health outcomes. Most theories of immigrant reception make a distinction between private and public contexts with family and household structures conceptualized and measured separately from government policies and community determinants (Reitz 2002). In contrast, most scholarship on gender and immigration focuses on the household as an important context of immigrant incorporation where it is considered both a site of resistance against societal discrimination as well as a site of negotiation in gender, generational and cultural relations. Until recently, few studies in this field have addressed health and access to health outcomes.

The variation in immigrant household structures affects help-seeking and access to healthcare in complex ways. Transnational families structures may limit immigrants from seeking care in the U.S. With family obligations in two countries, immigrants may choose to seek healthcare when they return to their country of origin, or to prioritize remitting money that would have gone to paying for healthcare. Spouses who immigrant to reunite with family may

have advantage in gaining important knowledge of resources through established family and community networks. However, family networks that tend to be cohesive may have less diverse knowledge sources and can concentrate burden, thus be more constraining for women.

This contrasts with people who migrate alone and need to establish networks. They also need to establish less traditional household structures such as sharing a house with other immigrants, taking a room with a distant relative, or living in employer-provided housing (i.e. domestic workers or agricultural workers). These household arrangements are often temporary and unstable which make establishing a regular source of healthcare more difficult (George 2005; Hondagneu-Sotelo 1994; Parrenas 2002).

Gender and immigration scholars have posited that changing gender relations in the immigrant household are rooted in the structural conditions of immigration and incorporation, and not just a result of the acculturation processes of cultural exposure and adaptation to norms and values of the host society. This counters the assumptions that men and women, regardless of nativity, duration in the U.S. or immigration pattern, have similar attitudes towards help-seeking or similar constraints or opportunities to accessing healthcare. These notions of masculinity and femininity as it pertains to help-seeking are further supported by the “traditional-modern” gender paradigm, detailed in Chapter One, in which immigrants health behaviors are often framed.

Immigrant households are dynamic structures that experience considerable change during the immigration process. What seems like gendered preferences or predisposed tendencies towards help-seeking and access to healthcare are rooted in the social structures in society including the immigrant household. Gender relations within the immigrant household have been found to vary considerably and are influenced by immigration related factors such as how men

and women migrate (i.e. alone, together with spouse, with children, or with extended family), the migration period, and their legal status (Espiritu 1999; Hondagneu-Sotelo 1994; Pessar 1999).

To discuss how the multiple structural dimensions in which gender relations operates within an immigrant household to affect access to healthcare, I further draw upon Connell's (2009) theory of gender structure with a focus on help-seeking behaviors in relation to caregiving responsibilities and social support. A large body of literature on gendered access to healthcare emphasizes that men are more reluctant to seek help and access healthcare compared with women. Men's help-seeking behavior is widely attributed to masculine ideals of stoicism, strength and silence, and having a more distant caring role within the family (Courtenay 2000; O'Brien, Hunt, and Hart 2005). There are important gaps in the literature that have implications for immigrant men and women. First, there are few studies on diverse populations so there is little evidence that these findings on help-seeking in White populations may be generalizable to immigrant and racial and ethnic populations. This is especially relevant among vulnerable populations that experience discrimination and marginalization across a wide range of societal institutions including healthcare.

Second, there is a lack of gender comparative studies on the same disease or symptom outcomes pointing to possible differences in assessment of need or lack of enabling resources instead of reluctance for help (Hunt et al. 2016). This critique of the literature emphasizes that time and contexts are important. Timing and type of help-seeking (i.e. consultations for common symptoms vs. chronic conditions) may matter for better cultural, gender and systemic understanding of help-seeking. The assumptions of clear gender differences fail to acknowledge the wide variation of help-seeking behaviors. Reproductive needs may advantage women establishing a place for healthcare and relationship with a provider, considered an important

facilitator in future help-seeking behaviors. On the other hand, Annandale (2009) who calls on the field to look deeper into the complexities of gender and health emphasizes that it is too common to assume that since men are reluctant to seek help, that women are not, and that women's willingness to seek help for reproductive needs means they are willing to seek help for all health needs.

Third, there are few studies that examine the gendered household structure as a context of incorporation that facilitates or constrains help-seeking. The emphasis is less on predisposed individual-level willingness or preferences, but on health access opportunities and legal and cultural challenges that men and women face when health needs arise, and how some roles within the household and family networks exacerbate or facilitate help-seeking (Menjívar 2000; Simon 1995a, 1997; Thoits 2010). To include the household as a context of immigrant incorporation highlights the interaction of social contexts with immigration and gender. Immigration and settlement processes shape the immigrant household as both a site of resistance and refuge against discrimination and hardship, and a site of negotiations and renegotiations along gender production, power, emotions and culture. Immigrant and gender access to healthcare is not a linear story of adaptation and acculturation where social status is static and fixed, but a more complex, varied story of structural negotiations and constraints in which immigrant and gender interact with processes of inequities.

In this following section, I will highlight how production, power and emotional dimensions of gender relations in the household affect help-seeking behavior and opportunities to access healthcare. More details found in the empirical study in Chapter Five.

Gendered Production

Gendered production refers to the division of labor outside (paid) and inside (unpaid) the household. Labor force participation allows for more independent access to economic resources and in the U.S., private healthcare insurance. Over the decades, women in the U.S. and in sending countries have greatly increased their participation in the domestic and international labor force. These changes are reflected in many immigrant households in which women are just as likely to work as men but may differ in type of work, salary and health insurance benefits. In the U.S., access to health insurance, one of the central and strongest facilitator to healthcare access, is largely determined by being employed and income. Paid production outside the home becomes inextricably linked to accessing healthcare. For people in the household who do paid and unpaid work, they may have more resources to access healthcare, but face other barriers such as time and other responsibilities to the family.

Gendered Power Relations

Gendered power relations refers to how authority and control are managed and shared within and outside the household as indicated by decision making and responsibility. For immigrants, power is renegotiated and reconstructed upon migration and is influenced by the larger social contexts of reception revealing more complexity to decisions and their implications. Dynamics of power, production, are in flux and must be understood in the context of changing gender relations in the home country, migration decisions (alone, in stages or with family), dynamics of family separation and reunification, social networks, and access to resources. Power can affect help-seeking in multiple ways. The person with more power may dictate who and how

resources are allocated for healthcare. On the other hand, with access to insurance, a person who has less power may seek care as a way to manage stress.

Gendered Emotional Relations

Gendered emotional relations refers to emotional or sexual attachments, and gendered cultural relations refers to symbolic meanings and representations. In Gender and Power theory, Connell addresses emotional and cultural relations as distinct dimensions. In my model, I combine the two concepts to discuss how emotional attachment and cultural meaning are demonstrated in the family or community roles and how caregiving and help-seeking affect access to healthcare through mechanisms such as identity, responsibility, support and strain.

Healthcare Access Outcomes

Outcomes measures include potential and realized access to healthcare, and outcomes of healthcare access.

Potential access overlap with some enabling variables which increase the likelihood of use of primary healthcare. Measures of potential access include having a regular source of care (provider or facility), health insurance coverage, financial barriers to medical coverage or care, availability of geographically accessible services; availability of trusted services; availability of interpretation services

Realized access is the actual use of services, or lack thereof. Measures include actual utilization of medical care (time since last visit; the number of visits within last 12 months), delay or denial in treatment, prenatal care; immunizations; age-related screenings.

CONCLUSION and DISCUSSION

This paper presents a framework for analyzing the intersection of contextual determinants of immigrant and gender associated with access to healthcare. This framework builds and synthesizes extensive research from the fields of healthcare access, immigrant contexts of incorporation; gender and immigration, and gender and health to better highlight how immigrant and gender-related structural inequities are reproduced between and within groups. This framework builds on the literature emphasizing the importance of contextual level variables to test and validate structural determinants of healthcare access. My contribution includes developing a contextual approach to address the intersection of gendered dimensions within immigrant contexts of incorporation.

Addressing access to healthcare with a contextual approach allows for the delineation of how different contextual levels interact with individual level knowledge and behaviors to affect access to healthcare. My proposed model acknowledges how individual level of predisposed, enabling and need interact with contexts along different dimensions of gender relations. The household shapes family relations of power, production and emotion. The community and network level shapes experiences of support or isolation from local healthcare infrastructure, family/friends and ethnic communities. The government level shapes the relationship to U.S. society in terms of rights and protections, risks and benefits, and finding a 'place' of belonging and engagement.

The gender variation across different contexts of immigrant incorporation underscores Annandale's (2009) challenge to further examine the dynamic and interconnected processes that contribute to structural inequities. When it comes to the complex processes and experiences of

immigration and settlement that intersect with gendered dimensions, assumptions of the meanings of similarity and difference, the distinctions between equality and inequality should be discussed, revisited and reformulated. For example, Annandale (2009) and Cole (2009) caution us on the unconscious tendency to valorize gender distinctions rather than similarities. It is not that men are reluctant to access healthcare, and women are not, but that there are different structural factors that facilitate and constrain gendered behaviors and beliefs. Applying an intersectional approach, this critique can also be applied to making assumptions across with race and ethnicity and immigrant status with how gender is constructed, performed and institutionalized.

This framework has limitations that include data gaps in measuring contextual variables, and methodological challenges of complex intersectional relationships, especially when considering using multivariate quantitative methods. While the Andersen model is a dominant model, the focus on the large breath of contributing factors makes it hard to address fundamental mechanisms. Moreover, the behaviors premise of help-seeking and accessing healthcare is predicated on a rational-choice model of action (Pescosolido 1992; Pescosolido, Gardner, and Lubell 1998). While further developments of the Andersen model have moved from this principle and even placed access as an intermediate variable, the assumptions and subsequent application of the Andersen model does not adequately address the complex network structures that affect help-seeking (Andersen 1995; Andersen, Davidson, and Baumeister 2014; Pescosolido 1992).

Multi-dimensional measures of gender and gender relations are also limited in quantitative data using large nationally represented datasets. While there are valid critiques and compelling arguments for the expansive use of gender, gender relations and gender expression as

it relates to health, health surveys are often limited in social variables, and social surveys are often limited in health variables, and fewer collect comprehensive data on diverse groups across national origin ethnicity, language, legal status, and location.

The use of perceived measures of access and treatment also can address data gaps in language access compliance at the local level. While language access is legally mandated through Title VI of the Civil Rights Act, there are few mechanisms for compliance across all states, and limited dedicated funding to maintain compliance. This also means that current data on linguistic compliance is systematically unavailable, and available data may be biased towards states that already have supportive and well-funded policies and mechanisms to ensure immigrant access to healthcare. Variables using perceptions of linguistic available services may offer an alternative, but issues of data validity and whether they are conflated individual measures of discrimination remain.

Much debate continues on how to measure, test and validate intersectional frameworks. Much the intersectional literature that this paper draws from comes from qualitative studies. These studies have been able to add depth to the intersectional approach to health inequities, but there continues to be limited quantitative methodological approaches to broaden the breadth. Recent papers directly discuss the use of quantitative methods to advance the understanding of intersectionality in policy or health studies (Black and Veenstra 2011; Hankivsky et al. 2010; Hankivsky and Cormier 2011; Scott 2010; Scott and Siltanen 2017). After testing three types of regression models, Scott and Siltanen (2017) conclude that using multi-level regression including context as a higher-order level of analysis was the most consistent to adhering to feminist underpinnings of intersectional theory.

The systematic approach suggested by this framework aims to highlight how social positions of immigration and gender act as a conduit between structural processes and social factors of inequity, and the importance of contextual analysis to reflect the complex environment which produce inequities in healthcare access. With an emphasis on the intersection of immigration and gender, I aim to enable research, policy and program development to take action on increasing healthcare access for immigrants men and women, and for new directions in intersectional research to address the cross-cutting and complex processes of health inequality.

CHAPTER THREE

GENDER and IMMIGRANT ACCESS to HEALTHCARE: The EFFECTS of MIGRATION DECISIONS, INCORPORATION and TRANSNATIONALISM

Acculturation is the most widely used approach to understanding processes that affect immigrant health. Broadly, acculturation refers to social change processes in which immigrants adopt behaviors, values, and beliefs prevalent in the destination society (Lopez-Class et al. 2011; Schwartz et al. 2011). Acculturation is an interdisciplinary concept that remains highly contested with ongoing efforts to re-conceptualize and advance measurement to better understand its effect on health. Criticisms of acculturation include the assumptions of uni-dimensional linear trajectories of social change, and projections of Anglo-conformity and ethnic stereotyping when interpreting the complex social processes that occur when immigrants establish themselves in the U.S., (Alegria 2009; Hunt et al. 2004; Lara et al. 2005; Salant and Lauderdale 2003).

The ongoing debate of acculturation has resulted in both refinement of the concept that takes the form of ethnic or disease specific scales (Berry et al. 1987; Chun et al. 2003), the use of contextual frameworks (Kimbrow 2009; Leu et al. 2011; Schwartz et al. 2010), and expansion to a multi-dimensional concept to include the contexts of exit and original migration decisions, markers of U.S. societal incorporation, and continued orientation towards the country of origin (Abraído-Lanza et al. 2005; Abraído-Lanza, Echeverría, and Flórez 2016a; Lara et al. 2005; Zane and Mak 2003). The multi-dimensional acculturation process recognizes that original decisions regarding migration, social incorporation into the country of destination, and the selective maintenance of ties to the country and culture of origin, work independently and in conjunction with each other, to influence health status and health behaviors over time. Instead of

a linear uni-dimension trajectory, the process and pace of acculturation can differ across dimensions, with each dimension having distinct mechanisms, and potentially having differing effects on health and social outcomes. In this paper, I refer to acculturation as a multi-dimensional concept along three dimensions: migration decisions, incorporation processes to the U.S.; and the maintenance of ties to the country of origin to ask the question: What are the gendered effects of acculturation on access to healthcare?

Gender and Acculturation

The multi-dimensional approach to acculturation in immigrant health has identified increasing variation across gender, age, cohort and ethnicity. Recent research suggests that factors related to migration decisions play a role in explaining gender differences in immigrant health selectivity, the tendency to be more healthier than average due to migration factors. The non-random reasons for migration shape the context in which immigrants establish themselves and inform their decisions and behaviors such as help-seeking and accessing healthcare. Since self-rated and diagnosed health need is an important determinant of healthcare access (Andersen 1995), these differences in health selectivity can differentially influence men's and women's likelihood of accessing healthcare. Among voluntary migrants, male immigrants tend to be more selective in health because they are more likely to choose work as their primary reason for migration. Men are also more likely to be the primary visa holder among documented immigrants. While female immigrants also migrate to work, they are more likely to migrate to join family and come under spousal visas, therefore they may be less selective in health, or less healthy, compared with men (Gorman et al. 2014; Kimbro 2009). The varying relationship among acculturation processes, health selectivity and gender is further impacted by the rapid

increase in immigration from a wider range of countries, changes to gender composition of ethnic immigrant groups, increasing educational status of female immigrants, changing priorities for immigration, and settlement into a wider range of new destinations (Donato et al. 2011).

Incorporation into U.S. society has also been found to differ by gender. A common measure of incorporation, English proficiency, has been found to be strongest and most consistent predictor of gender differences in access to healthcare, but in more complex ways than expected. Compared to men, immigrant women experience lower rates of having health insurance and English proficiency, but they often have higher rates of healthcare access. A number of studies have found immigrant women with low English proficiency were much more likely to access healthcare compared with men (Akresh 2009b; Leclere, Jensen, and Biddlecom 2009; Read and Smith 2017). One study also found very few gender differences in health access found among immigrants with high English proficiency (Read and Smith 2017). Moreover, among studies that examined multiple ethnic groups, these gender patterns associated with English proficiency varied by ethnic groups, with the stronger effects among Mexicans and lesser effects with other Latinos and Asians (Akresh 2009b; Gorman et al. 2010; Gorman, Wade, and Solazzo 2016; Leclere et al. 2009; Read and Reynolds 2012; Read and Smith 2017).

Gender and Acculturation: Addressing Assumptions

In the examination among gender, acculturation and health in the literature, gender is often analyzed as differences in the pace and flexibility in adopting or shedding cultural norms and behaviors that affect health outcomes and health behaviors (Abraído-Lanza et al. 2016a; Antecol and Bedard 2006; Kulis, Marsiglia, and Nagoshi 2012; Lopez-Gonzalez et al. 2005). A commonly held assumption of the relationship between gender and acculturation is that gendered

constraints on health behaviors from “patriarchal” gender norms from countries of origin and beliefs will relax and modernize with increased years in the U.S. and more exposure to U.S. norms and gender ideologies (Gorman, Novoa, and Kimbro 2015; p. 5-6). In this perspective, acculturation, specifically incorporation into U.S. society, enables immigrant women more tools and power to renegotiate gender roles and move up in status, especially in the household. I refer to this assumption as the traditional-modern gender paradigm. Many studies posit that exposure to “modern” gender norms allows women to gain more social status through increased access to employment, education and financial resources. In turn, men are more likely to lose social power and face more status loss in the larger society. This acculturation-related transition from “traditional to “modern” results in immigrant women gaining more independence and autonomy from patriarchal gender roles and status hierarchies from their country of origin, and is associated with both improved health (i.e. mental health) and deleterious health behaviors (i.e. smoking and alcohol use) (Erving 2011; Gorman et al. 2014, 2010; Kaushik 2011; Leu et al. 2011; Read and Reynolds 2012).

Health is changed by gendered acculturation processes, but the traditional-modern gender paradigm used in the health literature reifies many of the ethnic and gender stereotypes addressed in critiques of acculturation (Hunt et al. 2004). Among the few health studies that have examined values within a gender-acculturation framework have found more similarities, than differences (Kimbro 2009; Rhodes et al. 2008). For example, using English proficiency and a traditional values scale that assessed the approval or disapproval on social issues such as unmarried childbearing and cohabitation among Latinos, Kimbro’s (2009) found more similar values shared across gender and nativity than expected, and that values had few effects with health behaviors. Gender had a moderating effect on English proficiency and smoking, but not drinking. More

importantly, contrary to what was expected, no gendered effects between traditional values and health behaviors were found. These findings point to the importance of addressing acculturation and gender, separately and in conjunction, in order to analyze their independent and multi-dimensional effects. To date, there are limited number of studies on immigrant health which have addressed gender as a multi-dimensional relational concept that shapes acculturation and health processes to address the assumptions of traditional-modern gender paradigm.

Acculturation and Enabling Resources

Acculturation processes are also closely related to various enabling mechanisms that facilitate or impede access to healthcare for immigrant men and women. Enabling resources are a key part of the Andersen model of healthcare utilization that delineates the effects of predisposing, enabling and need factors on access to healthcare. Enabling factors are central because they encompass the financial, legal, social and environmental resources, and enabling resources have high levels of mutability which are important for development of policy and behavioral interventions. Mutability is inherent in the process of acculturation. The joint effects of acculturation and enabling resources also vary by gender to differentially affect access to healthcare.

Acculturation is tightly intertwined with important enabling factors such as health insurance and social safety net programs. Eligibility for specific types of private and public health insurance is contingent on duration of time in the U.S. as well as legal status such as visa status upon entry and changes in status as a resident. Other forms of public assistance, such as public housing, that positively affects help-seeking and health are only eligible to U.S. citizens. Public safety net programs tend to give more opportunities to women and female-headed

households, making women who are more likely to be affected by duration and citizenship limitations to public insurance coverage. Moreover, these limitations greatly affect children and family access to health insurance because coverage may be contingent on parental status. Even when the children are U.S. citizens, immigrant parents, without legal eligibility, may be reluctant to bring eligible children into care, or do not want to choose care for some children but not all.

English proficiency is also an important factor linking acculturation with enabling resources. Under Executive Order 13116, all federal agencies are mandated to develop and implement a system for limited English proficient individuals can meaningfully access services. This applies to direct government programs such as voting guides and Census data collection, as well as indirect government support programs such as healthcare, housing and public health emergency information. Despite the legal and public service obligations, there is significant variation to the extent to which each federal agency and their state and local counterparts are in compliance through their public programs. More importantly, even though it is the law for publically funded health clinics to provide linguistic access, implementation and enforcement of the law continues to be underfunded. Language access has been and remains a significant barrier to access to healthcare for immigrants, and English proficiency levels vary by ethnic group and gender, with women usually having lower levels of good English proficiency. Language access barriers continue to affect access to healthcare, which is surprisingly still very high for the Spanish-speaking population, who by far is the largest non-English language group in the U.S. (Fernández-Kelly and Portes 2012; Gorman et al. 2016; Portes, Fernández-Kelly, and Light 2012; Read and Smith 2017). This highlights that all other languages, especially among the Asian languages with smaller immigrant populations, may face even larger barriers regarding language access.

Networks of support and social capital also play a pivotal role in incorporation and affect access to healthcare in multiple ways. Immigrants rely heavily on family and friend networks and established institutions in immigrant enclaves for a wide range of resources, social support and identity (Hirschman 2004). Moreover, having a spouse and family, and being tied to a community eases acculturation stressors which may decrease the likelihood of healthcare access for some conditions, like emotional distress, or encourage access for other conditions, like diabetes. On the other hand, family and friend networks may be too demanding, especially among those with financial and resource constraints. Demands and need are also harder to meet among immigrant families with mixed legal status, multiple family and immigrant generations living together, and transnational family responsibilities. Access to healthcare may provide emotional aid as well as open up different opportunities to gain information and resources that are not available in their own networks.

Hypotheses

To assess the gendered effects of acculturation on access to healthcare, this paper uses the theoretical framework discussed in detail in Chapter Two. The framework integrates three components, an individual-level model of healthcare use (Andersen 1995; Davidson et al. 2004), contextual analysis of the household (Bird and Rieker 2008; Portes and Rumbaut 2006; Portes and Zhou 1993), and a structural analysis of gender relations (Connell 2009) to comprehensively examine how the interaction between gender and household gender relations facilitate or constrain access to healthcare. I posit the following hypotheses:

H1: Gender will moderate the relationship between reasons for migration and access to healthcare with migrating to work more positively affecting men's access to healthcare

compared with women, and migrating for family more negatively affecting women's access to healthcare compared to men

H2: Gender will moderate the relationship between incorporation to U.S. society and access to healthcare with increased incorporation more positively affecting men's access to healthcare, compared with women.

H3: Gender will moderate the relationship between maintaining transnational ties and access to healthcare with transnational ties more positively affecting men's access to healthcare, compared with women.

METHODS

Data and sample

The data used in this paper comes from the National Latino and Asian American Study (NLAAS), a nationally representative household cross-sectional sample of Latinos and Asian Americans (Alegria et al. 2004). NLAAS data was collected from May 2002 to November 2003 from adults from four Latino ethnic groups (Cuban, Mexican, Puerto Rican, and Other Latino), four Asian ethnic groups (Chinese, Filipino, Vietnamese and Other Asian), and a control group of non-Latino, non-Asian, white respondents. Interviews were conducted in Cantonese, English, Mandarin, Spanish, Tagalog, and Vietnamese. The weighted response rate was 65.6% for the Asian sample (n= 2,095) and 75.5% for the Latino (n=2,554) sample. This paper uses the full sample of Asians and Latinos (n=4,649). The final sample for analysis comprises of individual adult respondents who identified as immigrant (foreign-born) and in a married or cohabitating relationship (n=2,324).

The NLAAS sampling method is comprised of three components: (1) core sampling where participants were recruited with a multistage stratified area probability sampling design; (2) high density sampling where Census block groups were oversampled in areas where ethnic groups were represented in at least 5% of households; (3) second-respondent sampling to recruit participants from households with one eligible respondent. The NLAAS sampling procedure required the construction of weighting corrections to take into account joint probabilities of selection under the three components of the sampling design (Alegria et al. 2004; Heeringa et al. 2004; Pennell et al. 2004). The NLAAS sampling design requires the construction of weighting corrections that adjust for the hierarchical nature of the multistage survey design. Analyses were done using the STATA 15 Statistical Software SVY program (StataCorp 2017), which takes into account complex survey sampling methods such as stratification, clustering and unequal weighting allows for weighting adjustments to account for the complex sampling design.

Measures

Dependent Variables

There are three dependent variables to distinguish between potential access and realized access to healthcare. Each outcome variable measures a distinct type of interaction with the healthcare system.

Has a Usual Healthcare Provider, (1=Yes, 0=No). Respondents were asked whether they had a usual provider for medical care.

This outcome of potential access measures the level of awareness of the healthcare system indicated by having a medical provider they could go to on a regular basis. Because of additional barriers to access faced by immigrants, such as availability of interpretation services and levels

of cultural competency, immigrants who may have insurance to pay for services still may not have a usual place to go to for healthcare.

Use of Medical Services within the last 12 months, (1=Yes, 0=No). Respondents were asked whether they used any medical services within the last 12 months, including routine, dental/ophthalmologist, urgent or scheduled treatment or surgery.

This outcome of realized access measures the level of engagement with the healthcare system. Because it was not feasible to fully control for medical visits for reproductive needs among women, a broader measure of healthcare utilization was chosen over the more limited measure of use of routine or primary healthcare.

Number of visits within the last 12 months: Respondents were asked about the number of visits in the past 12 months to a general practitioner or other medical doctor

This outcome of realized access measures the frequency of utilization. There are no strict guidelines for frequency of healthcare utilization for the general age-adjusted population, but a yearly visit for routine or primary care for preventative reasons is a general recommendation by medical professionals. More than one medical visit within a year, after controlling for individuals with diagnosed chronic diseases, may indicate a higher exposure to conditions that affect acute mental and physical health such as stressors, infections, and injury.

Predisposing Factors

Gender, (1=Female, 0=Male).

Age, (years)

Ethnicity, (Asians: Chinese, Vietnamese, Filipino and Other Asian; Latinos: Mexicans, Puerto Ricans, Cubans and Other Latinos)

Need Factors

Need factors include two self-rated health measures and one measure of diagnosed chronic condition. Assessment of need also considers past diagnosed conditions given the tendency to over-estimate health in self-rated measures among groups who have the least access to healthcare such as immigrant men and recent immigrants.

Poor self-rated physical and mental health, (1=Poor/Fair, 0=Good/Excellent). Respondents were asked to rate their own physical and mental health on a four-point scale in separate questions.

This variable refers to whether a respondent answered poor or fair to either question.

Chronic disease diagnosis, (1=Yes, 0=No). This measure summarizes whether the respondent had at least one chronic disease diagnosis from a medical provider. Chronic diseases include heart disease, high blood pressure, asthma, chronic lung disease, diabetes, stomach or intestinal ulcer, epilepsy or seizures or cancer.

Acculturation Factors

Measures of acculturation reflect multiple processes of acculturation that include: 1) original migration decisions, 2) orientation towards the U.S.; and 3) transnational ties.

Reason for migration: job, to join family, or medical. Respondents were allowed to choose more than one response and rate how important the reason was for their decisions on a scale from 1 = very important to 3 = not very important. Responses were recoded into a dummy variable, 1 = somewhat/very important, and 0 = not important. Reasons for migration often shape the context for settlement (i.e. place, legal status) as well as level of health selectivity. Immigrants who migrate for work exhibit healthier behaviors and health statuses compared to immigrants who

migrate for other reasons. This health selectivity associated with immigrants has been found to apply more to men than women because of migration reasons.

Proportion of life in the U.S. Calculated as current age minus age of migration divided by current age. The amount of time spent in the U.S. was calculated in relation to the respondent's age and age at immigration. This contrasts to studies that use measures of years in the U.S. (duration).

Evidence suggests that the age of immigration is also relevant to understanding cultural change and societal incorporation. A variable measuring the proportion of life in the U.S has been used in previous studies (De Leersnyder, Mesquita, and Kim 2011; Leu et al. 2011).

Poor/Fair English proficiency. English proficiency has been found to have a significant effect on healthcare access across racial and ethnic groups and gender. Respondents were asked three questions to rate their ability to read, write, and speak English on a four-point scale ($\alpha = 0.97$) Responses ranging from poor to excellent in English proficiency, were recoded into a dichotomous variable (1 = poor/fair, 0 = good/excellent).

Citizenship status, (1 = naturalized U.S. citizen, 0 = not a U.S. citizen). Respondents were asked whether they have naturalized as U.S. citizens. It is also a measure of more established immigrants that indicate a shift in social identity towards the U.S. as well as being able to take advantage of specific rights and privileges. Citizens have more legal access to services and are also less inhibited in using public services because they are much less likely to fear being labeled a public charge (Gee et al. 2016).

Frequent visits to country of origin. Respondents were asked about their frequency in which they return to their country of origin, 1=often, 2= sometime, 3= rarely, 4=never. This variable was recoded into 1=often/sometimes, 0= rarely/never. The frequency of return visits to the country of

origin indicates the maintenance of transnational ties well as additional opportunities to access healthcare that is more affordable or culturally and linguistically congruent.

Enabling Factors

Three types of factors that enable or inhibit access to healthcare are measured: socioeconomic-legal resources, past experiences of access or treatment barriers to healthcare, and types of social network support.

Education (in years)

Financial strain, (1=Yes, 0=No). Respondents were asked if they were having any difficulty in paying monthly bills.

Type of health insurance (private, public, no insurance). Health insurance is a vital resource that people gain through their employer, the state, or open market. For immigrants, health insurance is a socioeconomic-legal resource where employment status, income, legal status and duration in the U.S. determines whether a person is eligible for insurance (see Chapter Three for more details). Dummy variables were constructed on three types of insurance, private, public and none.

Number of Past Barriers to Healthcare. Respondents were asked if they experienced any past access or treatment barriers to healthcare within the last 12 months. Barriers included experiences with difficulty in getting an appointment by phone and referral to a specialist, experiences of a provider spending limited time with them during an appointment, long waits in clinic, difficulty in getting advice over the phone, not being able to get an assigned clinic, not able to get prescription to medication, and not receiving continuity of care.

Social support is an important contributor to better health and well-being. For healthcare access, supportive networks among friends and relatives can complement support received from a spouse/partner, and can affect access in both directions. Support networks are important sources of information, resources, emotional care that can encourage seeking healthcare or be a substitute for healthcare services (i.e. mental health counseling)

Relative Support, (scale, 3-13). Respondents were asked three questions and rate their frequency of contact and levels of support with family or relatives (not including spouse/partner/children) on a 4-point scale with 1=a lot to 4=not at all. Questions included, “How often do you talk on the phone or get together with family or relatives who do not live with you?” “How much can you rely on your relatives who do not live with you for help if you need to talk to someone about your worries?” “How much can you open up to relatives who do not live with you if you need to talk to someone about your worries?”

Responses were recoded into a binary variable with 1=a lot/some 0=a little/not at all.

Friend Support, (scale, 5-15). Similar questions were asked about level of support with friends.

Household Gender Relations variables capture three dimensions of power, production and emotion.

Gender relations of power is measured using two variables on *decision making* and *economic responsibility* measured on a 5 point scale.

Decision making, (scale 1-5). Respondents were asked, “When it comes to making major decisions, who has the final say, you or your spouse?” 1=Respondent, 2=Both, 3=

Spouse/Partner. This questions was followed up with asking:

Do you/your partner have 1=a lot more say, 2= somewhat, or 3 a little say than you/your partner?

The variable was recoded with the gender of the respondent and the responses to the scaled questions with 3 = equalitarian share of decision making, and 1 and 5 reflecting an asymmetrical share of decision making, with 1 = female spouse/partner having a lot more say, and 5 = male spouse/partner having a lot more say.

Economic responsibilities, (scale 1-5). Respondents were asked, “When it comes to paying for household expenses – like mortgage or rent, electricity bills, who has the most responsibility?” This variable was recoded like the decision making variable, where responses were coded with gender of the respondent and a 1-5 point scale was constructed with 3 = egalitarian share of economic responsibilities, 1 = female spouse/partner having most of the economic responsibilities, and 5 = male spouse/partner spouse/partner male spouse/partner having most of the economic responsibilities.

Gender relations of production is measured using two variables on *female household employment* and *household chores*.

Female household employment, (1=Yes, 0=No). Female household employment was coded from the sex of the respondent and their answer to questions on the employment status of themselves and their spouse/partner. This variable was coded to include any combination where the female in the household was employed (dual employed households or female sole employed households). This include part time and full time employment.

For *household chores*, (scale 1-5). A similar scale and coding for decision making and economic responsibilities variables was used. Respondents were asked. “When it comes to household chores – like cooking, cleaning, childcare, grocery shopping, who has the most responsibility?”

Gender relations of emotion is measured using four variables that capture different levels of spouse/partner, child and family dynamics of emotional support, strain that are related to help-seeking and caregiving behaviors that affect access to healthcare.

Partner support, (1=Yes, 0=No). Respondents were asked four questions on the level of emotional support they receive from their spouse/partner. “How much does your spouse/partner really care about you?” “How much does your spouse/partner understand the way you feel about things?” “How much can you rely on your spouse/partner for help if you have a serious problem?” “How much can you open up to your spouse/partner if you need to talk about your worries?” Responses ranged from 1 (not at all) to 4 (a lot). The scale ranged from 4 – 16 with increasing numbers indicating more support, and recoded into a binary variable with scores more than 8 indicating support =1 , and score 8 or less indicating no support = 0.

Partner strain, (1=Yes, 0=No) was measured and coded in the similar way as partner support. Questions included “How often does your spouse/partner make too many demands on you?” “How often does your spouse/partner criticize you? “How often does you spouses/partner let you down when you are counting on him/her? How often does your spouse/partner get on your nerves? The scale ranged from 4 – 16 with increasing numbers indicating more support, and recoded into a dichotomous variable with scores more than 12 indicating strain =1, and scores 12 or less indicating no strain = 0.

To facilitate comparability, coding for the partner support and strain measures in the same way as other studies that have used the same dataset and variable.

Child under 18, (1=Yes, 0=No). This variable measures the need for caregiving within the family indicated by having one or more children living in household under the age of 18.

Number in Household. This variable measures the extent of caregiving needed in the family.

Family cultural conflict, (scale 5-15): To address immigrant specific family dynamics, I include an acculturation-related household variable that measures emotional strain at the family level, I use part of the Hispanic Stress Inventory (Cervantes et al. 2016; Cervantes, Padilla, and Salgado de Snyder 1991), the scale includes items such as “You have felt that being too close to your family interfered with your own goals”, and “Because you have different customs, you have had arguments with other members of your family” “Because of lack of family unity, you have felt lonely and isolated. Responses ranged from 1 (hardly ever or never) to 3 (often), yielding a minimum and maximum sum score from 5-15 ($\alpha = .77$). Higher values indicate greater family cultural conflict.

Analytical Strategy

Table 3.1 provides descriptive statistics for the total sample, stratified by gender. Weighted percentage and means are reported along with results from Chi-squared tests to determine whether gender differences observed were statistically significant.

Tables 3.2a and 3.2b reports the results from a series of linear probability models that focus on the relationship between migration and acculturation factors and having a usual provider for medical care. Estimates and standard errors are reported. The analysis is performed in four steps. Model 1 tests the relationship of predisposing and need variables with having a usual provider for medical care. Model 2 adds acculturation factors to determine their relationship to having a usual provider for medical care. These factors include variables that measure the reasons for migration and incorporation towards U.S. society. Model 3 adds

enabling and household gender relations factors to determine if the effects of acculturation measures on having a usual provider for medical care remain. Models 4 and subsequent models add gender and acculturation interaction terms. Interaction terms are added independently to each model with statistically significant models shown. Figures of predicted probabilities are also shown to further highlight the gendered effects between covariates and healthcare access outcome. Additional analysis, not shown, are conducted with all the gender and acculturation interaction terms in one model to measure the effect of each interaction terms while controlling for all other covariates.

Tables 3.3a and 3.3b reports the results from a series of linear probability models that focus on the relationship between enabling factors and having used any medical services within the last 12 months. It follows the same modeling pattern as Table 2.

Tables 3.4a and 3.4b reports the results from a series of negative binomial regression models that focus on the relationship between enabling factors and the number of visits to medical services within the last 12 months. It follows the same pattern as Tables 2 and 3.

Linear probability models were used instead of logistic regression models for ease of interpretation. All models were run using logistic regression to and confirmed similar results. All models used robust standard errors.

FINDINGS

Descriptive statistics

Table 3.1 provides descriptive statistics for the total sample of married or cohabitating immigrants, stratified by gender. Weighted percentage and means are reported along with results from chi-square tests to determine whether gender differences observed were statistically significant.

The rate of access is 59.34% for having a usual provider for medical care, 79.4% for having used any medical service within the last 12 months, and an average of 2.63 medical service visits within the last 12 months. Across all three outcomes, women have significantly higher rates of healthcare access compared with men. This gender pattern is consistent with past research.

The average age of the sample is 40.72 years. Mexicans (39.75%) were the largest ethnic group followed by Chinese (10.1%), Filipino (6.85%) and Vietnamese (5.55%). Other Asians (32.5%) and Other Latinos (18.36%) are also a large proportion of the sample. Mexicans are the only ethnic group with a significantly larger male population. Chinese, Filipinos and other Asians have a larger female population (p-value <0.10).

A quarter of the sample (26.41%) have poor/fair self-rated physical health, 11.36% of the sample report having poor/fair self-rated mental health, and 29.64% report having been diagnosed with at least one chronic medical condition. None of these health need factors significantly differed by gender.

Acculturation measures reflect the gendered nature of migration to and incorporation into U.S. society based on gender differences along the different dimensions. On migration

Table 3.1. Descriptive Statistics for Total Sample and Stratified by Gender (Immigrants, Married and Cohabiting Sample n=2,324)

Variable	Total Sample		Men		Women		Gender Difference
	% or Weighted Mean	SE	% or Weighted Mean	SE	% or Weighted Mean	SE	
	n=2,324		n=1,210		n=1,114		
Potential Access							
Usual Provider for Medical Care	59.34	(1.84)	51.33	(2.32)	68.06	(2.21)	***
Realized Access							
Use of any medical service within past 12 months (routine, dentist/opt, urgent, scheduled treatment/surgery)	79.4	(1.96)	71.67	(2.72)	87.8	(1.52)	***
Number of medical service visits within past 12 months	2.63	(0.09)	2.05	(0.15)	2.23	(0.14)	***
Predisposing Factors							
Female	47.92						
Age (years)	40.72	(0.58)	41.38	(0.74)	40.01	(0.57)	*
Ethnicity:							
Mexican (reference)	39.75	(4.04)	43.83	(3.8)	35.32	(4.69)	**
Puerto Rican	4.34	(0.5)	4.55	(0.56)	4.12	(0.61)	
Cuban	4.21	(0.5)	4.35	(0.55)	4.06	(0.51)	
Other Latinos	18.36	(1.82)	17.71	(2.)	19.08	(2.2)	
Chinese	10.1	(1.29)	9.14	(1.27)	11.13	(1.53)	+
Vietnamese	5.55	(0.87)	4.71	(0.78)	6.46	(1.06)	
Filipino	6.85	(0.98)	6.16	(0.98)	7.61	(1.13)	+
Other Asian	32.5	(2.74)	9.55	(1.4)	12.23	(1.66)	+
Need Factors							
Poor/Fair Self-rated physical health	26.41	(2.02)	24.9	(2.14)	28.05	(2.76)	
Poor/Fair Self-rated mental health	11.36	(1.1)	11.92	(1.63)	10.75	(1.01)	
Diagnosed chronic condition	29.64	(1.62)	28.75	(2.18)	30.62	(1.51)	
Migration & Acculturation Factors							
Reason for Immigration (Very important)							
Employment	67.67	(1.47)	71.38	(1.43)	63.63	(2.43)	**
To Join Family	49.86	(2.14)	46.21	(2.49)	53.83	(2.73)	**
Medical	13.58	(1.4)	12.9	(1.44)	14.3	(2.)	
Proportion of Life in US	42.28	(0.01)	44.52	(0.01)	39.93	(0.01)	***
English Proficiency Poor/Fair	65.9	(2.04)	64.35	(2.3)	67.59	(2.15)	+
Naturalized Citizen	37.32	(2.08)	37.78	(2.34)	36.82	(2.42)	
Visits Country of Origin (Often/Sometimes)	44.75	(1.55)	47.15	(2.61)	42.15	(1.74)	
Enabling Factors							
Education (years)	10.87	(0.23)	10.79	(0.23)	10.97	0.29	
Financial strain	42.82	(2.35)	41.17	(2.86)	44.62	(2.43)	
Health insurance status:							
Private (ref)	49.83	(2.71)	51.74	(2.7)	47.96	(3.1)	+
Public	17.75	(1.21)	13.85	(1.4)	21.98	(1.62)	***
Uninsured	32.32	(2.29)	34.4	(2.6)	30.06	(2.61)	+
Number of past barriers to medical care	0.76	(0.04)	0.666	(0.07)	0.85	(0.05)	*
Social Support Networks							
Relative Support Scale (3-15)	11.18	(0.09)	11.06	(0.11)	11.38	(0.13)	*
Friend Support Scale (5-15)	9.59	(0.07)	9.4	(0.1)	9.81	(0.1)	**
Household Gender Relations							
Decision Making (1-5)	3.32	(0.36)	3.43	(0.05)	3.19	(0.04)	***
Economic Responsibilities (1-5)	2.35	(0.04)	2.28	(0.04)	2.43	(0.05)	**
Household Chores (1-5)	3.69	(0.03)	3.59	(0.04)	3.8	0.03	***
Female Employment	51.33	(2.12)	51.31	(2.24)	51.35	(2.61)	
Children under 18	48.78	(2.09)	45.35	(2.62)	52.51	(2.3)	**
Household Size	3.25	(0.06)	3.13	(0.09)	3.38	(0.07)	*
Family Cultural Conflict (5-15)	6.16	(0.05)	6	(0.06)	6.34	0.07	***
Partner Emotional Strain	42.84	(1.64)	44.45	(2.61)	41.09	(1.21)	
Partner Emotional Support	8.26	(0.82)	5.53	(1.05)	11.24	(1.27)	**

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

measures, 67.67% of the sample responded that migrating for work was very important. 49.86% responded that migrating to join family was very important. A smaller percentage (13.58%) responded that migrating for medical reasons. Reasons for migration are not mutually exclusive. As reflected in the literature, more men reported migrating for work reasons and more women report migrating to join family.

On incorporation measures, the mean proportion of life spent in the U.S. is 42.28 which reflects a more established immigrant sample in terms of duration. This contrasts with, 65.9% reported having poor/fair English proficiency and 37.32% being naturalized U.S. citizens which reflects lower levels of acculturation to the U.S. Men spent a higher proportion of their life in the U.S., and have slightly lower rates of poor/fair English proficiency compared with women. This differs from other studies which found higher rates of poor/fair English proficiency among women.

On the maintenance of transnational ties, 44.75% of respondents reported that they visited their country of origin often or sometimes. There were no gender differences with this measure.

The average number of years of education is 10.87. Almost half (42.82%) of the sample are experiencing financial strain. Almost half of the sample have private health insurance (49.83%), followed by 32.78% who are uninsured and 17.75% have some form of public health insurance. There are slightly more men among those with private insurance and the uninsured, and women comprise significantly more of those with public health insurance. These gender differences in health insurance reflect a gender and immigrant stratified labor market and its relationship to market-based health insurance and public policy programs. A third (34.78%) of the sample have experienced at least one healthcare access or treatment barrier in the past. The

mean number of barriers was 0.76 with the range being between 0 and 8. More women experienced any barriers and experienced a higher mean number of barriers compared with men. The social networks are robust with high levels of relative (mean: 11.18) and friend support (mean: 9.59). As expected, women reported higher levels of relative (11.38 vs. 11.06) and friend support (9.81 vs. 9.4) than men.

Household gender relations measures are categorized along dimensions of power, division of labor and emotion. For scaled measures (1-5), lower numbers reflect asymmetrical gender relations that where women have more power and responsibility, work outside the home, and do less household work. Higher numbers reflect asymmetrical gender relations indicate men have more power, responsibility and do less household work. The median number (3) reflect an egalitarian structure. In the measurement of power relations, the mean of decision making and economic responsibility measures indicate egalitarian gender structure, with decision making (3.32) skewing more towards men and economic decisions (2.35) skewing more towards women. Two variables have some small gender differences, with men reporting having more decision making power (3.43 vs. 3.19) and women reporting having more economic responsibilities (2.28 vs. 2.43).

With household gender division of labor, the mean of household chores is 3.69 indicating an egalitarian structure. The rate of household female employment is moderate at 51.33%. As expected, there are some small gender differences in reporting the gender structure of household chores, with women reporting living in households where they are doing more household chores (3.8 vs. 3.59).

With household relations of caregiving and emotional support, almost half the sample (48.78%) have at least one child under the age of 18 living with them with more immigrant

women having a child dependent. The household size mean was 3.25. The mean of family cultural conflict was 6.16 indicating low levels of conflict, although women reported higher mean levels than men (6.34 vs 6). There are no gender differences in partner strain with 42.84% of the sample reporting high levels of emotional strain from their spouse/partner. By contrast, only 8.26% reported receiving partner emotional support with women receiving significantly more than men (11.24% vs. 5.53%). Overall, both men and women show high levels of emotional strain from child, partner and family relations and low levels of partner/spouse emotional support. Women reported higher levels of having dependent children and experiencing family cultural conflict compared with men, but women also reported receiving higher spousal/partner emotional support.

The various dimensions of household gender relations reflect more egalitarian gender relations along decision making, economic responsibilities, female employment and household chores than assumed by much of the immigration health literature. The findings on emotional caregiving and support also affirms past literature with women having more caregiving and emotional strain than men in terms of child and family dynamics, but receiving less strain and more support from their male spouses/partners. Gender differences in perspective of household gender relations along dimensions of power, production and emotion also point to saliency of different family roles and their relationship with stressors, the difference between having power and having responsibilities, and gendered perceptions of household management and division of labor.

Findings on Potential Access to Healthcare

Tables 3.2a and 3.2b present results from multivariate linear probability models on having a usual provider for medical care, a measure of potential access to healthcare. Estimates and standard errors are reported. Model 1 includes predisposing and health need factors and show that being female significantly increases the probability of having a usual provider by 0.16. This positive effect of being female remains consistent across all models with variation in effect strength. Mexicans, compared with all immigrant groups in the sample, are the least likely to have a usual provider for care. This finding remains fairly stable throughout all the models. Having poor/fair self-rated mental health significantly decreases the probability of having a usual provider for care by 0.12, and having at least one diagnosed medical condition significantly increases the probability of having a usual provider by 0.13. The effect of these two health need factors remains in all subsequent models.

Model 2 shows the effect of acculturation factors. Migration decision related to work increases the probability of having a usual provider by 0.07. With incorporation measures, an increase in proportion of life in the U.S. significantly increases the probability of having a usual provider for care by 0.20. As expected, having poor/fair English proficiency significantly decreases the probability of having a usual provider by 0.07. Frequent visits to the country of origin also increase the probability of having a usual place for care by 0.10.

Model 3 is the full model with the addition of enabling factors and dimensions of household gender relations. On enabling factors, as expected, not having health insurance decreases the probability of having a usual health provider by 0.32 compared with having private insurance. Other socioeconomic factors such as education and experiencing financial strain do

Table 3.2a Multivariate Linear Probability Models
Effects of Acculturation on Having a Usual Provider for Medical Care among Married/Cohabiting Immigrants

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.16	*** (0.02)	0.18	*** (0.02)	0.16	*** (0.02)
Age (years)	0.01	*** (0.001)	0.01	*** (0.001)	0.005	*** (0.001)
Mexicans (reference)						
Puerto Ricans	0.27	*** (0.06)	0.24	*** (0.07)	0.15	* (0.07)
Cubans	0.11	** (0.04)	0.16	*** (0.04)	0.09	* (0.04)
Other Latinos	0.18	*** (0.05)	0.18	*** (0.05)	0.10	+ (0.05)
Chinese	0.15	*** (0.05)	0.21	*** (0.05)	0.12	* (0.05)
Vietnamese	0.21	*** (0.04)	0.18	*** (0.05)	0.10	* (0.04)
Filipino	0.19	*** (0.04)	0.21	*** (0.05)	0.10	+ (0.05)
Other Asian	0.23	*** (0.03)	0.20	*** (0.04)	0.08	* (0.04)
Need Factors						
Poor/Fair Self-rated mental health	-0.12	*** (0.04)	-0.09	* (0.04)	-0.08	* (0.04)
Poor/Fair Self-rated physical health	-0.02	(0.03)	0.003	(0.03)	0.03	(0.03)
Diagnosed chronic condition	0.13	*** (0.03)	0.11	*** (0.03)	0.07	* (0.03)
Acculturation Factors						
Migration reason: to work			0.07	** (0.03)	0.08	*** (0.03)
Migration reason: to join family			0.004	(0.02)	-0.01	(0.02)
Migration reason: medical care			-0.02	(0.04)	-0.04	(0.04)
Proportion of Life in US			0.20	*** (0.05)	0.11	* (0.05)
English Proficiency Poor/Fair			-0.07	*** (0.02)	-0.01	(0.02)
Naturalized Citizen			0.06	(0.04)	0.03	(0.03)
Visits Country of Origin			0.10	*** (0.02)	0.08	*** (0.03)

Table 3.2a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)					0.001	(0.003)
Financial strain					-0.01	(0.03)
Private Insurance (reference)						
Public Insurance					-0.03	(0.04)
No Insurance					-0.32	*** (0.04)
Number of past barriers to medical care					0.02	(0.01)
Relative Support					0.003	(0.01)
Friend Support					0.01	* (0.005)
Household Gender Relations						
Decision Making					-0.005	(0.01)
Economic Responsibilities					-0.002	(0.01)
Household Chores					-0.002	(0.01)
Female Employment					-0.004	(0.03)
Children under 18					0.05	(0.03)
Household size					-0.02	* (0.01)
Family Cultural Conflict					-0.01	(0.01)
Partner Emotional Strain					-0.004	(0.03)
Partner Emotional Support					0.001	(0.05)
	2,323		2,283		2,195	
	0.1686		0.2072		0.2849	
N						
R-Squared						

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 3.2b Multivariate Linear Probability Models
Effects of Acculturation on Having a Usual Provider for Medical Care among Married/Cohabiting Immigrants

	Model 3		Model 4		Model 5	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.16	*** (0.02)	0.09	*	0.21	*** (0.03)
Age (years)	0.005	*** (0.001)	0.005	***	0.005	*** (0.001)
Mexicans (reference)						
Puerto Ricans	0.15	*	0.15	*	0.15	*
Cubans	0.09	*	0.09	*	0.09	*
Other Latinos	0.10	+	0.10	+	0.10	+
Chinese	0.12	*	0.12	*	0.12	*
Vietnamese	0.10	*	0.10	*	0.10	**
Filipino	0.10	+	0.10	+	0.10	+
Other Asian	0.08	*	0.08	+	0.08	*
Need Factors						
Poor/Fair Self-rated mental health	-0.08	*	-0.08	*	-0.08	+
Poor/Fair Self-rated physical health	0.03		0.03		0.04	
Diagnosed chronic condition	0.07	*	0.07	*	0.07	*
Acculturation Factors						
Migration reason: to work	0.08	***	0.08	***	0.07	***
Migration reason: to join family	-0.01		-0.01		-0.01	
Migration reason: medical care	-0.04		-0.04		-0.04	
Proportion of Life in US	0.11	*	0.03		0.11	*
English Proficiency Poor/Fair	-0.01		-0.01		-0.02	
Naturalized Citizen	0.03		0.03		0.03	
Visits to Country of Origin	0.08	***	0.08	***	0.14	*

Table 3.2b (continued)

	Model 3		Model 4		Model 5	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)	0.001	(0.003)	0.001	(0.003)	0.001	(0.003)
Financial strain	-0.01	(0.03)	-0.01	(0.03)	-0.01	(0.03)
Private Insurance (reference)						
Public Insurance	-0.03	(0.04)	-0.03	(0.04)	-0.03	(0.04)
No Insurance	-0.32	*** (0.04)	-0.32	*** (0.04)	-0.32	*** (0.04)
Number of past barriers to medical care	0.02	(0.01)	0.02	(0.01)	0.02	(0.01)
Relative Support	0.003	(0.01)	0.003	(0.005)	0.003	(0.01)
Friend Support	0.01	* (0.005)	0.01	* (0.004)	0.01	* (0.004)
Household Gender Relations						
Decision Making	-0.005	(0.01)	-0.005	(0.01)	-0.003	(0.01)
Economic Responsibilities	-0.002	(0.01)	-0.003	(0.01)	-0.002	(0.01)
Household Chores	-0.002	(0.01)	0.000	(0.01)	0.000	(0.01)
Female Employment	-0.004	(0.03)	-0.003	(0.03)	0.001	(0.03)
Children under 18	0.05	(0.03)	0.05	(0.03)	0.05	(0.03)
Household size	-0.02	* (0.01)	-0.02	* (0.01)	-0.02	* (0.01)
Family Cultural Conflict	-0.01	(0.01)	-0.01	(0.01)	-0.01	(0.01)
Partner Emotional Strain	0.00	(0.03)	0.00	(0.03)	0.00	(0.03)
Partner Emotional Support	0.00	(0.05)	0.00	(0.05)	0.00	(0.05)
Interactions: Gender & Acculturation						
Female*Migration reason: work						
Female*Migration reason: to join family						
Female*Migration reason: medical						
Female*Proportion Life in US						
Female*Poor English Proficiency						
Female*Naturalized Citizen						
Female*Visits to Country of Origin						
			0.16	+	0.09	
					-0.13	***
						0.04
N	2,195		2,195		2,195	
R-Squared	0.2849		0.2864		0.2890	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

not have a significant effect on potential access. Support from a network of friends had a significant positive effect, with every increase in the scale of friend support increasing the probability of having a usual provider for care by 0.01. The only household gender relations variables that has a significant effect was household size which was associated with a 0.02 decrease in the likelihood of having a usual provider for care. When enabling and household gender relations factors are added to the model, the positive effect of migrating for work, increasing proportion of life in the U.S. and frequent visits to the country of origin remained, while poor English proficiency no longer had an effect.

Models 4 and 5 present interactions with gender and proportion of life in the U.S., and gender and frequent visits to the country or origin. Model 4 shows when gender is included as a moderator, we see the relationship between proportion of life in the U.S and potential access significantly differs by gender. Figure 3.1 illustrates that women increase their probability of having a usual healthcare provider as their proportion of life in the U.S. increases, but men's probability remains low and stable.

Model 5 shows that both gender and having frequent visits to the country or origin have an effect on potential access, and that this effect is different for men and women. With frequent visits to, men's predicted probability of having a usual provider increases by 0.13 compared to not visiting frequent. This change is much higher compared with women who only increased their predicted probability by 0.01 (Figure 3.2).

Additional analysis with all gender and acculturation interactions included in the model, not shown, find that the moderating effects of gender on proportion of life in the U.S. and frequent visits to the country of origin continue to have a significant effect on having a usual

healthcare provider. This model also show that gender also moderates the effect between being a naturalized U.S. citizen and potential access.

Figures 3.1–3.2. Predicted Probabilities of Having a Usual Provider by Gender and Acculturation Factors

Figure 3.1 Proportion of Life in the U.S.

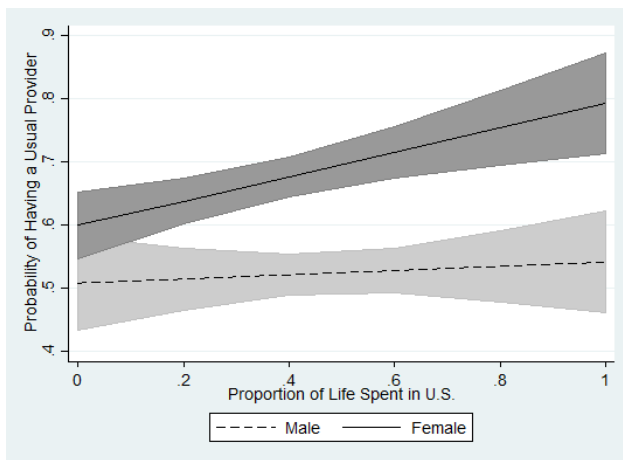
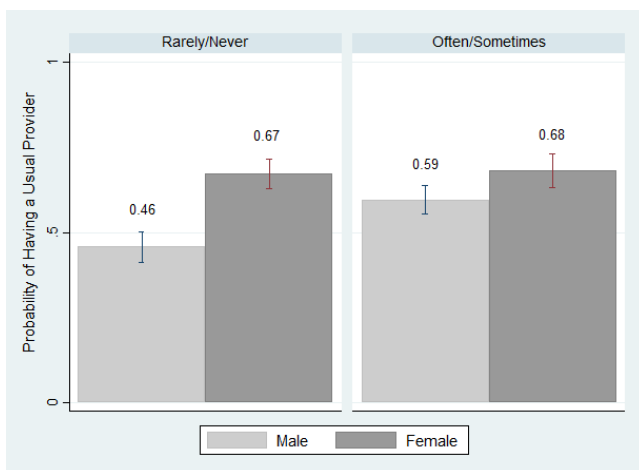


Figure 3.2 Frequent Visits to the Country of Origin



Findings on Realized Access to Healthcare

Tables 3.3a and 3.3b present results from multivariate linear probability models on having used a medical service within the last 12 months, a measure of realized access to healthcare. Like in the previous outcome, being female has a consistent positive effect on having used a medical service within the last 12 months across all models. Mexicans, relative to all other immigrant groups, are least likely to have accessed medical care. Having poor/fair self-rated mental health decreases the likelihood of having used medical services by 0.13 and having a diagnosed chronic condition increases the likelihood of having used medical services by 0.09.

Model 2 shows that migration reasons only have a minimal effect on realized access. Incorporation measures of poor/fair English proficiency decreases the probability of having used a medical service by 0.08 and being a naturalized U.S. citizen increases the probability of having used a medical service by 0.06.

When enabling factors and dimensions of household gender relations are added in Model 3, migrating for work reasons has a significant positive effect. Other migration and incorporation measures have a small effect (p-value <0.10). Having financial strain significantly decreases realized access by 0.05. Having no health insurance has a significant negative effect. Interestingly, an increasing number of past experiences with barriers to healthcare significantly increase the probability of having used a medical service within the last 12 months by 0.02. This finding on barriers is unexpected since the assumption is that barriers would have no effect or deter access. Having friend support has a positive effect, but it is small (p-value <0.10). One measure of emotional household gender relations, related to family cultural conflict, was found to increase the probability of using medical services by 0.02. This measure also is related to acculturation, but occurring at the household level instead of individual or institutional level.

Table 3.3a Multivariate Linear Probability Models
Effects of Acculturation on Using any Medical Service within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.15	*** (0.02)	0.16	*** (0.02)	0.15	*** (0.02)
Age (years)	0.003	*** (0.001)	0.003	* (0.001)	0.003	* (0.001)
Mexicans (reference)						
Puerto Ricans	0.15	*** (0.04)	0.13	*** (0.04)	0.04	(0.04)
Cubans	0.07	(0.04)	0.08	(0.05)	0.01	(0.04)
Other Latinos	0.18	*** (0.04)	0.16	*** (0.04)	0.09	* (0.04)
Chinese	0.18	*** (0.04)	0.17	*** (0.05)	0.07	* (0.03)
Vietnamese	0.19	*** (0.04)	0.13	*** (0.04)	-0.01	(0.04)
Filipino	0.15	*** (0.04)	0.12	** (0.04)	-0.01	(0.04)
Other Asian	0.18	*** (0.05)	0.11	* (0.05)	-0.03	(0.04)
Need Factors						
Poor/Fair Self-rated mental health	-0.13	*** (0.04)	-0.10	* (0.04)	-0.09	* (0.04)
Poor/Fair Self-rated physical health	-0.03	(0.03)	-0.01	(0.03)	0.01	(0.03)
Diagnosed chronic condition	0.09	*** (0.03)	0.07	** (0.02)	0.04	* (0.02)
Acculturation Factors						
Migration reason: to work			0.05	+ (0.02)	0.06	* (0.02)
Migration reason: to join family			-0.04	+ (0.02)	-0.04	+ (0.02)
Migration reason: medical care			0.02	(0.03)	0.01	(0.02)
Proportion of Life in US			0.01	(0.07)	-0.07	(0.06)
English Proficiency Poor/Fair			-0.08	*** (0.02)	-0.04	+ (0.02)
Naturalized Citizen			0.06	* (0.03)	0.05	+ (0.03)
Visits to Country of Origin			0.05	(0.03)	0.03	(0.03)

Table 3.3a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)					0.005	(0.003)
Financial strain					-0.05	(0.02) *
Private Insurance (reference)						
Public Insurance					0.03	(0.02)
No Insurance					-0.24	(0.04) ***
Number of past barriers to medical care					0.02	(0.01) ***
Relative Support					0.00	(0.004)
Friend Support					0.01	(0.004) +
Household Gender Relations						
Decision Making					-0.001	(0.01)
Economic Responsibilities					0.01	(0.01)
Household Chores					-0.02	(0.01)
Female Employment					0.01	(0.02)
Children under 18					0.04	(0.03)
Household size					0.002	(0.01)
Family Cultural Conflict					0.02	(0.01) ***
Partner Emotional Strain					-0.01	(0.02)
Partner Emotional Support					-0.04	(0.04)
N	2,323		2,283		2,195	
R-Squared	0.1455		0.1455		0.2621	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 3.3b Multivariate Linear Probability Models
Effects of Acculturation on Using any Medical Service within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 3		Model 4		Model 5		Model 6	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors								
Female	0.15	*** (0.02)	0.10	*** (0.02)	0.21	*** (0.03)	0.20	*** (0.03)
Age (years)	0.00	* (0.001)	0.00	* (0.001)	0.00	* (0.001)	0.00	* (0.001)
Mexicans (reference)								
Puerto Ricans	0.04	(0.04)	0.04	(0.04)	0.04	(0.04)	0.04	(0.04)
Cubans	0.01	(0.04)	0.01	(0.04)	0.01	(0.04)	0.02	(0.04)
Other Latinos	0.09	* (0.04)	0.09	* (0.04)	0.09	* (0.04)	0.08	* (0.04)
Chinese	0.07	* (0.03)	0.07	* (0.03)	0.07	* (0.03)	0.07	* (0.03)
Vietnamese	-0.01	(0.04)	-0.01	(0.03)	-0.01	(0.04)	0.00	(0.04)
Filipino	-0.01	(0.04)	-0.01	(0.04)	-0.01	(0.04)	-0.01	(0.04)
Other Asian	-0.03	(0.04)	-0.02	(0.04)	-0.02	(0.04)	-0.02	(0.04)
Need Factors								
Poor/Fair Self-rated mental health	-0.09	* (0.04)	-0.09	* (0.04)	-0.09	* (0.04)	-0.08	* (0.04)
Poor/Fair Self-rated physical health	0.01	(0.03)	0.01	(0.02)	0.02	(0.02)	0.01	(0.02)
Diagnosed chronic condition	0.04	* (0.02)	0.04	* (0.02)	0.04	* (0.02)	0.04	* (0.02)
Acculturation Factors								
Migration reason: to work	0.06	* (0.02)	0.06	* (0.02)	0.05	* (0.02)	0.06	* (0.03)
Migration reason: to join family	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)
Migration reason: medical care	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)
Proportion of Life in US	-0.07	(0.06)	-0.06	(0.06)	-0.07	(0.06)	-0.06	(0.06)
English Proficiency Poor/Fair	-0.04	+ (0.02)	-0.07	* (0.03)	-0.04	+ (0.02)	-0.04	(0.02)
Naturalized Citizen	0.05	+ (0.03)	0.05	+ (0.03)	0.04	+ (0.02)	0.11	** (0.04)
Visits to Country of Origin	0.03	(0.03)	0.03	(0.03)	0.09	* (0.03)	-0.13	*** (0.04)

Table 3.3b (continued)

	Model 3		Model 4		Model 5		Model 6	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors								
Education (years)	0.00	(0.003)	0.00	(0.003)	0.00	(0.003)	0.03	(0.03)
Financial strain	-0.05	*(0.02)	-0.05	** (0.02)	-0.05	*(0.02)	-0.05	*(0.02)
Private Insurance (reference)								
Public Insurance	0.03	(0.02)	0.03	(0.02)	0.03	(0.02)	0.02	(0.02)
No Insurance	-0.24	*** (0.04)	-0.24	*** (0.04)	-0.24	*(0.04)	-0.25	*** (0.04)
Number of past barriers to medical care	0.02	*** (0.01)	0.02	*** (0.01)	0.02	** (0.01)	0.02	*** (0.01)
Relative Support	0.00	(0.004)	0.00	(0.004)	0.00	*** (0.004)	0.00	(0.004)
Friend Support	0.01	+ (0.004)	0.01	+ (0.003)	0.01	*** (0.003)	0.01	*(0.004)
Household Gender Relations								
Decision Making	0.00	(0.01)	0.00	(0.01)	0.00	** (0.01)	0.00	(0.01)
Economic Responsibilities	0.01	(0.01)	0.01	(0.01)	0.01	** (0.01)	0.01	(0.01)
Household Chores	-0.02	(0.01)	-0.02	(0.01)	-0.02	** (0.01)	-0.02	(0.01)
Female Employment	0.01	(0.02)	0.01	(0.02)	0.01	*(0.02)	0.01	(0.02)
Children under 18	0.04	(0.03)	0.04	(0.03)	0.04	*(0.03)	0.04	(0.03)
Household size	0.00	(0.01)	0.00	(0.01)	0.00	** (0.01)	0.00	(0.01)
Family Cultural Conflict	0.02	*** (0.01)	0.02	*** (0.01)	0.02	** (0.01)	0.02	*** (0.01)
Partner Emotional Strain	-0.01	(0.02)	-0.01	(0.02)	-0.01	*(0.02)	-0.01	(0.02)
Partner Emotional Support	-0.04	(0.04)	-0.04	(0.04)	-0.04	*(0.04)	-0.04	(0.04)
Interactions: Gender & Migration/Acculturation								
Female*Migration reason: work								
Female*Migration reason: to join family								
Female*Migration reason: medical								
Female*Proportion Life in US								
Female*Poor English Proficiency			0.07	*(0.03)				
Female*Naturalized Citizen								
Female*Visits to Country of Origin					-0.12	** (0.04)	-0.13	*** (0.04)
N	2,195		2,195		2,195		2,195	
R-Squared	0.2621		0.2639		0.2679		0.289	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Figures 3.3–3.5. Predicted Probabilities of Having Used a Medical Service within the last 12 months by Gender and Acculturation Factors

Figure 3.3 Poor/Fair English Proficiency

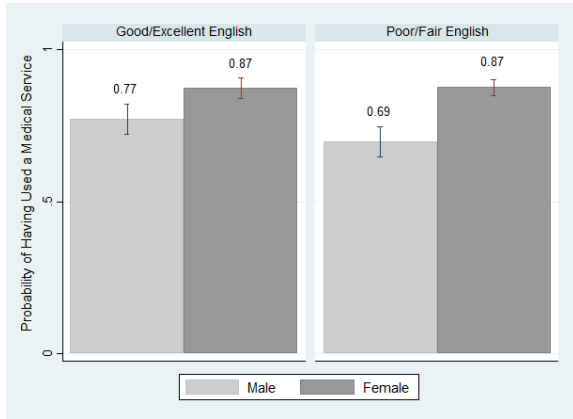


Figure 3.4 Being a Naturalized Citizen

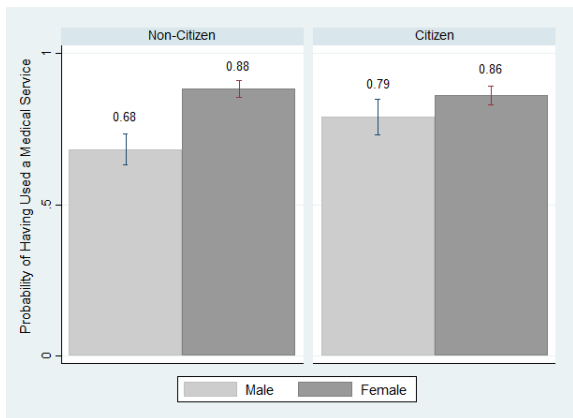
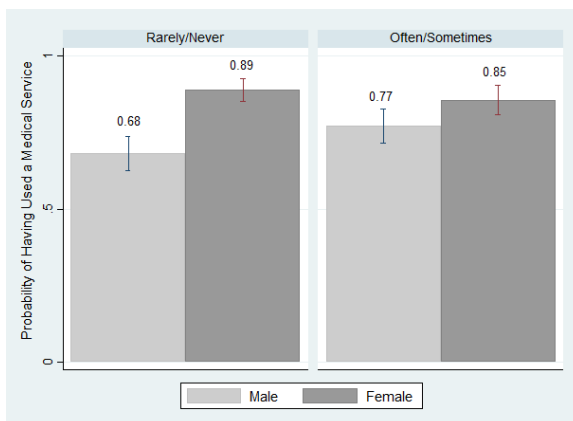


Figure 3.5 Frequent Visits to the Country of Origin



Models 4, 5 and 6 show interactions with gender and poor/fair English proficiency, gender and being a naturalized U.S. citizen, and gender and frequent visits to the country of origin. Model 4 shows that poor/fair English proficiency the significant negative effect on realized access to healthcare is modified by gender. Figure 3.3 shows that men's access to healthcare is more affected by English proficiency than women. Men with poor/fair English predicted probability of healthcare access is 0.08 less than men with good/excellent English proficiency. Among women, their access is higher than men but not affected by English proficiency. This finding is contrary to much of the literature which find that English language proficiency has more of an effect on women's health behaviors and access to healthcare (Read and Smith 2017).

Model 5 shows that the positive effect of being a naturalized U.S. citizen on realized access is modified by gender. Figure 3.4 illustrates that women's higher probability of using medical services remains constant with naturalization, while among men, being a naturalized citizen, significantly increases the predicted probability of using medical services by 0.11 compared to men who are not naturalized. Clearly, the effect of naturalization depends on gender.

Model 6 shows that the effect of frequent visits to the country of origin number on having used a medical service, and has an opposing gender effect. Figure 3.5 illustrates that with frequent visits, men increased their predicted probability of having used a medical service by 0.09, compared to men who did not make frequent transnational visits, while women who made frequent visits experienced a decrease in access by 0.04 compared to women who did not make frequent visits to the home country.

Additional analysis with all gender and acculturation factors included in the model, not shown, find that the moderating effects of gender on being a naturalized U.S. citizen and frequent visits to the country of origin remain statistically significant on using medical services within the last 12 months.

Tables 3.4a and 3.4b present results from multivariate negative binomial probability models on the number of visits to medical services within the last 12 months, a measure of realized access to healthcare. The coefficients in the tables represent the change in the natural log (ln) of expected number of medical visits within the last 12 months for a one-unit change in the predicted independent variable. The exponential form of the coefficient is reported in the findings.

As with the other healthcare access outcomes, being female was associated with a positive effect on healthcare access. Model 1 shows that being female, relative to men, is associated with having more medical visits by a factor of 1.55 ($e^{.44}$). Compared with Mexicans, all other immigrant groups have higher predicted number of visits to medical services. These racial and ethnic differences diminish in the full model. As expected, having poor/fair self-rated physical health and having a previously diagnosed chronic medical condition significantly increases the number of medical visits.

Acculturation measures are added in Model 2 and only migration reasons related to work have a significant effect. Immigrants who reported migrating for work as very important is associated with a reduction in the number of medical visits by a factor of 0.86 ($e^{-.15}$) compared to those who stated migrating for work was somewhat important or not important at all. The effect of measures of incorporation and maintaining transnational ties are not statistically significant.

Table 3.4a Multivariate Negative Binomial Models
Effects of Acculturation on the Number of Medical Visits within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.44	*** (0.09)	0.44	*** (0.08)	0.46	*** (0.08)
Age (years)	-0.003	(0.003)	-0.003	(0.002)	-0.003	(0.002)
Mexicans (reference)						
Puerto Ricans	0.36	(0.25)	0.30	(0.21)	0.14	(0.21)
Cubans	0.22	* (0.1)	0.15	(0.12)	0.03	(0.11)
Other Latinos	0.30	*** (0.1)	0.26	** (0.1)	0.19	+ (0.1)
Chinese	0.56	*** (0.14)	0.50	*** (0.16)	0.31	* (0.13)
Vietnamese	0.30	*** (0.1)	0.23	(0.14)	0.04	(0.12)
Filipino	0.16	(0.13)	0.11	(0.17)	-0.01	(0.15)
Other Asian	0.32	*** (0.1)	0.22	+ (0.12)	-0.02	(0.1)
Need Factors						
Poor/Fair Self-rated mental health	-0.17	(0.15)	-0.14	(0.16)	-0.11	(0.16)
Poor/Fair Self-rated physical health	0.16	+ (0.09)	0.19	* (0.08)	0.16	* (0.07)
Diagnosed chronic condition	0.42	*** (0.11)	0.41	*** (0.11)	0.34	*** (0.09)
Acculturation Factors						
Migration reason: to work			-0.15	* (0.07)	-0.09	(0.07)
Migration reason: to join family			-0.01	(0.07)	-0.09	(0.06)
Migration reason: medical care			0.07	(0.13)	0.02	(0.13)
Proportion of Life in US			0.17	(0.24)	0.003	(0.19)
English Proficiency Poor/Fair			-0.09	(0.09)	-0.01	(0.09)
Naturalized Citizen			0.11	(0.1)	0.10	(0.09)
Visits to Country of Origin			-0.01	(0.06)	-0.04	(0.06)

Table 3.4a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)					0.02	(0.01)
Financial strain					-0.07	(0.08)
Private Insurance (reference)						
Public Insurance					0.24	(0.1)
No Insurance					-0.45	(0.15)
Number of past barriers to medical care					0.08	(0.03)
Relative Support					0.02	(0.01)
Friend Support					-0.02	(0.02)
Household Gender Relations						
Decision Making					-0.03	(0.04)
Economic Responsibilities					-0.02	(0.03)
Household Chores					-0.03	(0.03)
Female Employment					-0.09	(0.08)
Children under 18					0.31	(0.11)
Household size					-0.05	(0.03)
Family Cultural Conflict					0.03	(0.02)
Partner Emotional Strain					0.10	(0.08)
Partner Emotional Support					-0.33	(0.09)
Intercept	0.46		0.58		0.59	
Dispersion Parameter	0.83	0.10	0.82	0.18	0.73	0.39

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

**Table 3.4b Multivariate Negative Binomial Models
Effects of Acculturation on the Number of Medical Visits within the last 12 months
among Married/Cohabiting Immigrants**

Variable	Model 3		Model 4	
	Estimate	SE	Estimate	SE
Predisposing Factors				
Female	0.46	*** (0.08)	0.59	*** (0.1)
Age (years)	0.00	(0.002)	0.00	(0.002)
Mexicans (reference)				
Puerto Ricans	0.14	(0.21)	0.17	(0.22)
Cubans	0.03	(0.11)	0.04	(0.11)
Other Latinos	0.19	+ (0.1)	0.18	+ (0.1)
Chinese	0.31	* (0.13)	0.32	* (0.13)
Vietnamese	0.04	(0.12)	0.06	(0.12)
Filipino	-0.01	(0.15)	0.00	(0.15)
Other Asian	-0.02	(0.1)	-0.01	(0.1)
Need Factors				
Poor/Fair Self-rated mental health	-0.11	(0.16)	-0.09	(0.16)
Poor/Fair Self-rated physical health	0.16	* (0.07)	0.16	* (0.07)
Diagnosed chronic condition	0.34	*** (0.09)	0.34	*** (0.09)
Acculturation Factors				
Migration reason: to work	-0.09	(0.07)	-0.09	(0.07)
Migration reason: to join family	-0.09	(0.06)	-0.09	(0.06)
Migration reason: medical care	0.02	(0.13)	0.02	(0.12)
Proportion of Life in US	0.00	(0.19)	0.00	(0.19)
English Proficiency Poor/Fair	-0.01	(0.09)	-0.01	(0.09)
Naturalized Citizen	0.10	(0.09)	0.27	* (0.11)
Visits to Country of Origin	-0.04	(0.06)	-0.04	(0.06)

Table 3.4b (continued)

	Model 3		Model 4	
	Estimate	SE	Estimate	SE
Enabling Factors				
Education (years)	0.02	(0.01)	0.02	(0.01)
Financial strain	-0.07	(0.08)	-0.07	(0.08)
Private Insurance (reference)				
Public Insurance	0.24	(0.1)	0.22	(0.09)
No Insurance	-0.45	(0.15)	-0.47	(0.15)
Number of past barriers to medical care	0.08	(0.03)	0.08	(0.03)
Relative Support	0.02	(0.01)	0.02	(0.01)
Friend Support	-0.02	(0.02)	-0.02	(0.02)
Household Gender Relations				
Decision Making	-0.03	(0.04)	-0.03	(0.04)
Economic Responsibilities	-0.02	(0.03)	-0.01	(0.03)
Household Chores	-0.03	(0.03)	-0.02	(0.03)
Female Employment	-0.09	(0.08)	-0.09	(0.08)
Children under 18	0.31	(0.11)	0.32	(0.11)
Household Size	-0.05	(0.03)	-0.05	(0.03)
Family Cultural Conflict	0.03	(0.02)	0.03	(0.01)
Partner Emotional Strain	0.10	(0.08)	0.10	(0.08)
Partner Emotional Support	-0.33	(0.09)	-0.34	(0.09)
Interactions: Gender & Migration/Acculturation				
Female*Migration reason: work				
Female*Migration reason: to join family				
Female*Migration reason: medical				
Female*Proportion Life in US				
Female*Poor English Proficiency				
Female*Naturalized Citizen				
Female*Visits to Country of Origin				
Intercept	0.59	0.39	0.53	0.40
Dispersion Parameter	0.73		0.72	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

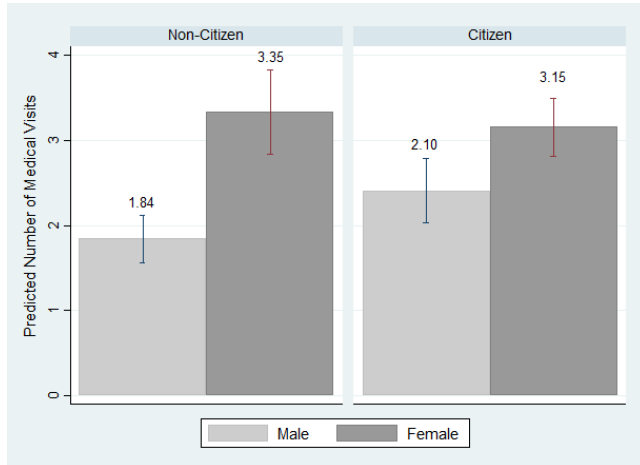
When enabling factors and dimensions of household gender relations variables are added in Model 3, no acculturation factors have a significant effect on the number of medical visits. Among the enabling factors, years of education, having public insurance compared with private insurance, and experiencing past barriers to medical care significantly increased the number of medical visits. As expected, having no insurance, compared to having private insurance, significantly reduced the number of medical visits by a factor of 0.64. Emotional household gender relations continue to have an effect on the number of visits. Having children and experiencing family cultural conflict, an acculturation-related household measure, increase the number of medical visits. Experiencing partner support has a strong significant negative relationship with realized access, with those experiencing partner support reducing their number of medical visits by 28% ($1 - e^{-.33}$).

Model 4 shows that the significant effect on being a naturalized U.S. citizen on the number of medical visits differs for men and women. Figure 3.6 illustrates a similar pattern found in having used a medical service where women's higher predicted number of medical visits is slightly reduced by 0.18 visits with naturalization, while naturalization among men significantly increases the predicted number of visits by 0.56 visits

Additional analysis with all gender and migration and acculturation interactions included in the model, not shown, find that the moderating effects of gender on being a naturalized U.S. citizen remain statistically significant on the number of medical visits within the last 12 months.

Figures 3.6 Predicted Expected Number of Medical Visits within the last 12 months by Gender and Acculturation Factors

Figure 3.6 Being a Naturalized Citizen



CONCLUSION and DISCUSSION

The findings show that three dimensions of acculturation had an association with access to healthcare. Migrating for work, increasing proportion of life in the U.S., being a naturalized U.S. citizen, having good/excellent English proficiency, and frequent visits to the country of origin had a significant positive effect on access to healthcare. However, there was no evidence to support the hypothesis of gender moderating the relationship between reasons for migration and access to healthcare (H1).

As hypothesized, the findings showed that gender modified the relationship between measures of incorporation (H2), maintaining transnational ties to the country of origin (H3) and access to healthcare, but in some unexpected ways. Citizenship status and frequent visits to the country of origin had a much larger positive effect on access to healthcare among men compared to women. This pattern is consistent across two access outcomes. Unexpectedly, poor/fair

English proficiency had a more negative effect on use of medical services among men compared to women. This contrasts with much of the literature on access or healthcare where immigrant women's access to healthcare are found to be more affected by language barriers.

There was also some evidence that women's access to having a usual medical provider for care was more positively associated with an increase in proportion of life in the U.S. compared with men. This was only found in the potential access outcome and this measure of incorporation related to duration did not have any association with realized access outcomes.

Overall, the findings on the relationship between gender, acculturation and immigrant access to healthcare highlight that access to healthcare among married/cohabitating immigrant men largely reflects their responsiveness to institutional and community level acculturation factors. The positive effect of citizenship status and frequent visits to the country of origin on immigrant men's likelihood of accessing healthcare indicates forms of social privilege and status, and attachment to status enhancing institutions were more salient for immigrant men's access to healthcare.

In contrast, women's higher level of access was only slightly affected by measures of acculturation at the institutional level. Instead, acculturation-related factors occurring in the household and family, like family cultural conflict, had a positive effect on access to healthcare for immigrant women, as well as men.

The findings on household gender relations also reflect more egalitarian relations along multiple dimensions. This contrasts to the assumptions of the traditional-modern gender paradigm used in much of the health literature. More details and examination of household gender relations is found in Chapter Five.

Both naturalization and transnationalism are gendered practices that reinforce social identity, status and privileges. While naturalization, a marker of incorporation, and making frequent visits to the country of origin, a marker of maintaining transnational ties, may seem to be at odds, these two measures of acculturation often occur concurrently and have much in common. Multiple studies have found that participation in transnational practices do not negatively effect the process of incorporation, nor does naturalization entirely erode interest in cultural, politics or identity in the country or origin (DeSipio 2006; Itzigsohn and Giorguli-Saucedo 2005; Roger Waldinger and Lauren Duquette-Rury 2016). Both processes constitute real and aspirational forms of privilege, identity and status that are affirmed by community and societal institutions.

Acculturation-related processes of migration, incorporation and transnationalism are highly gendered, where men and women perceive, live and respond differently to leaving their home country, being in the country of destination, and being part of both countries. While there few gender differences in rates of naturalization, the social identities, legal rights, institutional attachments and group membership associated with citizenship often embody different meanings for men and women.

Frequent visits to the country of origin indicate maintenance of social ties to relatives, friends and community, as well as the maintenance of a social identity and social status within the country origin. Having the time and resources to visit frequently and engage in transnational activities often elevates an immigrant's status and privilege, which has a larger effect on men's status (Itzigsohn and Giorguli-Saucedo 2005; Portes 2006). Moreover, frequent transnational trips also increase healthcare options that are more culturally and linguistically congruent and affordable (Fernández-Kelly and Portes 2012). This study did not specify the country where

healthcare access occurred. There may be some respondents, although a small proportion, who make frequent trips to their country of origin also utilized healthcare there.

The literature has found that immigrant men, especially married men, tend to make more frequent transnational trips and are more invested in maintaining public and institutional transnational ties than women. This has been found among immigrants from Mexico, as well Puerto Rico, Dominican Republic, India and Hong Kong (DeSipio 2006; Itzigsohn and Giorguli-Saucedo 2005; Ley 2013; Portes 2006). Women are much more likely to be affirmed by maintaining ties with close family in both countries and focused on participating in life in the country of destination (Itzigsohn and Giorguli-Saucedo 2005; Portes 2006).

With the relative loss in social status, a possible threat to gender identity, immigrant men may be looking towards their country of origin to reinforce or regain their masculinity, cultural and socioeconomic status and privileges that are limited in the destination country. The same can be said with naturalization, men who experience positive experiences and opportunities to incorporate into the country of destination will want to exercise and secure their rights and privileges through naturalization (DeSipio 2006; Itzigsohn and Giorguli-Saucedo 2005; Roger Waldinger and Lauren Duquette-Rury 2016).

Men's responsiveness to institutions in both countries of origin and destination indicates that it is not that immigrant men do not want to go to the doctor, but that healthcare systems have not been proactive in identifying *in what ways* immigrant men visit the doctor and under what circumstances. The findings in this study also affirm the importance of conceptualizing healthcare as a domain of incorporation instead of just a flexible resource. This widens the role of healthcare and the motivations of help-seeking to reflect immigrant needs for affirming pathways to engage with societal institutions like the healthcare system. Moreover, the gendered

experiences not only reflect that immigrant men's and women's experience with healthcare are different but that their interactions between cultural and gender status, social networks, healthcare providers, and societal institutions, that inform their likelihood to seek help through medical services, are different and dynamic (Annandale et al. 2007).

It is important to remember that despite immigrant women's higher rates of healthcare access compared to immigrant men, immigrants, in general, have lower rates of access compared with the U.S. born. This means that interventions to increase women's healthcare access are also important, and should be focused on women's responsiveness to family relations and networks, and the importance of linking healthcare as one of the support systems that women can use to improve their health and well-being.

Limitations

The findings in this study should be considered with some limitations. First, the cross-sectional nature of the NLAAS dataset limits the ability to address issues of causality. Although the Andersen model suggests that specific factors contribute to healthcare access, less has been studied on the relationship between acculturation and household gender relations on access to healthcare.

Second, the data is from 2002 to 2003. It is unclear to what extent these findings would generalize to the present time. NLAAS is the only nationally representative dataset with large samples of Latino and Asian immigrants that includes the key variables on multiple healthcare access outcomes and multi-dimensional measures of acculturation and household gender

relations. Research on more recent data and longitudinal data would be important to replicate and extend this analysis.

Third, the generalizability of the findings to the present time is especially relevant after the implementation of the Affordable Care Act (ACA) made significant changes to the U.S. healthcare system. The ACA increased, mainly through socioeconomic mechanisms related to health insurance and the expansion of the healthcare safety net, potential and realized access for the entire country, including immigrants. However, the ACA did not change many of the legal restrictions placed on immigrant access to healthcare. Undocumented immigrants continue to be ineligible for any form of federal subsidy or program for health insurance coverage, and must continue to rely on the local and state based safety net that varies considerable by county and state. Moreover, recent documented immigrants must still wait for five years to receive any form of public assistance such as Medicaid, and still risk being labeled a public charge that would jeopardize their eligibility for further services and their application for citizenship. Thus, ACA would affect many of the socioeconomic enabling factors such as insurance for some, but not all immigrants, but not the acculturation related factors linked to legal status such as the association with citizenship, maintaining ties with the country of origin and English proficiency.

Given the increased legal stratification among immigrants in relation to access to health insurance, many of the effects of this study may be considered conservative among undocumented and recent immigrants who make up a larger proportion of the uninsured post-ACA than pre-ACA. Given immigrant men's elasticity in relation to institutional factors, they decreasing options for health insurance may more negatively affect their willingness to seek help and ability to access healthcare

Men's responsiveness to institutions underscores the importance of constructing policy and program interventions related to increasing healthcare access to address important markers of social identity, attachment and belonging, and role and status within their own community in the U.S. Moreover, compliance with language access laws is still paramount in ensuring access to healthcare for all immigrants. Language access for Mexicans is especially important because despite being the largest immigrant group with multiple generations living in established enclaves and Spanish-language media, Mexicans continue to have lower levels of healthcare access, lower levels of English proficiency and lower levels of naturalization compared with other immigrant groups (Passel 2007). It is important to emphasize that the results in this study point to the importance of language access compliance not only occurring within the exam room between the patient and provider, but as a clear marker of institutional identity between the local clinic or healthcare plan and the immigrant community.

In conclusion, this study provides preliminary evidence on the effect of multi-dimensional measures of gender and acculturation on immigrant access to healthcare. The findings address determinants of gender inequalities in accessing healthcare to point to important gender-informed policy and program interventions that aim to increase immigrant access to healthcare.

CHAPTER FOUR

WOMEN GO TO THEIR FAMILY, and MEN GO TO THEIR COMMUNITY: GENDER and IMMIGRANT ROUTES TO HEALTHCARE

The literature on access to healthcare is extensive and uses various methods and interdisciplinary approaches to address practice, policy and theoretical aims to increase equitable access to healthcare. Evidence on the inequalities in healthcare access across race and ethnicity, immigrant status and gender are becoming well established (Akresh 2009a; Derose et al. 2007b; Galdas et al. 2007; Kuhlmann and Annandale 2016; Pitkin Derose et al. 2009; Yang and Hwang 2016), but only recently have there been studies that have examined gender and immigration together as intersecting statuses that affect access to healthcare (Gorman et al. 2016; Read and Smith 2017). Moreover, recent studies have found that access to healthcare plays a key mediating role in the health gap between immigrants and non-immigrants, recent and established immigrants, and men and women (Gorman et al. 2014; Read and Reynolds 2012). These findings across multiple populations highlight access to healthcare as an important issue for further examination, especially as is it contributes to immigrant and gender health inequities.

Access to healthcare is a multi-dimensional concept used to define a broad set of determinants that center on the degree to which individuals and groups are able to utilize services from the medical system in a timely manner that maximizes their opportunity to achieve the best possible health outcomes. Access is defined in multiple ways. Potential access includes factors that increase the likelihood of use of primary healthcare such as having a usual place for care. Potential access also can include factors that enable or impede access to care such as health insurance coverage. Realized access refers to utilization of medical services and the frequency of use (Services and Millman 1993). More recent developments have also included whether

potential or realized access is equitable, effective or efficient. These outcomes move away from solely addressing the individual-level behaviors and motivations in help-seeking, to addressing the systematic and institutional gaps in access that contribute to existing social and health inequalities (Andersen et al. 2014).

The Andersen model (1968, 1995) identifies three domains that determine healthcare access: predisposing, enabling and need, and occur at the individual level or arise from interactions with healthcare institutions and within contexts (Andersen et al. 2014). Financial, legal, social, emotional or environmental factors that enable or impede access to healthcare play an important role in understanding the causes of health disparities, but there remains limited research examining the gender and immigrant-specific enabling factors that may differentially shape healthcare access for immigrant men and women.

A considerable amount of literature has focused on socioeconomic and financial factors, especially in the U.S. when healthcare coverage is not universal, the cost of medical care continues to increase, and access to affordable health insurance is tenuous. The importance of socioeconomic factors is also supported by theories of health inequalities which posit that access to and capacity to purposefully use flexible resources is a key mechanism to decrease health vulnerability and minimize negative health consequences. With a strong emphasis on socioeconomic status as a fundamental cause of health, Link and Phelan (1995) posit that the relationship between access to flexible resources and capacity to use them is what continues to drive inequities in health despite significant medical and social advances (Adler et al. 1994; Link and Phelan 1995; Wilkinson 1997).

The importance of socioeconomic enabling factors is supported by studies of gender and access to healthcare. In a study among Asians and Latinos, health insurance was found to

mediate a larger proportion of gender differences in accessing routine care than other predisposing or need-based characteristics (Gorman et al. 2016). Studies on immigrants have found more variation, with acculturation-related enabling factors, like English proficiency, having large effect on gender differences in some ethnic groups than others (Howe Hasanali, De Jong, and Graefe 2016; Read and Smith 2017). With a strong theoretical and empirical support for socioeconomic enabling resources, few studies on immigrants have focused on examining a broader range of enabling factors that may produce differing responses from immigrant men and women. To address the question, “How do enabling factors differentially facilitate or hinder immigrant men’s and women’s help-seeking behaviors via the healthcare system?”, I identify three types of enabling factors that have gender and immigrant implications for access to healthcare: socioeconomic-legal resources; institutional barriers; and social network support

Socioeconomic-legal resources

Healthcare insurance is the principal means in which to obtain medical services, and is a consistent predictor of healthcare utilization and contributor to health inequalities (Kominski 2014). For the U.S. born population, access to health insurance largely reflects socioeconomic status because eligibility and subsidies are based on employment status and income level. For immigrants, access to health insurance is also contingent on their legal status upon entry and the subsequent changes in legal status during their settlement in the U.S. Among immigrants, having health insurance has been found to be more consistently associated with realized use than income given resident duration and other restrictions (Ku and Matani 2001; Yang and Hwang 2016).

In the U.S., health insurance is obtained through private (i.e. full-time employment, open market) and public (i.e. state, federal) mechanisms. Insurance coverage is both individual and family based with most types of insurance coverage extending to qualified dependents (spouse or children) and public coverage based on a function of income level and family status (number of dependents). Because there is no universal coverage, a significant proportion of the U.S. population is uninsured on a consistent basis, or during lapses of unemployment, under employment (part-time status) or residential mobility. Before the enactment of the Affordable Care Act (ACA) in 2014, the uninsured rate hovered at around 16% of the non-elderly population or approximately 44 million people. Even with expanded coverage under the ACA, 9% or 28 million people remain uninsured to this day (Kaiser Family Foundation 2017a).

Pre- and post-ACA, immigrants are disproportionately represented among the uninsured because of socioeconomic and legal barriers. Undocumented immigrants remain ineligible for any private or federal public coverage regardless of income or poverty status. Among documented immigrants who have not naturalized as citizens, only those who have passed a five year waiting period after receiving a qualified immigration status can be eligible for federal public assistance (Hacker et al. 2015; Pitkin Derose et al. 2009). While the ACA has brought more socioeconomic relief in making health insurance more accessible for the population, both immigrant and U.S. born, the ACA did not relax any legal restrictions. The effect is increased stratification based on immigrant and legal status, especially among undocumented immigrants who continue to be made categorically unequal in accessing health insurance and care. The only option for healthcare for undocumented immigrants is the local safety net services that vary considerably by zip code, county and state.

The combination of legal and socioeconomic restrictions, further exacerbate inequalities and isolate immigrant families, many of which include individuals with mixed immigration status, and may include documented immigrants, undocumented immigrants, and/or citizens within one family. To date, over 12 million children, most of which are U.S. born citizens, live with a noncitizen parent (Kaiser Family Foundation 2017a). This highlights for immigrants and their families, insurance coverage is not confined to financial or employment based socioeconomic resources, but is also intertwined with legal statuses that impact individual and family access to healthcare.

Gender also interacts with the ability to obtain health insurance because of the strong association between gender, socioeconomic status, and legal status. Men are often advantaged for employer-based private health insurance compared with women because of their higher likelihood for having more skills and work in formal professional industries, more full-time employment, and higher wages. This gives them more access to employer and private market health insurance options, whereas women are more likely to obtain health insurance as a dependent from their spouse's insurance plan. Even among immigrants from nations with high rates of female migration flows for work in various service sectors (i.e. nursing, domestic labor, manufacturing), women may not necessarily exceed men in private health insurance coverage because of their employment in more informal sectors (i.e. domestic work) and in industries that seldom offer full time employment (i.e. service) (Donato et al. 2008; George 2005; Parrenas 2002).

Moreover, among documented immigrants, women are more likely to arrive in the U.S. under spousal visas which may restrict their ability to work, stay in the country, or obtain private health insurance independent of their spouses. In contrast, public health insurance and social

safety net programs are more likely to outreach to women's health needs and family roles, which increase women's likelihood of obtaining public forms of health insurance (Bird and Rieker 2008; Ku and Matani 2001).

Social Support and Social Capital Resources

Co-ethnic immigrant communities and their institutions provide immigrants resources, refuge and respectability (Hirschman 2004) to settle and set on a pathway towards full incorporation into society. Immigrant networks and established enclaves have been found to be a strong protective factor against health and social risks by offering resources, advice and support with finding jobs, housing, education and healthcare, providing a refuge from unfair treatment and discrimination, and promoting cultural norms and practices. Immigrants who have networks who they can rely on for resources and support are more likely to access healthcare when their contacts referring them to trusted healthcare organizations and providers.

A mix of co-ethnic, family and neighborhood networks are vital for an immigrant's access to healthcare through the mechanisms of resource sharing, social support and other social capital benefits. There is evidence that the perception of social support is just as effective or more effective than realized support (Thoits 1995). Both men and women who have kin or close contacts in the U.S. on arrival are much more likely to benefit from established social capital and resources within immigrant and ethnic networks in which that find appropriate enabling resources such as insurance and a trusted place for care (Hondagneu-Sotelo 1994). Additional, social networks can act as both an encouraging force to seek healthcare and a source of advice

which may temporarily substitute for professional care, especially concerning emotional stressors.

Social networks are distinctly gendered which are reified through cultural norms and expectations (Menjívar 1997, 2000). These factors may put immigrant women at an advantage in gaining important and timely health information. Given women's overall likelihood of accessing care more than men, women's networks are more likely be comprised of women who have had more interaction with the healthcare system. Thus, women may be able to share and obtain more knowledge of trusted providers and how to navigate the healthcare system compared with men (Hondagneu-Sotelo 2000), although this may not be enough to overcome important barriers such as lack of health insurance or language interpretation.

Utilizing the benefits of marriage or cohabitation, women who immigrate after their husbands may have even more relative advantages, because they benefit from the accumulated knowledge, experience and contacts of their husbands, as well as their friend and family networks. Kossoudiji and Raney (1984) found that women who were able to use their husband's network contacts to secure better jobs than single women who had less close ties.

Having health insurance, a neighborhood clinic and access to safety net services are essential for access, but they are not enough to ensure immigrant access and encourage help-seeking. For immigrants, access to healthcare is more than just a flexible resource to improve health (Phelan et al. 2010), but is recognized, among immigrants, as a domain of societal importation they rely on to ease their settlement process, to develop a sense of belonging, and to build trust with government supported systems (Hacker et al. 2015). However, interaction with the healthcare system comes with as many risks such as poor treatment, discrimination and criminalization, as there are health and social benefits.

Many immigrant communities will not access health services if they do not trust the local health organizations and providers to provide quality culturally and linguistically competent care, and feel that they will not face discrimination when seeking help. Alternatively, immigrants may be accessing healthcare in other ways such as through private “bodega clinics” that can be found in some urban immigrant enclaves (Varney 2013), non-Western medicine providers and healers, or through the health system in their country of origin. These access points are not officially part of the healthcare safety net and not well regulated, but in the absence of trusted medical providers, their use may indicate a willingness to seek help.

Just as healthcare and immigration policies are intertwined, so are immigrants’ concerns regarding accessing healthcare are not just about the quality of medical care. In the effort to gauge their rights and entitlements to accessing societal institutions, immigrants must calculate their risk of seeing a doctor and giving personal information based on whether they trust the health providers, clinics and emergency rooms to not report them or share their health conditions to law or immigration enforcement. Trusted healthcare organizations are seen as advocating and being a refuge for immigrants on a wide range of challenges. To build the trust that encourages help-seeking, providers must provide quality care that includes culturally and linguistic appropriate services. Clinics and hospitals also must ensure immigrants that their medical information is confidential and will not be shared with other state agencies like immigration and law enforcement. Immigrants embedded in established social networks that pass on information about services and whether clinics are trustworthy places are more likely to access local health services.

Institutional barriers: Interactions with Healthcare Services

Healthcare access barriers play an important role in understanding the determinants of health inequalities. Barriers to healthcare can affect health outcomes by delaying access to medical services. Delayed care often results in late presentation of disease, decreased opportunities for prevention and screening, and decreased opportunities for care and treatment. The lower levels of access among immigrants compared to non-immigrants can be attributed to the compounding barriers of language discordance, cultural barriers and disproportionate experience of unfair treatment. However, language and cultural barriers are not the only institutional barriers that face immigrants. Given different immigrant and gender related enabling factors, responses to barriers can differ between immigrants and non-immigrants and between immigrant men and women (Carrillo et al. 2011; Kalich, Heinemann, and Ghahari 2016; Scheppers et al. 2006).

Barriers to healthcare include financial barriers such as health insurance, as well as the out-of-pocket costs such as co-pays, drugs and equipment; structural barriers such as access issues like waiting time, inability to getting an appointment through the phone, transportation, operating hours; and treatment issues like getting limited time with providers, not being able to get advice over the phone or prescription filled, lack of interpretation services and cultural competency. Knowledge and emotional barriers include lack of awareness of resources, level of health literacy, understanding the diagnosis and treatment, and fear of stigma and other negative consequences from seeking healthcare.

Because the healthcare system is more than a health resource for immigrants, barriers, even universally experienced ones like wait times, can be an additional burden for immigrants

that exacerbates other social, legal and economic constraints. Like most other populations, immigrants access healthcare when they are already vulnerable because of illness or injury, underscoring the need for affirming interactions that open up opportunities to build trust with societal institutions. These positive interactions also help to bridge potential access to healthcare (i.e. insurance, a regular place of care) and realized access (i.e. visits to a provider, having needs met) for acute, chronic and preventative health issues. When an immigrant gains access to healthcare, the interaction goes beyond individual level medical provision between a patient and the medical provider, it marks a community level relationship with a key government-supported service that entails both risk and relief.

While health providers and local organizations often uphold a humanist and moral orientation with the aim to help and heal (re: Hippocratic oath), U.S. healthcare policies that regulate the healthcare system and insurance often limit and actively exclude some immigrants from accessing healthcare. This creates a tension, or institutional ambivalence, which can erode overall immigrant trust in social service systems, divide families and communities among those who are deserving and non-deserving of healthcare, and to delay or block full incorporation into U.S. society (Light 2012). Under these tensions, seemingly universal barriers, like wait times, may result in more systematic marginalization.

Hypotheses

To assess the gendered effects of enabling factors on immigrant access to healthcare, this paper uses the theoretical framework discussed in detail in Chapter Two. The framework integrates three components: an individual-level model of healthcare use (Andersen 1995; Davidson et al. 2004); a contextual analysis of the household (Bird and Rieker 2008; Portes and

Rumbaut 2006; Portes and Zhou 1993); and a structural analysis of gender relations (Connell 2009) to comprehensively examine how the interaction between gender and household gender relations facilitate or constrain access to healthcare. Using this framework, I posit the following hypotheses:

H1: Socioeconomic-legal resources and social support networks are more likely to have a positive association with access to healthcare.

H2: Past experiences of barriers of healthcare are more likely to have a negative association with access to healthcare.

H3: Gender will moderate the relationship between socioeconomic-legal factors, barriers to healthcare and social support networks and access to healthcare. Socioeconomic-legal resources and past barriers to healthcare will more positively affect men's access to healthcare, and social support resources will more positively affect women's access to healthcare.

METHODS

Data and sample

The data used in this paper comes from the National Latino and Asian American Study (NLAAS), a nationally representative household cross-sectional sample of Latinos and Asian Americans (Alegria et al. 2004). NLAAS data was collected from May 2002 to November 2003 from adults from four Latino ethnic groups (Cuban, Mexican, Puerto Rican, and Other Latino), four Asian ethnic groups (Chinese, Filipino, Vietnamese and Other Asian), and a control group of non-Latino, non-Asian, white respondents. Interviews were conducted in Cantonese, English,

Mandarin, Spanish, Tagalog, and Vietnamese. The weighted response rate was 65.6% for the Asian sample (n= 2,095) and 75.5% for the Latino (n=2,554) sample. This paper uses the full sample of Asians and Latinos (n=4,649). The final sample for analysis comprises of individual adult respondents who identified as immigrant (foreign-born) and in a married or cohabitating relationship (n=2,324).

The NLAAS sampling method is comprised of three components: (1) core sampling where participants were recruited with a multistage stratified area probability sampling design; (2) high density sampling where Census block groups were oversampled in areas where ethnic groups were represented in at least 5% of households; (3) second-respondent sampling to recruit participants from households with one eligible respondent. The NLAAS sampling procedure required the construction of weighting corrections to take into account joint probabilities of selection under the three components of the sampling design (Alegria et al. 2004; Heeringa et al. 2004; Pennell et al. 2004). The NLAAS sampling design requires the construction of weighting corrections that adjust for the hierarchical nature of the multistage survey design. Analyses were done using the STATA 15 Statistical Software SVY program (StataCorp 2017), which takes into account complex survey sampling methods such as stratification, clustering and unequal weighting allows for weighting adjustments to account for the complex sampling design.

Measures

Dependent Variables

There are three dependent variables to distinguish between potential access and realized access to healthcare. Each outcome variable measures a distinct type of interaction with the healthcare system.

Has a Usual Healthcare Provider, (1=Yes, 0=No). Respondents were asked whether they had a usual provider for medical care.

This outcome of potential access measures the level of awareness of the healthcare system indicated by having a medical provider they could go to on a regular basis. Because of additional barriers to access faced by immigrants, such as availability of interpretation services and levels of cultural competency, immigrants who may have insurance to pay for services still may not have a usual place to go to for healthcare.

Use of Medical Services within the last 12 months, (1=Yes, 0=No). Respondents were asked whether they used any medical services within the last 12 months, including routine, dental/ophthalmologist, urgent or scheduled treatment or surgery.

This outcome of realized access measures the level of engagement with the healthcare system. Because it was not feasible to fully control for medical visits for reproductive needs among women, a broader measure of healthcare utilization was chosen over the more limited measure of use of routine or primary healthcare.

Number of visits within the last 12 months: Respondents were asked about the number of visits in the past 12 months to a general practitioner or other medical doctor

This outcome of realized access measures the frequency of utilization. There are no strict guidelines for frequency of healthcare utilization for the general age-adjusted population, but a yearly visit for routine or primary care for preventative reasons is a general recommendation by medical professionals. More than one medical visit within a year, after controlling for individuals with diagnosed chronic diseases, may indicate a higher exposure to conditions that affect acute mental and physical health such as stressors, infections, and injury.

Predisposing Factors

Gender, (1=Female, 0=Male).

Age, (years)

Ethnicity, (Asians: Chinese, Vietnamese, Filipino and Other Asian; Latinos: Mexicans, Puerto Ricans, Cubans and Other Latinos)

Need Factors

Need factors include two self-rated health measures and one measure of diagnosed chronic condition. Assessment of need also considers past diagnosed conditions given the tendency to over-estimate health in self-rated measures among groups who have the least access to healthcare such as immigrant men and recent immigrants.

Poor self-rated physical and mental health, (1=Poor/Fair, 0=Good/Excellent). Respondents were asked to rate their own physical and mental health on a four-point scale in separate questions.

This variable refers to whether a respondent answered poor or fair to either question.

Chronic disease diagnosis, (1=Yes, 0=No). This measure summarizes whether the respondent had at least one chronic disease diagnosis from a medical provider. Chronic diseases include heart disease, high blood pressure, asthma, chronic lung disease, diabetes, stomach or intestinal ulcer, epilepsy or seizures or cancer.

Acculturation Factors

Measures of acculturation reflect multiple processes of acculturation that include: 1) original migration decisions, 2) orientation towards the U.S.; and 3) transnational ties.

Reason for migration: job, to join family, or medical. Respondents were allowed to choose more than one response and rate how important the reason was for their decisions on a scale from 1 = very important to 3 = not very important. Responses were recoded into a dummy variable, 1 = somewhat/very important, and 0 = not important. Reasons for migration often shape the context for settlement (i.e. place, legal status) as well as level of health selectivity. Immigrants who migrate for work exhibit healthier behaviors and health statuses compared to immigrants who migrate for other reasons. This health selectivity associated with immigrants has been found to apply more to men than women because of migration reasons.

Proportion of life in the U.S. Calculated as current age minus age of migration divided by current age. The amount of time spent in the U.S. was calculated in relation to the respondent's age and age at immigration. This contrasts to studies that use measures of years in the U.S. (duration). Evidence suggests that the age of immigration is also relevant to understanding cultural change and societal incorporation. A variable measuring the proportion of life in the U.S has been used in previous studies (De Leersnyder et al. 2011; Leu et al. 2011).

Poor/Fair English proficiency. English proficiency has been found to have a significant effect on healthcare access across racial and ethnic groups and gender. Respondents were asked three questions to rate their ability to read, write, and speak English on a four-point scale ($\alpha = 0.97$) Responses ranging from poor to excellent in English proficiency, were recoded into a dichotomous variable (1 = poor/fair, 0 = good/excellent).

Citizenship status, (1 = naturalized U.S. citizen, 0 = not a U.S. citizen). Respondents were asked whether they have naturalized as U.S. citizens. It is also a measure of more established immigrants that indicate a shift in social identity towards the U.S. as well as being able to take advantage of specific rights and privileges. Citizens have more legal access to services and are

also less inhibited in using public services because they are much less likely to fear being labeled a public charge (Gee et al. 2016).

Frequent visits to country of origin. Respondents were asked about their frequency in which they return to their country of origin, 1=often, 2= sometime, 3= rarely, 4=never. This variable was recoded into 1=often/sometimes, 0= rarely/never. The frequency of return visits to the country of origin indicates the maintenance of transnational ties well as additional opportunities to access healthcare that is more affordable or culturally and linguistically congruent.

Enabling Factors

Three types of factors that enable or inhibit access to healthcare are measured: socioeconomic-legal resources, past experiences of access or treatment barriers to healthcare, and types of social network support.

Education (in years)

Financial strain, (1=Yes, 0=No). Respondents were asked if they were having any difficulty in paying monthly bills.

Type of health insurance (private, public, no insurance). Health insurance is a vital resource that people gain through their employer, the state, or open market. For immigrants, health insurance is a socioeconomic-legal resource where employment status, income, legal status and duration in the U.S. determines whether a person is eligible for insurance (see Chapter Three for more details). Dummy variables were constructed on three types of insurance, private, public and none.

Number of Past Barriers to Healthcare. Respondents were asked if they experienced any past access or treatment barriers to healthcare within the last 12 months. Barriers included experiences with difficulty in getting an appointment by phone and referral to a specialist, experiences of a provider spending limited time with them during an appointment, long waits in clinic, difficulty in getting advice over the phone, not being able to get an assigned clinic, not able to get prescription to medication, and not receiving continuity of care.

Social support is an important contributor to better health and well-being. For healthcare access, supportive networks among friends and relatives can complement support received from a spouse/partner, and can affect access in both directions. Support networks are important sources of information, resources, emotional care that can encourage seeking healthcare or be a substitute for healthcare services (i.e. mental health counseling)

Relative Support, (scale, 3-13). Respondents were asked three questions and rate their frequency of contact and levels of support with family or relatives (not including spouse/partner/children) on a 4-point scale with 1=a lot to 4=not at all. Questions included, “How often do you talk on the phone or get together with family or relatives who do not live with you?” “How much can you rely on your relatives who do not live with you for help if you need to talk to someone about your worries?” “How much can you open up to relatives who do not live with you if you need to talk to someone about your worries?”

Responses were recoded into a binary variable with 1=a lot/some 0=a little/not at all.

Friend Support, (scale, 5-15). Similar questions were asked about level of support with friends.

Household Gender Relations variables capture three dimensions of power, production and emotion.

Gender relations of power is measured using two variables on *decision making* and *economic responsibility* measured on a 5 point scale.

Decision making, (scale 1-5). Respondents were asked, “When it comes to making major decisions, who has the final say, you or your spouse?” 1=Respondent, 2=Both, 3=Spouse/Partner. This questions was followed up with asking:

Do you/your partner have 1=a lot more say, 2= somewhat, or 3 a little say than you/your partner?

The variable was recoded with the gender of the respondent and the responses to the scaled questions with 3 = equalitarian share of decision making, and 1 and 5 reflecting an asymmetrical share of decision making, with 1 = female spouse/partner having a lot more say, and 5 = male spouse/partner having a lot more say.

Economic responsibilities, (scale 1-5). Respondents were asked, “When it comes to paying for household expenses – like mortgage or rent, electricity bills, who has the most responsibility?”

This variable was recoded like the decision making variable, where responses were coded with gender of the respondent and a 1-5 point scale was constructed with 3 = egalitarian share of economic responsibilities, 1 = female spouse/partner having most of the economic responsibilities, and 5 = male spouse/partner spouse/partner male spouse/partner having most of the economic responsibilities.

Gender relations of production is measured using two variables on *female household employment* and *household chores*.

Female household employment, (1=Yes, 0=No). Female household employment was coded from the sex of the respondent and their answer to questions on the employment status of themselves and their spouse/partner. This variable was coded to include any combination where the female in the household was employed (dual employed households or female sole employed households). This include part time and full time employment.

For *household chores*, (scale 1-5). A similar scale and coding for decision making and economic responsibilities variables was used. Respondents were asked. “When it comes to household chores – like cooking, cleaning, childcare, grocery shopping, who has the most responsibility?”

Gender relations of emotion is measured using four variables that capture different levels of spouse/partner, child and family dynamics of emotional support, strain that are related to help-seeking and caregiving behaviors that affect access to healthcare.

Partner support, (1=Yes, 0=No). Respondents were asked four questions on the level of emotional support they receive from their spouse/partner. “How much does your spouse/partner really care about you?” “How much does your spouse/partner understand the way you feel about things?” “How much can you rely on your spouse/partner for help if you have a serious problem?” “How much can you open up to your spouse/partner if you need to talk about your worries?” Responses ranged from 1 (not at all) to 4 (a lot). The scale ranged from 4 – 16 with increasing numbers indicating more support, and recoded into a binary variable with scores more than 8 indicating support =1 , and score 8 or less indicating no support = 0.

Partner strain, (1=Yes, 0=No) was measured and coded in the similar way as partner support. Questions included “How often does your spouse/partner make too many demands on you?” “How often does your spouse/partner criticize you? “How often does you spouses/partner let you

down when you are counting on him/her? How often does your spouse/partner get on your nerves? The scale ranged from 4 – 16 with increasing numbers indicating more support, and recoded into a dichotomous variable with scores more than 12 indicating strain =1, and scores 12 or less indicating no strain = 0.

To facilitate comparability, coding for the partner support and strain measures in the same way as other studies that have used the same dataset and variable.

Child under 18, (1=Yes, 0=No). This variable measures the need for caregiving within the family indicated by having one or more children living in household under the age of 18.

Number in Household. This variable measures the extent of caregiving needed in the family.

Family cultural conflict, (scale 5-15): To address immigrant specific family dynamics, I include an acculturation-related household variable that measures emotional strain at the family level, I use part of the Hispanic Stress Inventory (Cervantes et al. 2016, 1991), the scale includes items such as “You have felt that being too close to your family interfered with your own goals”, and “Because you have different customs, you have had arguments with other members of your family” “Because of lack of family unity, you have felt lonely and isolated. Responses ranged from 1 (hardly ever or never) to 3 (often), yielding a minimum and maximum sum score from 5-15 ($\alpha = .77$). Higher values indicate greater family cultural conflict.

Analytical Strategy

Table 4.1 provides descriptive statistics for the total sample, stratified by gender. Weighted percentage and means are reported along with results from chi-square tests to determine whether gender differences observed were statistically significant.

Tables 4.2a and 4.2b report the results from a series of linear probability models that focus on the relationship between enabling factors and having a usual provider for medical care. Estimates and standard errors are reported. The analysis is performed in four steps. Model 1 tests the relationship of predisposing, need and acculturation factors to determine their relationship to having a usual provider for medical care. Model 2 adds the enabling factors. Models 3 the household gender relations variables to examine their effect on enabling factors, controlling for all other covariates, on having a usual provider for medical care. Model 4 and subsequent models add gender and enabling interaction terms. Interaction terms are added independently to each model with statistically significant models shown. Figures of predicted probabilities are also shown to further highlight the gendered effects between covariates and healthcare access outcome. Additional analysis, not shown, are conducted with all the gender and enabling interaction terms in one model to measure the effect of each interaction term while controlling for all other covariates.

Tables 4.3a and 4.3b reports the results from a series of linear probability models that focus on the relationship between enabling factors and having used any medical services within the last 12 months. It follows the same modeling pattern as Table 2.

Tables 4.4a and 4.4b reports the results from a series of negative binomial regression models that focus on the relationship between enabling factors and the number of visits to medical services within the last 12 months. It follows the same pattern as Tables 2 and 3.

Linear probability models were used instead of logistic regression models for ease of interpretation. All models were run using logistic regression to and confirmed similar results. All models used robust standard errors.

FINDINGS

Descriptive statistics

Table 4.1 provides descriptive statistics for the total sample of married or cohabitating immigrants, stratified by gender. Weighted percentage and means are reported along with results from chi-square tests to determine whether gender differences observed were statistically significant.

The rate of access is 59.34% for having a usual provider for medical care, 79.4% for having used any medical service within the last 12 months, and an average of 2.63 medical service visits within the last 12 months. Across all three outcomes, women have significantly higher rates of healthcare access compared with men. This gender pattern is consistent with past research.

The average age of the sample is 40.72 years. Mexicans (39.75%) were the largest ethnic group followed by Chinese (10.1%), Filipino (6.85%) and Vietnamese (5.55%). Other Asians (32.5%) and Other Latinos (18.36%) are also a large proportion of the sample. Mexicans are the

Table 4.1. Descriptive Statistics for Total Sample and Stratified by Gender (Immigrants, Married and Cohabiting Sample n=2,324)

Variable	Total Sample		Men		Women		Gender Difference
	% or Weighted Mean	SE	% or Weighted Mean	SE	% or Weighted Mean	SE	
	n=2,324		n=1,210		n=1,114		
Potential Access							
Usual Provider for Medical Care	59.34	(1.84)	51.33	(2.32)	68.06	(2.21)	***
Realized Access							
Use of any medical service within past 12 months (routine, dentist/opth, urgent, scheduled treatment/surgery)	79.4	(1.96)	71.67	(2.72)	87.8	(1.52)	***
Number of medical service visits within past 12 months	2.63	(0.09)	2.05	(0.15)	2.23	(0.14)	***
Predisposing Factors							
Female	47.92						
Age (years)	40.72	(0.58)	41.38	(0.74)	40.01	(0.57)	*
Ethnicity:							
Mexican (reference)	39.75	(4.04)	43.83	(3.8)	35.32	(4.69)	**
Puerto Rican	4.34	(0.5)	4.55	(0.56)	4.12	(0.61)	
Cuban	4.21	(0.5)	4.35	(0.55)	4.06	(0.51)	
Other Latinos	18.36	(1.82)	17.71	(2.)	19.08	(2.2)	
Chinese	10.1	(1.29)	9.14	(1.27)	11.13	(1.53)	+
Vietnamese	5.55	(0.87)	4.71	(0.78)	6.46	(1.06)	
Filipino	6.85	(0.98)	6.16	(0.98)	7.61	(1.13)	+
Other Asian	32.5	(2.74)	9.55	(1.4)	12.23	(1.66)	+
Need Factors							
Poor/Fair Self-rated physical health	26.41	(2.02)	24.9	(2.14)	28.05	(2.76)	
Poor/Fair Self-rated mental health	11.36	(1.1)	11.92	(1.63)	10.75	(1.01)	
Diagnosed chronic condition	29.64	(1.62)	28.75	(2.18)	30.62	(1.51)	
Migration & Acculturation Factors							
Reason for Immigration (Very important)							
Employment	67.67	(1.47)	71.38	(1.43)	63.63	(2.43)	**
To Join Family	49.86	(2.14)	46.21	(2.49)	53.83	(2.73)	**
Medical	13.58	(1.4)	12.9	(1.44)	14.3	(2.)	
Proportion of Life in US	42.28	(0.01)	44.52	(0.01)	39.93	(0.01)	***
English Proficiency Poor/Fair	65.9	(2.04)	64.35	(2.3)	67.59	(2.15)	+
Naturalized Citizen	37.32	(2.08)	37.78	(2.34)	36.82	(2.42)	
Visits Country of Origin (Often/Sometimes)	44.75	(1.55)	47.15	(2.61)	42.15	(1.74)	
Enabling Factors							
Education (years)	10.87	(0.23)	10.79	(0.23)	10.97	0.29	
Financial strain	42.82	(2.35)	41.17	(2.86)	44.62	(2.43)	
Health insurance status:							
Private (ref)	49.83	(2.71)	51.74	(2.7)	47.96	(3.1)	+
Public	17.75	(1.21)	13.85	(1.4)	21.98	(1.62)	***
Uninsured	32.32	(2.29)	34.4	(2.6)	30.06	(2.61)	+
Number of past barriers to medical care	0.76	(0.04)	0.666	(0.07)	0.85	(0.05)	*
Social Support Networks							
Relative Support Scale (3-15)	11.18	(0.09)	11.06	(0.11)	11.38	(0.13)	*
Friend Support Scale (5-15)	9.59	(0.07)	9.4	(0.1)	9.81	(0.1)	**
Household Gender Relations							
Decision Making (1-5)	3.32	(0.36)	3.43	(0.05)	3.19	(0.04)	***
Economic Responsibilities (1-5)	2.35	(0.04)	2.28	(0.04)	2.43	(0.05)	**
Household Chores (1-5)	3.69	(0.03)	3.59	(0.04)	3.8	0.03	***
Female Employment	51.33	(2.12)	51.31	(2.24)	51.35	(2.61)	
Children under 18	48.78	(2.09)	45.35	(2.62)	52.51	(2.3)	**
Household Size	3.25	(0.06)	3.13	(0.09)	3.38	(0.07)	*
Family Cultural Conflict (5-15)	6.16	(0.05)	6	(0.06)	6.34	0.07	***
Partner Emotional Strain	42.84	(1.64)	44.45	(2.61)	41.09	(1.21)	
Partner Emotional Support	8.26	(0.82)	5.53	(1.05)	11.24	(1.27)	**

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

only ethnic group with a significantly larger male population. Chinese, Filipinos and other Asians have a larger female population (p-value <0.10).

A quarter of the sample (26.41%) have poor/fair self-rated physical health, 11.36% of the sample report having poor/fair self-rated mental health, and 29.64% report having been diagnosed with at least one chronic medical condition. None of these health need factors significantly differed by gender.

Acculturation measures reflect the gendered nature of migration to and incorporation into U.S. society. On migration measures, 67.67% of the sample responded that migrating for work was very important. 49.86% responded that migrating to join family was very important. A smaller percentage (13.58%) responded that migrating for medical reasons. Reasons for migration are not mutually exclusive. As reflected in the literature, more men reported migrating for work reasons and more women report migrating to join family.

On incorporation measures, the mean proportion of life spent in the U.S. is 42.28 which reflects a more established immigrant sample in terms of duration. This contrasts with, 65.9% reported having poor/fair English proficiency and 37.32% being naturalized U.S. citizens which reflects lower levels of acculturation to the U.S. Men spent a higher proportion of their life in the U.S., and have slightly lower rates of poor/fair English proficiency compared with women. This differs from other studies which found higher rates of poor/fair English proficiency among women.

On the maintenance of transnational ties, 44.75% of respondents reported that they visited their country of origin often or sometimes. There were no gender differences with this measure.

The average number of years of education is 10.87. Almost half (42.82%) of the sample are experiencing financial strain. Almost half of the sample have private health insurance (49.83%), followed by 32.78% who are uninsured and 17.75% have some form of public health insurance. There are slightly more men among those with private insurance and the uninsured, and women comprise significantly more of those with public health insurance. These gender differences in health insurance reflect a gender and immigrant stratified labor market and its relationship to market-based health insurance and public policy programs. A third (34.78%) of the sample have experienced at least one healthcare access or treatment barrier in the past. The mean number of barriers was 0.76 with the range being between 0 and 8. More women experienced any barriers and experienced a higher mean number of barriers compared with men. The social networks are robust with high levels of relative (mean: 11.18) and friend support (mean: 9.59). As expected, women reported higher levels of relative (11.38 vs. 11.06) and friend support (9.81 vs. 9.4) than men.

Household gender relations measures are categorized along dimensions of power, division of labor and emotion. For scaled measures (1-5), lower numbers reflect asymmetrical gender relations that where women have more power and responsibility, work outside the home, and do less household work. Higher numbers reflect asymmetrical gender relations indicate men have more power, responsibility and do less household work. The median number (3) reflect an egalitarian structure. In the measurement of power relations, the mean of decision making and economic responsibility measures indicate egalitarian gender structure, with decision making (3.32) skewing more towards men and economic decisions (2.35) skewing more towards women. Two variables have some small gender differences, with men reporting having more decision

making power (3.43 vs. 3.19) and women reporting having more economic responsibilities (2.28 vs. 2.43).

With household gender division of labor, the mean of household chores is 3.69 indicating an egalitarian structure. The rate of household female employment is moderate at 51.33%. As expected, there are some small gender differences in reporting the gender structure of household chores, with women reporting living in households where they are doing more household chores (3.8 vs. 3.59).

With household relations of caregiving and emotional support, almost half the sample (48.78%) have at least one child under the age of 18 living with them with more immigrant women having a child dependent. The household size mean was 3.25. The mean of family cultural conflict was 6.16 indicating low levels of conflict, although women reported higher mean levels than men (6.34 vs 6). There are no gender differences in partner strain with 42.84% of the sample reporting high levels of emotional strain from their spouse/partner. By contrast, only 8.26% reported receiving partner emotional support with women receiving significantly more than men (11.24% vs. 5.53%). Overall, both men and women show high levels of emotional strain from child, partner and family relations and low levels of partner/spouse emotional support. Women reported higher levels of having dependent children and experiencing family cultural conflict compared with men, but women also reported receiving higher spousal/partner emotional support.

The various dimensions of household gender relations reflect more egalitarian gender relations along decision making, economic responsibilities, female employment and household chores than assumed by much of the immigration health literature. The findings on emotional caregiving and support also affirms past literature with women having more caregiving and

emotional strain than men in terms of child and family dynamics, but receiving less strain and more support from their male spouses/partners. Gender differences in perspective of household gender relations along dimensions of power, production and emotion also point to saliency of different family roles and their relationship with stressors, the difference between having power and having responsibilities, and gendered perceptions of household management and division of labor.

Findings on Potential Access to Healthcare

Tables 4.2a and 4.2b present results from multivariate linear probability models on having a usual provider for medical care, a measure of potential access to healthcare. Estimates and standard errors are reported. Model 1 includes predisposing, health need, and acculturation factors and shows that being female, relative to male, significantly increases the probability of having a usual provider by 0.18. This positive effect of being female remains consistent across all models. Mexicans, compared to all other Latino and Asian immigrant groups have a significantly lower likelihood of having a usual provider. Having poor/fair self-rated mental health significantly decreases the probability of having a usual provider for care by 0.09, and having at least one diagnosed medical condition significantly increases the probability of having a usual provider by 0.11. The effect of these two health need factors remains in all subsequent models. With acculturation measures, migrating for work reasons, increasing proportion of life in the U.S and frequent visits to the country of origin, significantly increases the probability of having a usual provider for care by 0.07, 0.20 and 0.10 respectively. As expected, having

Table 4.2a Multivariate Linear Probability Models
Effects of Enabling Factors on Having a Usual Provider for Medical Care among Married/Cohabiting Immigrants

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.18	*** (0.02)	0.16	*** (0.02)	0.16	*** (0.02)
Age (years)	0.01	*** (0.001)	0.005	*** (0.001)	0.005	*** (0.001)
Mexicans (reference)						
Puerto Ricans	0.24	*** (0.07)	0.14	* (0.07)	0.15	* (0.07)
Cubans	0.16	*** (0.04)	0.08	* (0.04)	0.09	* (0.04)
Other Latinos	0.18	*** (0.05)	0.10	+ (0.05)	0.10	+ (0.05)
Chinese	0.21	*** (0.05)	0.10	* (0.05)	0.12	* (0.05)
Vietnamese	0.18	*** (0.05)	0.07	(0.04)	0.10	* (0.04)
Filipino	0.21	*** (0.05)	0.08	(0.05)	0.10	+ (0.05)
Other Asian	0.20	*** (0.04)	0.08	* (0.04)	0.08	* (0.04)
Need Factors						
Poor/Fair Self-rated mental health	-0.09	* (0.04)	-0.08	+ (0.04)	-0.08	* (0.04)
Poor/Fair Self-rated physical health	0.003	(0.03)	0.03	(0.03)	0.03	(0.03)
Diagnosed chronic condition	0.11	*** (0.03)	0.07	** (0.03)	0.07	* (0.03)
Acculturation Factors						
Migration reason: to work	0.07	** (0.03)	0.07	*** (0.03)	0.08	*** (0.03)
Migration reason: to join family	0.004	(0.02)	0.001	(0.02)	-0.01	(0.02)
Migration reason: medical care	-0.02	(0.04)	-0.03	(0.04)	-0.04	(0.04)
Proportion of Life in US	0.20	*** (0.05)	0.10	* (0.05)	0.11	* (0.05)
English Proficiency Poor/Fair	-0.07	*** (0.02)	-0.02	(0.02)	-0.01	(0.02)
Naturalized Citizen	0.06	(0.04)	0.04	(0.03)	0.03	(0.03)
Visits to Country of Origin	0.10	*** (0.02)	0.07	*** (0.02)	0.08	*** (0.03)

Table 4.2a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)			0.002	(0.003)	0.001	(0.003)
Financial strain			-0.02	(0.03)	-0.01	(0.03)
Private Insurance (reference)						
Public Insurance			-0.03	(0.04)	-0.03	(0.04)
No Insurance			-0.33	*** (0.03)	-0.32	*** (0.04)
Number of past barriers to medical care			0.02	(0.01)	0.02	(0.01)
Relative Support			0.003	(0.01)	0.003	(0.01)
Friend Support			0.01	* (0.005)	0.01	* (0.005)
Household Gender Relations						
Decision Making					-0.005	(0.01)
Economic Responsibilities					-0.002	(0.01)
Household Chores					-0.002	(0.01)
Female Employment					-0.004	(0.03)
Children under 18					0.05	(0.03)
Household size					-0.02	* (0.01)
Family Cultural Conflict					-0.01	(0.01)
Partner Emotional Strain					-0.004	(0.03)
Partner Emotional Support					0.001	(0.05)
N	2,283		2,261		2,195	
R-Squared	0.2072		0.2902		0.2849	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 4.2b Multivariate Linear Probability Models
Effects of Enabling Factors on Having a Usual Provider for Medical Care among Married/Cohabiting Immigrants

	Model 3			Model 4			Model 5		
	Estimate	SE		Estimate	SE		Estimate	SE	
Predisposing Factors									
Female	0.16	*** (0.02)		0.24	*** (0.03)		0.12	*** (0.03)	
Age (years)	0.005	*** (0.001)		0.005	*** (0.001)		0.00	*** (0.001)	
Mexicans (reference)									
Puerto Ricans	0.15	* (0.07)		0.15	* (0.07)		0.15	* (0.07)	
Cubans	0.09	* (0.04)		0.09	* (0.04)		0.09	* (0.04)	
Other Latinos	0.10	+ (0.05)		0.11	+ (0.05)		0.11	* (0.05)	
Chinese	0.12	* (0.05)		0.12	* (0.05)		0.12	* (0.05)	
Vietnamese	0.10	* (0.04)		0.11	** (0.04)		0.11	** (0.04)	
Filipino	0.10	+ (0.05)		0.10	+ (0.05)		0.10	+ (0.05)	
Other Asian	0.08	* (0.04)		0.09	* (0.04)		0.09	* (0.04)	
Need Factors									
Poor/Fair Self-rated mental health	-0.08	* (0.04)		-0.07	+ (0.04)		-0.08	+ (0.04)	
Poor/Fair Self-rated physical health	0.03	(0.03)		0.03	(0.03)		0.03	(0.03)	
Diagnosed chronic condition	0.07	* (0.03)		0.07	* (0.03)		0.07	* (0.03)	
Acculturation Factors									
Migration reason: to work	0.08	*** (0.03)		0.08	*** (0.03)		0.08	*** (0.03)	
Migration reason: to join family	-0.01	(0.02)		-0.01	(0.02)		-0.01	(0.02)	
Migration reason: medical care	-0.04	(0.04)		-0.04	(0.04)		-0.04	(0.04)	
Proportion of Life in US	0.11	* (0.05)		0.12	** (0.05)		0.12	** (0.05)	
English Proficiency Poor/Fair	-0.01	(0.02)		-0.01	(0.02)		-0.01	(0.02)	
Naturalized Citizen	0.03	(0.03)		0.03	(0.03)		0.03	(0.03)	
Visits to Country of Origin	0.08	*** (0.03)		0.08	*** (0.03)		0.08	*** (0.03)	

Table 4.2b (continued)

	Model 3		Model 4		Model 5	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)	0.00	(0.003)	0.00	(0.003)	0.00	0.00
Financial strain	-0.01	(0.03)	-0.01	(0.03)	-0.01	0.03
Private Insurance (reference)			0.37	(0.04)	-0.02	0.04
Public Insurance	-0.03	(0.04)	0.36	(0.08)	-0.37	0.04
No Insurance	-0.32	(0.04)	reference			
Number of past barriers to medical care	0.02	(0.01)	0.02	(0.01)	0.02	0.01
Relative Support	0.003	(0.01)	0.003	(0.01)	0.00	0.01
Friend Support	0.01	(0.005)	0.01	(0.005)	0.01	0.00
Household Gender Relations						
Decision Making	-0.005	(0.01)	-0.005	(0.01)	0.00	0.01
Economic Responsibilities	-0.002	(0.01)	-0.002	(0.01)	0.00	0.01
Household Chores	-0.002	(0.01)	-0.002	(0.01)	0.00	0.01
Female Employment	-0.004	(0.03)	-0.002	(0.03)	0.00	0.03
Children under 18	0.05	(0.03)	0.05	(0.03)	0.05	0.03
Household size	-0.02	(0.01)	-0.02	(0.01)	-0.02	0.01
Family Cultural Conflict	-0.01	(0.01)	-0.01	(0.01)	-0.01	0.01
Partner Emotional Strain	-0.004	(0.03)	0.000	(0.03)	0.00	0.03
Partner Emotional Support	0.001	(0.05)	0.01	(0.05)	0.01	0.05
Interactions: Gender & Enabling Factors						
Female* Education						
Female*Financial Strain						
Female*Private Insurance			-0.12	(0.04)		
Female*Public Insurance			-0.13	(0.07)		
Female*No Insurance					0.12	0.04
Female*Number of past barriers to medical care						
Female*Relative Support						
Female*Friend Support						
N	2,195		2,195		2,195	
R-Squared	0.2849		0.2882		0.2881	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

poor/fair English proficiency significantly decreases the probability of having a usual provider by 0.07.

Model 2 adds the enabling factors. The only socioeconomic-legal factor with a significant association was having no health insurance, relative to having private health insurance, greatly decreased the likelihood of having a usual provider for care by 0.33. Social support from friends was positively associated with access to healthcare, but not relative support. When enabling factors were added to the model, the racial and ethnic differences with Mexicans diminished in magnitude and many remained statistically significant. The large negative effect of having poor/fair English proficiency decreased from 0.20 to 0.10.

Model 3 is the full model and adds the household gender relation variables. Household size has a negative effect on having a usual provider for care by 0.02. All other variables in the previous model have the same effect with some minor changes to racial and ethnic differences, relative to Mexicans.

Models 4 and 5 present the interactions effects on having a usual provider for healthcare with gender and insurance type. Model 4 shows the effect of having private and public insurance, relative to no insurance. As expected insurance of any kind increases the probability of having a usual healthcare provider, compared with having no insurance. Model 5 shows that the effect of having no health insurance on having a usual provider is negative, and this effect is significantly different for men and women.

Figures 4.1 - 4.3 illustrates the predicted probabilities of having a usual provider for care by insurance type and gender. As expected, both men and women's probability of having a usual healthcare provider is greatly affected by having some form of health insurance. Men's access to healthcare, relative to women, is much more positively affected when they have insurance

(Model 4) and much more negatively affected when they do not have health insurance. For men with private insurance, their predicted probability of having a usual provider for medical care is 0.35 greater than men without private insurance, while women's predicted probability with private insurance is 0.28 greater than women without private insurance. In contrast, men with no insurance experience a 0.38 reduction in their predicted probability of having usual provider compared to men with insurance, while the reduction among women with no insurance is 0.25. It is also important to note that when immigrant men have public insurance, their predicted probability of accessing care is similar to women. This is the only insurance type where men and women have more similar predicted probabilities in access which points to the responsiveness to safety net programs among immigrant men

This gendered pattern with insurance type is consistent across all three outcomes with men's utilization of medical services and the number of medical visits increasing considerably when they have insurance and lowering considerably when they have no health insurance, compared with women. The gender differences are even more pronounced in the outcome, having accessed a medical service within the last 12 months.

Figures 4.1–4.3. Predicted Probability of Having a Usual Medical Provider by Gender and Insurance Type with 95% confidence intervals

Figure 4.1 Private Insurance

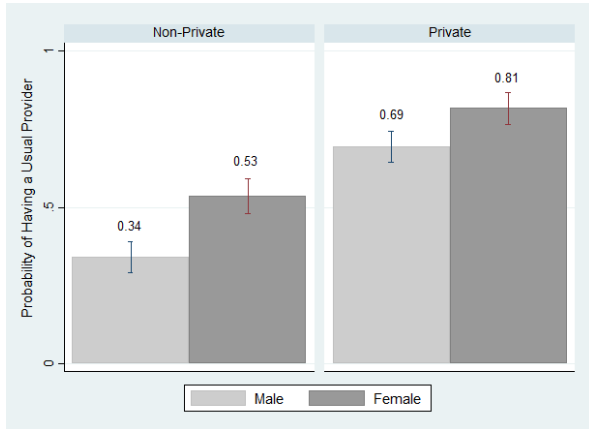


Figure 4.2 Public Insurance

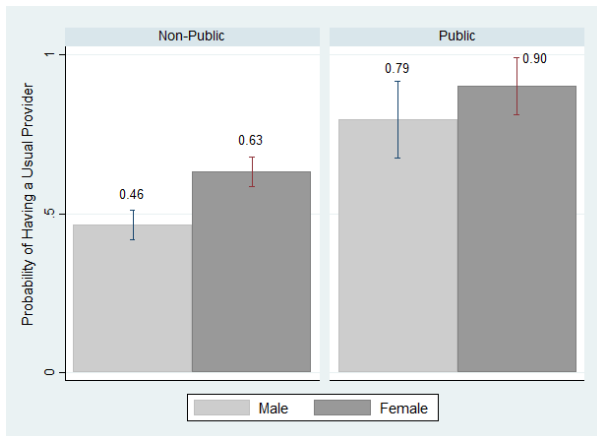
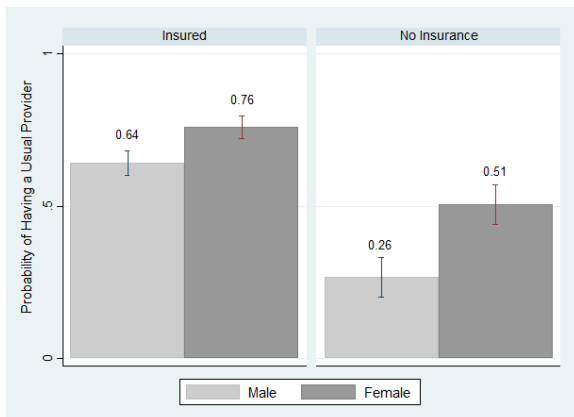


Figure 4.3 No Insurance



Findings on Realized Access to Healthcare

Tables 4.3a and 4.3b present results from multivariate linear probability models on having used a medical service within the last 12 months, a measure of realized access to healthcare. Like in the previous outcome on having a usual medical provider, being female has a consistently significant positive effect on having used a medical service within the last 12 months across all models, and the same patterns in health needs are present. Among the acculturation factors, having poor/fair English proficiency has a negative effect and being a naturalized citizen has a positive effect on having used a medical service.

Model 2 shows the addition of enabling factors. As in all the outcomes, having no insurance, relative to private insurance, significantly decreased access. Interestingly, the increase in the number of past barriers to healthcare *increases* the likelihood of having used a medical service by 0.02. Having financial strain and friend support both have small effects only at a p-value of <0.1. When enabling factors are added to the model, most of the acculturation effects no longer are significant with the exception of migrating for work reasons which increases the likelihood of using medical services by 0.05. Moreover, most racial and ethnic differences also do not remain.

Model 3 is the full model with the household gender relation variables. The only effect among these variables is that family cultural conflict increasing the likelihood of using a medical service by 0.02. The effects of enabling factors from the previous model remain.

Models 4 and 5 show interactions with gender and health insurance types on using medical services. Compared to the other outcomes, there is a similar pattern of men's greater increase of their access to healthcare with insurance and greater decrease of their access with

Table 4.3a Multivariate Linear Probability Models
Effects of Enabling Factors on Using any Medical Service within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.16	*** (0.02)	0.15	*** (0.02)	0.15	*** (0.02)
Age (years)	0.003	* (0.001)	0.002	(0.001)	0.003	* (0.001)
Mexicans (reference)						
Puerto Ricans	0.13	*** (0.04)	0.05	(0.04)	0.04	(0.04)
Cubans	0.08	(0.05)	0.01	(0.04)	0.01	(0.04)
Other Latinos	0.16	*** (0.04)	0.09	** (0.03)	0.09	* (0.04)
Chinese	0.17	*** (0.05)	0.06	+ (0.03)	0.07	* (0.03)
Vietnamese	0.13	*** (0.04)	0.03	(0.04)	-0.01	(0.04)
Filipino	0.12	** (0.04)	0.00	(0.04)	-0.01	(0.04)
Other Asian	0.11	* (0.05)	-0.01	(0.05)	-0.03	(0.04)
Need Factors						
Poor/Fair Self-rated mental health	-0.10	* (0.04)	-0.10	* (0.05)	-0.09	* (0.04)
Poor/Fair Self-rated physical health	-0.01	(0.03)	0.01	(0.03)	0.01	(0.03)
Diagnosed chronic condition	0.07	** (0.02)	0.04	* (0.02)	0.04	* (0.02)
Acculturation Factors						
Migration reason: to work	0.05	+ (0.02)	0.05	* (0.02)	0.06	* (0.02)
Migration reason: to join family	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)
Migration reason: medical care	0.02	(0.03)	0.01	(0.02)	0.01	(0.02)
Proportion of Life in US	0.01	(0.07)	-0.06	(0.06)	-0.07	(0.06)
English Proficiency Poor/Fair	-0.08	*** (0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)
Naturalized Citizen	0.06	* (0.03)	0.05	+ (0.03)	0.05	+ (0.03)
Visits to Country of Origin	0.05	(0.03)	0.03	(0.03)	0.03	(0.03)

Table 4.3a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)			0.005	(0.003)	0.005	(0.003)
Financial strain			-0.04	(0.02)	-0.05	(0.02)
Private Insurance (reference)						**
Public Insurance			0.03	(0.02)	0.03	(0.02)
No Insurance			-0.25	(0.05)	-0.24	(0.04)
Number of past barriers to medical care			0.02	(0.01)	0.02	(0.01)
Relative Support			-0.004	(0.003)	-0.002	(0.004)
Friend Support			0.01	(0.003)	0.01	(0.004)
Household Gender Relations						
Decision Making					-0.001	(0.01)
Economic Responsibilities					0.01	(0.01)
Household Chores					-0.02	(0.01)
Female Employment					0.01	(0.02)
Children under 18					0.04	(0.03)
Household size					0.002	(0.01)
Family Cultural Conflict					0.02	(0.01)
Partner Emotional Strain					-0.01	(0.02)
Partner Emotional Support					-0.04	(0.04)
N	2,283		2,261		2,195	
R-Squared	0.1628		0.2457		0.2621	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 4.3b Multivariate Linear Probability Models
Effects of Enabling Factors on Using any Medical Service within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 3		Model 4		Model 5		Model 6		Model 7	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors										
Female	0.15	*** (0.02)	0.33	*** (0.04)	0.07	*** (0.02)	0.19	*** (0.02)	0.03	(0.08)
Age (years)	0.00	* (0.001)	0.00	* (0.001)	0.00	* (0.001)	0.00	* (0.001)	0.00	* (0.001)
Mexicans (reference)										
Puerto Ricans	0.04	(0.04)	0.04	(0.04)	0.04	(0.04)	0.03	(0.04)	0.04	(0.04)
Cubans	0.01	(0.04)	0.02	(0.04)	0.02	(0.04)	0.01	(0.04)	0.01	(0.04)
Other Latinos	0.09	* (0.04)	0.09	** (0.04)	0.09	** (0.04)	0.08	* (0.04)	0.09	** (0.04)
Chinese	0.07	* (0.03)	0.08	* (0.03)	0.08	* (0.03)	0.07	* (0.03)	0.07	* (0.03)
Vietnamese	-0.01	(0.04)	0.00	(0.04)	0.00	(0.04)	-0.01	(0.04)	-0.01	(0.04)
Filipino	-0.01	(0.04)	0.00	(0.04)	0.00	(0.04)	-0.01	(0.04)	-0.01	(0.04)
Other Asian	-0.03	(0.04)	-0.01	(0.04)	-0.01	(0.04)	-0.02	(0.04)	-0.03	(0.04)
Need Factors										
Poor/Fair Self-rated mental health	-0.09	* (0.04)	-0.08	+ (0.04)	-0.08	+ (0.04)	-0.08	* (0.04)	-0.09	* (0.04)
Poor/Fair Self-rated physical health	0.01	(0.03)	0.01	(0.03)	0.01	(0.03)	0.01	(0.02)	0.01	(0.02)
Diagnosed chronic condition	0.04	* (0.02)	0.03	+ (0.02)	0.03	+ (0.02)	0.04	* (0.02)	0.04	* (0.02)
Acculturation Factors										
Migration reason: to work	0.06	* (0.02)	0.05	* (0.02)	0.05	* (0.03)	0.05	* (0.02)	0.06	* (0.02)
Migration reason: to join family	-0.04	+ (0.02)	-0.03	(0.02)	-0.03	(0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)
Migration reason: medical care	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)	0.00	(0.02)	0.01	(0.02)
Proportion of Life in US	-0.07	(0.06)	-0.05	(0.06)	-0.05	(0.06)	-0.05	(0.06)	-0.07	(0.06)
English Proficiency Poor/Fair	-0.04	+ (0.02)	-0.03	(0.02)	-0.03	(0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)
Naturalized Citizen	0.05	+ (0.03)	0.05	+ (0.03)	0.05	+ (0.03)	0.04	(0.03)	0.05	+ (0.02)
Visits to Country of Origin	0.03	(0.03)	0.04	(0.03)	0.04	(0.03)	0.03	(0.03)	0.03	(0.03)

Table 4.3b (continued)

	Model 3		Model 4		Model 5		Model 6		Model 7	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors										
Education (years)	0.00	(0.003)	0.01	(0.003)	0.01	(0.003)	0.01	(0.003)	0.00	(0.003)
Financial strain	-0.05	** (0.02)	-0.05	* (0.02)	-0.05	** (0.02)	-0.05	* (0.02)	-0.05	** (0.02)
Private Insurance (reference)			0.35	*** (0.05)						
Public Insurance	0.03	(0.02)	0.40	*** (0.07)	0.05	(0.02)	0.04	(0.02)	0.03	(0.02)
No Insurance	-0.24	*** (0.04)	reference		0.26	*** (0.04)	-0.24	*** (0.04)	-0.24	*** (0.04)
Number of past barriers to medical care	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.04	*** (0.01)	0.02	*** (0.01)
Relative Support	0.00	(0.004)	0.00	(0.004)	0.00	(0.004)	0.00	(0.004)	-0.01	+ (0.005)
Friend Support	0.01	+ (0.004)	0.01	* (0.003)	0.01	* (0.003)	0.01	* (0.003)	0.01	+ (0.004)
Household Gender Relations										
Decision Making	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)
Economic Responsibilities	0.01	(0.01)	0.01	(0.01)	0.01	(0.01)	0.01	(0.01)	0.01	(0.01)
Household Chores	-0.02	(0.01)	-0.02	+ (0.01)	-0.02	(0.01)	-0.02	(0.01)	-0.02	(0.01)
Female Employment	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)
Children under 18	0.04	(0.03)	0.05	(0.03)	0.05	(0.03)	0.04	(0.03)	0.04	(0.03)
Household size	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)	0.00	(0.01)
Family Cultural Conflict	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)
Partner Emotional Strain	-0.01	(0.02)	0.00	(0.02)	0.00	(0.02)	0.00	(0.02)	-0.01	(0.02)
Partner Emotional Support	-0.04	(0.04)	-0.03	(0.04)	-0.03	(0.04)	-0.03	(0.04)	-0.04	(0.04)
Interactions: Gender & Enabling Factors										
Female*Education										
Female*Financial Strain										
Female*Private Insurance			-0.26	*** 0.04						
Female*Public Insurance			-0.26	*** 0.06						
Female*No Insurance					0.26	*** 0.04				
Female*Number of past barriers							-0.05	*** 0.01	0.01	+ 0.01
Female*Relative Support										
Female*Friend Support										
N	2,195		2,195		2,195		2,195		2,195	
R-Squared	0.2621		0.284		0.284		0.2699		0.2635	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

having no insurance compared with women. The magnitude of men's responsiveness to insurance type is even larger compared to the prior outcome.

Model 6 shows the interaction effect of gender and experiencing barriers to healthcare on using medical services. An increasing number of barriers has a positive effect on potential access, and this positive effect is mainly attributed to men. Figure 4.4 illustrates that an increasing number of barriers to healthcare has an *increasing* effect on men's healthcare access, with men having no barriers having a predicted probability of accessing healthcare of 0.69 increasing by 0.35 among men who had eight (maximum allowed) barriers. In contrast, the number of barriers has a decreasing effect on women predicted probability of accessing health, with women having no barriers having a predicted probability of 0.81 decreasing by 0.07 when they experience the maximum number of barriers. This pattern continues in the other realized access outcome, number of medical visits within the last 12 months (Table 4.4b). This finding is in the opposite hypothesized direction since it is widely expected that barriers would have a negative effect on access for any population, and the magnitude of the negative effect would differ by sub-population. Additional analysis, not shown, was conducted to examine whether access or treatment barriers had a different effect. There were no differences with types of barriers that are related to the positive effect on men's access to healthcare.

Model 7 shows that relative support decreases the likelihood of accessing healthcare by 0.01 and this effect differs for men and women (p-value level <0.10). While this weak evidence, I highlight this effect because in additional analysis, not shown, with all gender interactions with enabling factors included in the model show that the moderating effects of gender on relative support strengthens. Figure 4.5 illustrates that with increasing relative support (outside the

immediate household), men experience a predicted decrease in accessing healthcare from 0.77 to 0.65.

Figures 4.4-4.5 Predicted Probability of having Used a Medical Service within the last 12 months by Gender and Enabling Factors with 95% confidence intervals

Figure 4.4 Number of Past Barriers to Healthcare

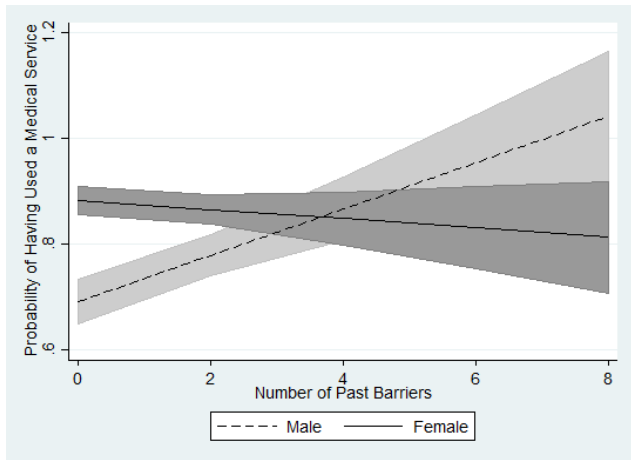
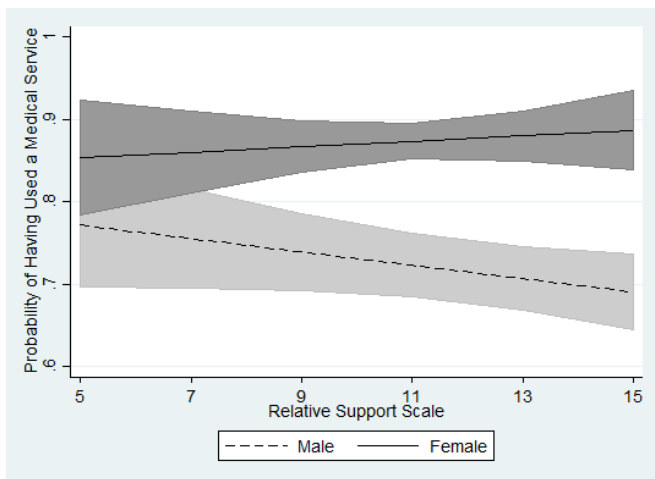


Figure 4.5 Relative Support



Tables 4.4a and 4.4b present results from multivariate negative binomial probability models on the number of visits to medical services within the last 12 months, a measure of realized access to healthcare. The coefficients in the tables represent the change in the natural log (ln) of expected number of medical visits within the last 12 months for a one-unit change in the predicted independent variable. The exponential form of the coefficient is reported in the findings.

As with the other healthcare access outcomes, being female was associated with a positive effect on the number of medical visits. Compared with other outcomes, there were fewer racial and ethnic differences. Having poor/fair self rated physical health and having a previously diagnosed chronic conditions increases the number of medical visits. Migrating to the U.S. for work reasons significantly reduced the expected number of visits by a factor of 0.86 (e^{-15}). This relationship differs from the other outcomes which found migrating for work increased access to healthcare.

Model 2 adds the enabling factors. As expected, having no insurance, relative to private insurance, reduced the expected number of visits by 37% ($1 - e^{-46}$). Having public insurance, relative to private insurance, is related to a 32% (e^{-28}) increase in the expected number, and having past healthcare barriers increases the expected number of visits by 6% (e^{06}). It is important to note that having public insurance had a larger effect on the number of visits relative to private insurance.

When household gender relations variables are added in Model 3, all significant enabling factors remain. Among household variables, having dependent children and experiencing family cultural conflict increase the number of medical visits. Experiencing spousal/partner support has

Table 4.4a Multivariate Negative Binomial Models
Effects of Enabling Factors on the Number of Medical Visits within the last 12 months among Married/Cohabiting Immig

Variable	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.44	*** (0.08)	0.43	*** (0.07)	0.46	*** (0.08)
Age (years)	-0.003	(0.002)	-0.01	** (0.002)	-0.003	(0.002)
Mexicans (reference)						
Puerto Ricans	0.30	(0.21)	0.11	(0.22)	0.14	(0.21)
Cubans	0.15	(0.12)	-0.02	(0.1)	0.03	(0.11)
Other Latinos	0.26	** (0.1)	0.13	(0.1)	0.19	+ (0.1)
Chinese	0.50	*** (0.16)	0.25	+ (0.13)	0.31	* (0.13)
Vietnamese	0.23	(0.14)	0.00	(0.11)	0.04	(0.12)
Filipino	0.11	(0.17)	-0.08	(0.14)	-0.01	(0.15)
Other Asian	0.22	+ (0.12)	0.00	(0.1)	-0.02	(0.1)
Need Factors						
Poor/Fair Self-rated mental health	-0.14	(0.16)	-0.12	(0.17)	-0.11	(0.16)
Poor/Fair Self-rated physical health	0.19	* (0.08)	0.17	* (0.07)	0.16	* (0.07)
Diagnosed chronic condition	0.41	*** (0.11)	0.34	*** (0.1)	0.34	*** (0.09)
Acculturation Factors						
Migration reason: to work	-0.15	* (0.07)	-0.09	(0.07)	-0.09	(0.07)
Migration reason: to join family	-0.01	(0.07)	-0.06	(0.07)	-0.09	(0.06)
Migration reason: medical care	0.07	(0.13)	0.09	(0.14)	0.02	(0.13)
Proportion of Life in US	0.17	(0.24)	-0.02	(0.21)	0.00	(0.19)
English Proficiency Poor/Fair	-0.09	(0.09)	0.00	(0.1)	-0.01	(0.09)
Naturalized Citizen	0.11	(0.1)	0.12	(0.1)	0.10	(0.09)
Visits to Country of Origin	-0.01	(0.06)	-0.02	(0.06)	-0.04	(0.06)

Table 4.4a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)			0.02	(0.01)	0.02	(0.01)
Financial strain			-0.06	(0.08)	-0.07	(0.08)
Private Insurance (reference)						
Public Insurance			0.28	(0.1)	0.24	(0.1)
No Insurance			-0.46	(0.15)	-0.45	(0.15)
Number of past barriers to medical care			0.06	(0.02)	0.08	(0.03)
Relative Support			0.02	(0.02)	0.02	(0.01)
Friend Support			-0.02	(0.02)	-0.02	(0.02)
Household Gender Relations						
Decision Making					-0.03	(0.04)
Economic Responsibilities					-0.02	(0.03)
Household Chores					-0.03	(0.03)
Female Employment					-0.09	(0.08)
Children under 18					0.31	(0.11)
Household size					-0.05	(0.03)
Family Cultural Conflict					0.03	(0.02)
Partner Emotional Strain					0.10	(0.08)
Partner Emotional Support					-0.33	(0.09)
Intercept	0.58	(0.18)	0.65	(0.32)	0.59	(0.39)
Dispersion Parameter	0.82		0.75		0.73	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 4.4b Multivariate Negative Binomial Models
Effects of Enabling Factors on the Number of Medical Visits within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 3		Model 4		Model 5		Model 6		Model 7	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors										
Female	0.46	*** (0.08)	1.06	*** (0.17)	0.25	*** (0.07)	0.61	*** (0.09)	-0.28	(0.23)
Age (years)	-0.003	(0.002)	-0.003	(0.002)	0.00	0.00	-0.003	(0.002)	-0.003	(0.002)
Mexicans (reference)										
Puerto Ricans	0.14	(0.21)	0.14	(0.21)	0.14	0.21	0.11	(0.21)	0.16	(0.22)
Cubans	0.03	(0.11)	0.04	(0.1)	0.05	0.10	0.01	(0.1)	0.08	(0.11)
Other Latinos	0.19	+ (0.1)	0.21	* (0.11)	0.20	+ 0.10	0.17	(0.1)	0.20	* (0.1)
Chinese	0.31	* (0.13)	0.33	** (0.13)	0.33	** 0.13	0.31	(0.13)	0.34	** (0.13)
Vietnamese	0.04	(0.12)	0.08	(0.11)	0.07	0.11	0.02	(0.11)	0.06	(0.12)
Filipino	-0.01	(0.15)	0.04	(0.15)	0.03	0.15	-0.03	(0.15)	0.01	(0.15)
Other Asian	-0.02	(0.1)	0.04	(0.1)	0.04	0.10	-0.03	(0.1)	0.00	(0.1)
Need Factors										
Poor/Fair Self-rated mental health	-0.11	(0.16)	-0.06	(0.15)	-0.07	0.16	-0.08	(0.15)	-0.11	(0.15)
Poor/Fair Self-rated physical health	0.16	* (0.07)	0.14	+ (0.08)	0.15	* 0.08	0.13	(0.07)	0.16	* (0.07)
Diagnosed chronic condition	0.34	*** (0.09)	0.32	*** (0.08)	0.32	*** 0.08	0.35	(0.09)	0.34	*** (0.09)
Acculturation Factors										
Migration reason: to work	-0.09	(0.07)	-0.11	(0.07)	-0.10	0.07	-0.09	(0.07)	-0.07	(0.07)
Migration reason: to join family	-0.09	(0.06)	-0.07	(0.06)	-0.07	0.06	-0.10	(0.06)	-0.10	(0.06)
Migration reason: medical care	0.02	(0.13)	0.002	(0.12)	0.01	0.12	0.01	(0.13)	0.01	(0.12)
Proportion of Life in US	0.003	(0.19)	-0.02	(0.19)	-0.01	0.19	0.03	(0.19)	-0.004	(0.19)
English Proficiency Poor/Fair	-0.01	(0.09)	-0.03	(0.09)	-0.02	0.09	-0.04	(0.09)	-0.02	(0.09)
Naturalized Citizen	0.10	(0.09)	0.10	(0.09)	0.10	0.09	0.09	(0.09)	0.10	(0.09)
Visits to Country of Origin	-0.04	(0.06)	-0.03	(0.06)	-0.03	0.06	-0.04	(0.06)	-0.04	(0.06)

Table 4.4b (continued)

	Model 3		Model 4		Model 5		Model 6		Model 7	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors										
Education (years)	0.02	(0.01)	0.02	(0.01)	0.02	0.01	0.02	(0.01)	0.02	(0.01)
Financial strain	-0.07	(0.08)	-0.04	(0.07)	-0.05	0.07	-0.06	(0.08)	-0.07	(0.08)
Private Insurance (reference)			0.86	(0.22)						
Public Insurance	0.24	(0.1)	1.30	(0.2)	0.27	0.09	0.26	(0.1)	0.23	(0.09)
No Insurance	-0.45	(0.15)	reference		-0.89	0.22	-0.46	(0.15)	-0.46	(0.14)
Number of past barriers to medical care	0.08	(0.03)	0.08	(0.02)	0.08	0.02	0.16	(0.03)	0.08	(0.02)
Relative Support	0.02	(0.01)	0.02	(0.02)	0.02	0.02	0.02	(0.01)	-0.02	(0.02)
Friend Support	-0.02	(0.02)	-0.02	(0.01)	-0.02	0.01	-0.02	(0.01)	-0.02	(0.01)
Household Gender Relations										
Decision Making	-0.03	(0.04)	-0.04	(0.03)	-0.04	0.03	-0.04	(0.03)	-0.02	(0.03)
Economic Responsibilities	-0.02	(0.03)	-0.02	(0.03)	-0.02	0.03	-0.02	(0.03)	-0.01	(0.03)
Household Chores	-0.03	(0.03)	-0.03	(0.03)	-0.03	0.03	-0.03	(0.03)	-0.02	(0.03)
Female Employment	-0.09	(0.08)	-0.07	(0.08)	-0.07	0.08	-0.09	(0.08)	-0.09	(0.07)
Children under 18	0.31	(0.11)	0.31	(0.11)	0.30	0.11	0.31	(0.1)	0.31	(0.11)
Household size	-0.05	(0.03)	-0.05	(0.03)	-0.05	0.03	-0.05	(0.03)	-0.05	(0.03)
Family Cultural Conflict	0.03	(0.02)	0.03	(0.02)	0.03	0.02	0.04	(0.01)	0.04	(0.01)
Partner Emotional Strain	0.10	(0.08)	0.11	(0.07)	0.11	0.07	0.10	(0.08)	0.11	(0.08)
Partner Emotional Support	-0.33	(0.09)	-0.27	(0.09)	-0.29	0.09	-0.30	(0.09)	-0.33	(0.09)
Interactions: Gender & Enabling Factors										
Female*Education										
Female*Financial Strain										
Female*Private Insurance			-0.73	(0.19)						
Female*Public Insurance			-1.04	(0.2)						
Female*No Insurance					0.81	(0.18)				
Female*Number of past barriers							-0.18	(0.03)	0.07	(0.02)
Female*Relative Support										
Female*Friend Support										
Intercept	0.59	(0.39)	-0.12	(0.39)	0.74	(0.37)	0.56	(0.38)	0.91	(0.37)
Dispersion Parameter	0.73		0.70		0.70		0.71		0.72	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

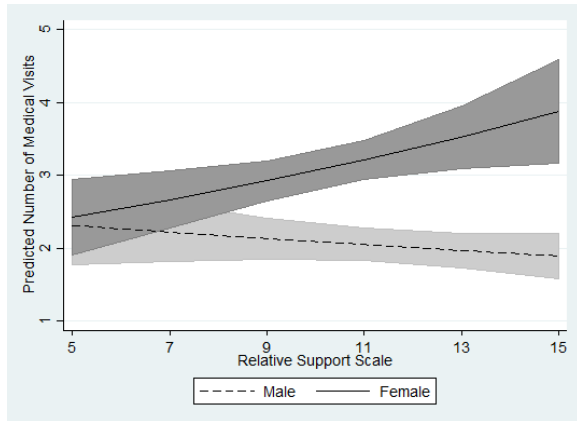
a strong significant negative relationship, with those experiencing spousal/partner support reducing their number of medical visits by 28%.

Models 4 and 5 show interactions with gender and insurance types on the number of medical visits, respectively. The pattern of these findings is similar to other outcomes. Model 6 shows that the positive effect of number of past healthcare barriers on number of medical visits. Again, this positive effect is attributed to men and not women.

Model 7 shows that while both relative and friend support do not have a significant effect on the expected number of medical visits within the last 12 months, there are significant gender interaction effects. Figure 4.6 illustrates that with increasing social network support from relatives (outside the immediate household), women's predicted number of medical visits increases by 1.45 visits, while men's predicted number of visits decreases by 0.42 visits. Additional analysis, not shown, with all gender interactions with enabling factors included in the model show that the moderating effects of gender on the relationship between insurance type, number of barriers and relative support remain, controlling for all covariates. Interestingly, in this model, there is an interaction between gender, friend support and number of medical visits. The predicted probability of this interaction indicates that friend support has a more positive effect on men than women. In contrast to relative support, increasing friend support increases men's predicted number of medical visits by a factor of 0.54 visits, while women's predicted number of visits reduces by a factor of 0.87 visits.

Figure 4.6 Predicted Expected Number of Medical Visits within the last 12 months by Gender and Social Support Networks with 95% confidence intervals

Figure 4.6 Relative Support



CONCLUSION and DISCUSSION

The findings highlight the strong and consistent relationship between three types of enabling factors on access to healthcare, with differing gender effects. As expected, socioeconomic-legal resources such as health insurance type were strongly associated with all access outcomes, and friend support networks were positively associated with two access outcomes (H1).

Gender also moderated all three types of enabling factors. Men's level of healthcare access was much more affected by type of insurance compared to women (H3). While women's consistent higher levels of access only changed slightly with insurance, having private or public insurance greatly increased men's healthcare access. The inverse is found in the relationship between having no health insurance and access, where men's healthcare access decreases much more when they had no health insurance.

With social support networks, friend support networks had the most consistent positive effect on having a usual provider for care and having used a medical service within the last 12 months for the entire sample. Gender had an opposing effect on the relationship between friend support networks and number of medical visits, with friend support networks increasing the number of visits among men and decreasing the number of visits among women. Relative support networks were moderated by gender on the two realized access outcomes. In contrast to friend networks, relative support networks increased access for women and decreased access, or had no effect on men's healthcare access.

The most unexpected finding was the relationship with having experiences of prior barriers to healthcare and men's increasing access to healthcare. Hypothesized as an institutional

barrier that would generally deter healthcare access with an increasing number of barriers (H2), especially among men who already have lower prevalence levels of healthcare access (H3). Yet, across two realized access outcomes, the effect of past healthcare barriers on men is in the opposite of the hypothesized direction. With increasing number of experiences of past healthcare barriers, immigrant men were much more likely to *increase* their access healthcare, while women's access remain constant or slightly decreased.

Overall, the strong effect of insurance over men's access compared to women and the positive effect of friend networks highlight that men's help seeking behaviors are associated with external attachments from the household and family. Health insurance, friend support networks, and even seemingly negative interactions with the healthcare system, all had a positive effect on men's access to healthcare much more than, or in opposing direction from women. In contrast, immigrant women were more responsive to closer family attachments such as relative support networks.

Within this framework of gendered attachments and responsiveness to enabling factors internal or external to the family or household highlights distinct gendered routes to help-seeking that end up at the doctors' office, but most likely start somewhere else. For women, relative networks seem to provide immigrant women with encouragement, support and information to access healthcare when they have health needs or concerns. As for relatives being burden or strain which also can increase access to healthcare, preliminary models also included a variable on strain for friend and relative networks, but they did not have a significant effect. Friend networks, which are considered to be more voluntary compared with obligations and demands from relatives or kin, seem to provide similar enabling resources for men's increased access.

While spousal/partner support seem to defer or deter the need for healthcare for both immigrant men and women.

I draw from the sociology of mental health on stress, social support and coping to illustrate a framework to analyze where healthcare, as a coping resource, falls within the gendered pathways of help-seeking. There are usually two sources of social stress addressed by coping strategies, situational demands and one's emotional response to those demands. Coping behavior can be problem-focused which is more likely to occur when one feels the demand is controllable, and emotion-focused which is more likely to occur when one feels the demand is uncontrollable (Lazarus and Folkman 1984). In a study on healthcare utilization among immigrant Latino men found that experiencing barriers to healthcare decreased access, but those with more abilities to cope, such as having behaviors or strategies to deal with life stresses, were more likely to utilize healthcare. Having couple strategies such as cognitive reframing, exploring alternatives, drawing on past experiences, and talking with family, friends and professional, more than doubled the odds of utilizing healthcare (Rhodes et al. 2008). There is evidence that coping strategies are gendered with men more likely to accept a problem or engage in problem solving, as women are more likely to seek social support and letting out their feelings (Thoits 1995, 2010). This gendered response is attributed to multiple factors such as socialization, a sense of mastery, and the availability of social capital resources. However, these gendered responses to stress and coping have not been thoroughly tested with racial, ethnic or immigrant populations, and are contested in the mainstream literature (Hill and Needham 2013).

Healthcare is an external source of support, help and coping. For immigrants who face additional linguistic, cultural and socioeconomic-legal barriers, healthcare may be considered external to their community, not just family. Conceptualized within a network of support,

healthcare options for immigrants would be positioned in the outer boundaries. For immigrant women, their help-seeking pathway starts with their small and close-knit family, spouse and relative networks. When these sources are not enough or cannot provide adequate information, support or resources needed to address their health concerns, an external source may be sought out which includes the healthcare system. On the other hand, immigrant men's help-seeking pathway starts with the friends and community institutions which are more loosely knit and more diverse than close family networks. When these sources of support are not sufficient, immigrant men may go to internal supports such as a spouse, and maybe a relative, before another external sources, like healthcare. Despite men's responsiveness to institutional factors external to the household, healthcare may be an option for health related issues only after community and family options that been exhausted.

This contrast of the gendered routes to the doctor and sources of support highlight the importance of addressing healthcare is part of a large network of enabling factors in which people utilize for care. Accessing healthcare is not just an individual rational choice where cost/benefit analysis is conducted under constraining contexts (Andersen 1968; Bird and Rieker 2008), but part of socially structured patterns of decision making and resource seeking that includes consultation with trusted others who affirm their social status, identity and values (Annandale et al. 2007; Pescosolido 1992; Pescosolido et al. 1998). Further research using network analysis or pathway model may extend this line of inquiry and highlight how immigrant men and women get to the doctor, not just if they get to the doctor.

The findings on the relationship between gender, past experiences of barriers to healthcare and realized access to healthcare is the most unexpected in this study. Additional analysis where past experiences of barriers was recoded as having at least one barrier, resulted in

the same gendered pattern that extended to the three access outcomes. Barriers were further disaggregated into access and treatment barriers, and both these types of barriers had the same effect on immigrant men's healthcare access. It is assumed that men may be undeterred by past barriers because they often delay access and wait until their symptoms are more serious. However, this would be associated with no effect or minor effect on access, not an increase of access we find in this study.

There are two possible explanations for this paradoxical finding. Again, drawing from the sociology of mental health literature, there is some evidence of the positive benefits of stress can solicit problem-solving, learning and persistence among those who face negative events (Thoits 1995). Assuming the pathway to healthcare scenario described above with men's propensity towards problem-solving and positive experiences with community-level institutions, it may be that given limited alternatives to healthcare after men have exhausted their other support resources or their support networks have encouraged them to seek care, they are more likely to approach barriers to healthcare with more active problem-solving for their own health benefits.

Alternatively, given men's responsiveness to institutional factors, it could mean that any interactions with the healthcare system, no matter how negative or deterring, seems to solicit a positive help-seeking response from immigrant men compared with no interactions at all. This may point to the importance of relationship building with a healthcare provider as well as accessing immigrant men's perception on the quality of care and treatment.

It may also be that the type of barriers measured in this study are not as significant a hurdle compared to other barriers faced by immigrant men. While this may not fully explain why the access increased among men in this study, this perspective addresses the problem-solving approach to coping. It may be that access and treatment barriers may be both small *and*

manageable compared to others societal barriers faced by immigrant men. This study did not test other barriers related to experiences of discrimination, unfair treatment or medical maltreatment inside or outside the healthcare setting. Future studies should examine whether types or levels of structural barriers that occur across multiple domains of incorporation such as labor, legal, or education, have differing effects on men's access to healthcare.

Moreover, this study did not specify the country where healthcare access occurred. There may be some respondents, although a small proportion, who make frequent trips to their country of origin that when deterred by their experiences of healthcare barriers in the U.S., utilized healthcare in the country of origin.

Limitations

The findings in this study should be considered with some limitations. First, the cross-sectional nature of the NLAAS dataset limits the ability to address issues of causality. Although the Andersen model suggests that specific factors contribute to healthcare access, less has been studied on the relationship between enabling factors using a multi-dimensional analysis of gender and gender relations on access to healthcare.

Second, the data is from 2002 - 2003. It is unclear to what extent these findings would generalize to the present time. NLAAS is the only nationally representative dataset with large samples of Latino and Asian immigrants that includes the key variables on multiple healthcare access outcomes and multi-dimensional measures of enabling, acculturation and household gender relations. Research on more recent data and longitudinal would be important to replicate and extend this analysis.

Third, the generalizability of the findings to the present time is especially relevant after the implementation of the Affordable Care Act (ACA) made significant changes to the U.S. healthcare system. The ACA increased, mainly through socioeconomic mechanisms related to health insurance and the expansion of the healthcare safety net, potential and realized access for the entire country, including immigrants. However, the ACA did not change many of the legal restrictions placed on immigrant access to healthcare. Undocumented immigrants continue to be ineligible for any form of federal subsidy or program for health insurance coverage. They must continue to rely on the local and state based safety net that varies considerable by county and state. Moreover, recent documented immigrants must still wait for five years to receive any form of public assistance such as Medicaid. Eligible immigrants still risk being labeled a public charge that would jeopardize their eligibility for further services and their application for citizenship. Thus, ACA would affect many of the socioeconomic enabling factors such as insurance, but not the social support mechanisms or the past legal, access and treatment barriers to healthcare. With updated data, it is important to determine the extent of the ACA in alleviating barriers to healthcare for immigrants.

Given the increased legal stratification among immigrants in relation to access to health insurance, many of the effects of this study may be considered conservative among the sub-population of undocumented and recent immigrants who, post-ACA, make up a larger proportion of the uninsured. In light of the study's findings, being uninsured is more likely to negatively affect immigrant men's access to healthcare. Among documented immigrants eligible for public and private insurance, their rates of health insurance should be higher which would more positively affect immigrant men.

Immigrant men's responsiveness to institutional factors underscores the importance of constructing policy and program interventions related socio-economic enabling factors such as insurance and social capital resources of friends and community to increase immigrant men's healthcare access. For men's access, increased access to public health insurance is predicted to make the most gains for men. Insurance and health services within the safety net are more accessible and tailored for women, and women with children. If the aim is to decrease the gender gap in insurance coverage among legibility immigrants, targeted outreach and programming towards men is necessary.

For immigrant women, programmatic interventions focused on increasing knowledge and messaging among extended family can positive influence women's access to healthcare. Messaging should focus on specific types of symptoms or conditions where women are less likely to go for medical services such as neo-natal care, pap smears, mental health, sexually transmitted diseases and domestic violence.

In conclusion, this study provides preliminary evidence on the moderating effect of gender on three types of enabling factors and immigrant access to healthcare. Men are more responsive to institutions and resources outside family structures, while women rely on relatives to enable them into healthcare. Emotional support from spouses both decrease healthcare access for both men and women. The findings on the social location and types of support also point to the importance of access to care being conceptualized as a part of a network that includes family and community. If increasing access to healthcare is a priority, then routes to healthcare must be cleared and widened so that immigrants can better trust healthcare providers and institutions as a viable source among friends, family and community to improve their health and wellness.

CHAPTER FIVE

GENDER in CONTEXT: HOUSEHOLD GENDER RELATIONS and IMMIGRANT ACCESS TO HEALTHCARE

It is well established that men, despite having more resources, are less likely to access healthcare than women. This gender difference is a consistent and enduring pattern across race, ethnicity, socioeconomic status, and immigration status (Gorman et al. 2016; Howe Hasanali et al. 2016; Kuhlmann and Annandale 2016; Lasser et al. 2006; Read and Smith 2017). For immigrants who face considerable legal, cultural and linguistic barriers to healthcare, the same gender pattern has also been found, with some scholars stating that “women go and men stay home” (Gorman et al. 2016). However, there are few studies, to date, that have examined the differing contexts that enable immigrant men and women to access (or not access) healthcare. What is happening in the home, a place where many important health decisions are made, that facilitates immigrant women to go to the doctor more than immigrant men?

Recent studies examining multiple health outcomes have found that access to healthcare is a significant mediator in the health gap between immigrants and non-immigrants, recent and established immigrants, and men and women, regardless of nativity (Gorman et al. 2010; Read and Reynolds 2012). The mediating effect of access to healthcare, more than other factors such as socioeconomic status, health behaviors, mental health status, or family characteristics, contributes to a renewed focus on access to healthcare as an important structural mechanism of health inequities (Gorman et al. 2010; Kuhlmann and Annandale 2016; Pitkin Derose et al. 2009; Read and Reynolds 2012; Read and Smith 2017).

On all measures of potential and realized access to healthcare, immigrants have lower levels of access compared to non-immigrants (Derose et al. 2007b, 2011; Pitkin Derose et al.

2009; Sarría-Santamera et al. 2016). Among immigrants, there is evidence of considerable variation in access across race and ethnicity, English language ability, and legal status. Immigrants, especially those with limited English proficiency, are also less satisfied with the quality of care and more likely to report unfair treatment or discrimination (Choi 2009; Vargas Bustamante et al. 2009). Duration in the U.S. has a strong effect with increasing years in the U.S. positively associated with access to healthcare (Chang, Chan, and Han 2015). Legal status also matters with undocumented immigrants being much less likely to access healthcare than documented immigrants, and permanent residents being less likely to access care compared to naturalized citizens (Akresh 2009; Derose et al. 2009; Derose, Escarce, and Lurie 2007; Yang and Hwang 2016). These patterns point to key socioeconomic factors, such as a lack of health insurance and income that enable or hinder access, but there are many structural factors that contribute to gender inequities in healthcare access such as acculturation processes, gender relations and contexts of immigrant incorporation that remain under-examined.

Many studies highlight how immigrant-related factors exacerbate the gender gap in healthcare access, while other factors minimize gender differences in access to healthcare. For example, one study found that while immigrant Asian women were more likely to utilize healthcare, they were also more likely to delay care (Shibusawa and Mui 2010). Other studies found little to no gender differences in utilization among some Asian groups (Choi 2009; Lee, Laiewski, and Choi 2014; Miltiades and Wu 2008; Read and Smith 2017), some Latino groups (De Jesus and Xiao 2013), while other studies found more differences among Latinos than Asians (Gorman et al. 2016; Read and Smith 2017).

There are few studies that address the moderating effect of gender within specific contexts and family dynamics on access to healthcare. From the gender and immigration and

gender and health literature, we have evidence that contexts of immigrant incorporation, including the household, have profound effects on health and social mobility trajectories (Hondagneu-Sotelo 1994; Pessar 1999; Walters, McDonough, and Strohschein 2002). The importance of examining gender in context is that gender is more than an individual-level variable, and accessing healthcare is not solely a purposeful rational choice. Gender is a multi-dimensional construct that structurally shapes social environments, manifests in relational interactions, and is constituted in the practice of help-seeking and accessing healthcare. Moreover, healthcare is a contextually-bound resource where availability and access are shaped by features of the physical and social environments that interact with individual, family and community level factors.

To address the important role of gender and gender relations in the immigrant household in shaping help-seeking and access to healthcare, this study uses a nationally representative sample of married and cohabitating Asian and Latino immigrants from the 2002-2003 National Latino and Asian American Study (NLAAS) to answer the following questions: 1) To what extent do immigrant households vary along dimensions of gender relations, and how are these dimensions associated with access to healthcare?; and 2) How do these dimensions of household gender relations differentially influence immigrant men's and women's access to healthcare?

Explanations of Gender in Immigrant Healthcare Access

Gender is known to be strongly associated with health status and to exert a significant influence upon help-seeking, access to and the delivery of healthcare. There is a significant body of research on gender and healthcare that has developed over the decades from an illness-

centered approach to one focused on how gender manifests in power relations, health policies and healthcare institutions (Kuhlmann and Annandale 2016).

The vast majority of the studies on access to healthcare have utilized the Andersen model (1968; 1995), the prevailing model of behavioral healthcare use, which measures three distinct factors - predisposing, enabling and need - that contribute to healthcare access. Other types of models classify factors as observed (i.e. income, language) and unobserved factors (i.e. attitudes, culture) (Vargas Bustamante et al. 2012). The Andersen model has been adapted to address contextual determinants and their interaction with individual level predisposing, enabling and health need factors that contribute to healthcare utilization (Andersen et al. 2014; Davidson et al. 2004). However, these models have not been applied to immigrant populations and have not integrated contextual theories of immigrant incorporation (Portes and Rumbaut 2006; Portes and Zhou 1993; Reitz 2002) or theories of gender relations (Annandale et al. 2007; Bird and Rieker 2008).

The Andersen model identifies three categories of individual-level factors: predisposing, enabling, and needs. Predisposing factors refer to socio-demographic characteristics that influence preferences or inclination to access healthcare. Enabling factors refer to personal, family or community resources that facilitate or hinder the ability to access healthcare. Need factors refer to perceived or clinically evaluated health conditions or illnesses and age- and sex-related preventative needs (e.g. mammograms).

Not only do these categories distinguish types of individual-level factors that affect access to healthcare in different ways, the Andersen model emphasizes that these categories also reflect the degree of mutability that help to identify interventions to eliminate disparities. Low mutability is often attributed to demographic characteristics such as age, gender or ethnicity.

Health beliefs and diagnosed needs are considered to have medium mutability. Many enabling factors such as health insurance and income, and perceived need are seen as highly mutable. Mutability is significant for the Andersen model because of its goal of policy interventions to address social inequalities, but assumptions of gender being limited to being a predisposing and fixed variable discounts significant advancements in the fields of gender theory and gender and health that emphasize the effects of the multi-dimensional structure of gender, as an individual interaction and structural measure, on various aspects of help-seeking, health behaviors and health outcomes.

Explanations of the effect of gender on access to healthcare have made significant theoretical and empirical advancement in the past few decades. Research among more diverse racial, ethnic and immigrant populations has confirmed some gender patterns found in the general population, but have also revealed increasing gender variation that reflect the intersection of gender with race, ethnicity, immigration status, and socioeconomic status. This has opened up the field to address more factors such as racial stratification, acculturation, legal status and discrimination, and challenged the healthcare field to address more complex and intersecting structural factors that produce health inequalities. I review three main ways the literature approaches gender and access to healthcare: 1) gender in relation to enabling resources; 2) gender roles and norms; and 3) gender as social structure.

The majority of immigrant healthcare access studies measure gender as a fixed predisposing variable with measuring on the extent of gender differences, and understanding the individual-level mediating mechanisms that explain observed gender differences. This approach has found important patterns in predisposing, enabling and need factors that differentially affecting men and women's access to healthcare. The main emphasis of inquiry has been on the

role of various enabling resources that facilitate or hinder access to healthcare, and the gender paradoxes that have emerged from the literature. For example, women are more likely to access healthcare despite having less enabling resources like socioeconomic status. Among the studies on immigrants, a similar paradox occurs with English proficiency where immigrant women are more likely to access healthcare despite lower levels of English language proficiency (Akresh 2009b; Read and Smith 2017).

The approach to gender has provided a foundational step in describing the relationship between gender and access to healthcare. However, the narrow application of gender limits the examination of how gender roles and relations function to affect health, and how gender operates with and through other forms of stratification which can give rise to wide variation of help-seeking behaviors among men and women.

Another approach is gender-role socialization and theories of “doing gender” which have made an important contribution in conceptualizing gender as a multi-dimensional social construct that is varied and conditional on context, time and place (Courtenay 2000; Knaak 2004). Health beliefs and help seeking behaviors can be understood as a means of expressing or enacting gender that shapes daily actions, expectations and experiences. For example, it is often argued that norms of stoicism and control associated with hegemonic forms of masculinity can deter men from seeking healthcare. Under this norm, seeking healthcare is seen as placing oneself in a passive, feminized sick role that undermines male identity and a man’s expected role within the family (Courtenay 2000; Galdas et al. 2005; O’Brien et al. 2005).

This link between gender and help-seeking can, at times, be interpreted through binary constructions of masculinity and femininity. Even though there is little consensus about what level of healthcare utilization is ideal, assumptions hold that on average, men will access

healthcare less and with only serious ailments, and women will access healthcare more frequently with less serious ailments. However, more recent studies among diverse population using cross-comparative study designs on the same illnesses or symptoms point to more variation in the association between gender and help-seeking (Chang and Subramaniam 2008; Galdas et al. 2007). For example, one of the few cross-cultural studies of gender and healthcare access found that White men and immigrant South Asian men in the United Kingdom had very different reactions to help-seeking in relation to their familial structure, cultural understanding of care giving roles, and social status. In a study on chest pain symptoms and help seeking, White men felt they needed to demonstrate how long they endured pain and discomfort before seeking help, while South Asian men consulted health providers quickly. None of the South Asian men thought it was “unmanly” or a sign of weakness to seek help. They placed greater emphasis on fulfilling their familial responsibilities, which they felt were at risk if they were not healthy. Moreover, most of the South Asian men consulted with family members regarding their symptoms. In contrast, the White men only disclosed to others as a last resort. In this study, South Asian men had a more collective masculine identity in relation to their families compared White men’s individual masculine identity.

Similar notions of group or collective based notions of masculinity were found among immigrant Latino men in the U.S. In a study on characteristics of Latino men and healthcare utilization, Rhodes et al. (2008) found that while Latino adherence to masculine beliefs about “strength” and “respect” were associated with utilizing healthcare, so were “asking for help” “and “being responsible”.

These findings call into question the enduring assumptions that specific forms (i.e. White) of hegemonic masculinity or femininity can be generalizable to more diverse racial,

ethnic or immigrant groups (Galdas et al. 2007). This also suggests that processes of immigration and racial stratification may contribute to the plurality of gender enactment and socialization associated with help-seeking (Cabassa 2007; Montes 2013).

The immigrant healthcare literature also adds acculturation to the relationship between gender socialization and access to health, and its role in shaping gender roles and socialization. Acculturation is a highly used, and much debated, concept that describes the change process in attitudes, values, and behaviors that occur as the result of contact between individuals or groups from different cultural backgrounds. Developments in theory and measurement have advanced to encompass a more multi-dimensional conceptualization of acculturation, which includes reasons and conditions for migration, legal status upon arrival, orientation toward and incorporation into the country of destination, and continued ties to the country of origin. These different dimensions of acculturation can be measured simultaneously and independently of each another (Abraído-Lanza, Echeverría, and Flórez 2016b; Alegria 2009; Antecol and Bedard 2006; Zane and Mak 2003).

With the acculturation approach to gender, gender differences in health and healthcare access are commonly attributed to immigrant men and women differing in their pace and flexibility in adopting or shedding cultural norms and behaviors. While there has been great advancement on the effects of gender and acculturation on different health outcomes using a wide range of methodologies, the explanation of the gender patterns in health and healthcare access mainly adopts a “traditional-modern” gender paradigm to discuss the rise or suppression of immigrant women’s social status and its effect on health. For example, in a study comparing immigrant and U.S. born Caribbeans did not find acculturation or living in the U.S. to mitigate female health disadvantage, the author acknowledges that even though gender inequality exists

in the U.S., “traditional gender roles and expectations” are more “entrenched in the Caribbean context” (Erving 2011; p.385). Erving posits that women in the Caribbean experience more expectations associated with stereotypical (re: traditional) gender roles and inequality in power, privilege and access to resources, and that gender socialization from the Caribbean (re: traditional) has a “carryover effect” to the U.S. (p. 395), which is more resistant to the modernizing effects of acculturation to U.S. culture. In another example in a study on gender, acculturation and multiple physical health outcomes, immigrant women’s higher gains in health, relative to men, along levels of acculturation, were explained by discussing how the “modest gains in independence and decision-making ability reflect an improvement in [health] status vis-à-vis gender relation [in their country of origin]” (Gorman et al. 2010; p. 442).

Even when structural factors are considered, the explanations do not acknowledge the plurality of masculinity and femininity across race, ethnicity and immigration status. For example, on Read and Reynolds’s (2012) findings on gender differences in seeking medical care, they suggest that men’s reluctance to seek help stems from their adherence to “hegemonic forms of masculinity” (p.102).

This paradigm conceptualizes cultural and social adaptation among immigrant, or lack thereof, as marked by exposure to “modern” liberal gender roles and norms in the U.S. or global north that allow immigrant women to gain more social status and power. The changes in immigrant women’s health status results from more autonomy from constraining and rigid “traditional” (i.e. Global South, non-White) gender roles and status hierarchies from their country or culture of origin (Blau 2015; Erving 2011; Gorman et al. 2014; Read and Gorman 2010; Read and Reynolds 2012). Interestingly, this traditional-modern gender acculturation paradigm is used to both explain why immigrant women are more likely to access healthcare

because their “status within the home and community which depends...on fulfilling [household and caregiving] duties (Read and Reynolds 2012; p. 102), and why immigrant women are unable to overcome barriers to healthcare given that there is “immense pressure on immigrant women to uphold these [traditional gender] roles after arrival to the United States” (Read and Reynolds 2012; p. 102). Fewer studies address how and if a change in social status with migration and acculturation affects immigrant men’s health and health behaviors (Batnitzky, McDowell, and Dyer 2009; Cabassa 2007; Cabieses et al. 2012; Walter et al. 2004).

The usage of the “traditional-modern” gender paradigm across a wide range of health studies, leaves a large gap in integrating gender and feminist theory into the immigrant health literature to more thoroughly investigate the multiple dimensions of gender as a basis for research design in immigrant health studies. Among the few studies that have directly addressed the effect of gender or cultural norms on health among immigrants, there have had mixed results which emphasizes the need for structural approaches to gender. For example, in a study on binge drinking and smoking among Latinos, Kimbro (2009) used a traditional values scale and found, contrary to expectations, there were no nativity differences in holding traditional values, and only small gender differences associated with holding traditional values and drinking or smoking.

In a study on immigrant Latino men and utilization of healthcare found that adherence to traditional notions of masculinity such as “strength”, “asking for help”, “being responsible” and “sticking to one’s beliefs” had a positive effect on healthcare utilization (Rhodes et al. 2008). It is important to highlight that these notions of masculinity that were defined as traditional among immigrant Latino men contrasts with the more individualist notions of hegemonic masculinity.

The structural approach addresses gender as a fundamental cause in the distribution of power that shapes social norms and opportunities for women and men at multiple levels of society (Phillips 2005; Risman 2004b; Risman and Davis 2013). In this approach to gender, it is necessary to understand the broader contexts in which men and women's health behaviors occur by addressing the gendered structures that foster or undermine attempts at health-seeking and accessing healthcare. This approach moves beyond views of categorical differences between men and women into understanding various ways gender organizes, regulates and upholds differential values, resources and opportunities for women and men.

The structural approach posits that gender is built into the social order of institutions and contexts that affect people's health and well-being. Institutions, like the healthcare system or marriage, or contexts, like households and families, constrain or facilitate resources and impose social controls and rewards that affect men and women's access to healthcare. This broader conceptualization of gender does not disregard individual level approaches, but emphasizes the importance of distal causes as well as the structural processes through which health inequality is reproduced even under changing mechanisms.

Addressing the need for a more comprehensive analysis, there are a small number of studies that have measured the effects of household and family characteristics on immigrant access to healthcare. However, the results, thus far, have been mixed. Some studies found that household size did not have an effect on access (Chang et al. 2015), while others found a positive effect [direction of effect (Leclere and Jensen 2009). Having other family members in the house that were sick was found to increase access (Akresh 2009b). Having children in the household decreased access (Akresh 2009b; Leclere et al. 2009), increased access (Read and Smith 2017),

and had minimal effect on healthcare access (Howe Hasanali et al. 2016). These studies also found variation by age of children and by racial and ethnic group.

Despite addressing more contextual factors, these studies have mainly conceptualized household and family characteristics as enabling variables with gender as a predisposing variable. Very few studies have examined how gender relations within immigrant household contexts facilitate or constrain health-seeking, and how household gender relations differentially affect men and women's access to healthcare. Gender relations, as gender negotiated in part through relationships of power, division of labor, cultural expectations, manifests in interactions located within contexts and institutions and constituted in the practice of health behaviors. More importantly, unlike social inequalities in socioeconomic status and race that are based on segregation and isolation, gender inequality is mainly produced through intense social interaction (Bird and Rieker 2008). This suggests a continuum of experiences that are shaped across multiple gendered dimensions of power, production, emotion and culture that elicit various behavioral responses (Connell 1987).

Addressing gender and immigration, together, calls for an intersecting approach that emphasizes gender inequities are sustained within contexts of social interactions and that immigrant experiences and life chances are shaped by contexts of social hostility or segregation (Annandale 2009; Bird and Rieker 2008; Ridgeway and Smith-Lovin 1999; Weber and Parra-Medina 2003). This need for this type of synthesis in the literature is important to note since much of the immigrant literature points to dynamics of gender relations, such as norms and roles within the context of the household and family, as a key explanation for gender differences in health access and outcomes, but rarely incorporates gender relations into the study design (Bottorff et al. 2011). At the same time, there is a significant body of literature in the field of

gender and health that has examined the household as an important site of gendered health-seeking and gender socialization (Addis and Mahalik 2003; Bird and Rieker 2008; Kuhlmann and Annandale 2016), but has not applied these findings to immigrant and racial and ethnic populations.

Gender in Context: Dimensions of Gender Relations in Immigrant Households

Households are primary social contexts where illness occurs, health-seeking decisions are made, and enabling resources for healthcare access are pooled and redistributed. People in the same household share similar physical, economic and social environments leading to common health vulnerabilities and exposures. Household members also share financial access to important enabling resources such as health insurance and social support. Pooled financial resources usually pay for family-based health insurance plans. Household members are also more likely to share similar beliefs and behaviors related to illness, help-seeking and health. These commonalities lead to assumptions that household members would mutually influence health behaviors. However, as evidence in the literature of gender and health shows, men and women within the same household can greatly differ in health beliefs, behavioral and emotional responses to stressors, and their health-seeking behaviors (Walters et al. 2002).

One of the studies on gender and healthcare access among Asians and Latinos, aptly titled “Women Go and Men Stay Home,” (Gorman et al. 2016), refers to the important household context in which help-seeking decisions in regards to accessing medical care are made. What is happening in the home that enables women to go to the doctor more frequently than men? Household constraints, where work and family decisions intersect, are the most apparent and

frequently experienced because they involve routines that occur on a daily basis that structure gender norms and roles and gender and family relations.

For immigrants and people of color, the household is more than just a context where men and women negotiate work and family decisions (Bird and Rieker 2008). The immigrant household is both a site of resistance against societal discrimination and a site of intense negotiation in gender, generational and cultural relations. This places the immigrant household within the contexts of immigrant incorporation as well as the social changes associated with acculturation. Emerging evidence shows contexts of immigrant incorporation at the household, neighborhood and national level do matter across nativity, immigrant status, and race and ethnicity (Choi 2009; Lasser et al. 2006; Siddiqi et al. 2013, 2009), but still little is known about how gender operates within these contexts of incorporation when it comes to accessing healthcare.

To address how household contexts shape gender relations and immigrant access to healthcare, I draw from Connell's theory of Gender and Power (2009) that conceptualizes gender as interconnected dimensions of gender relations that constrain or facilitate daily interactions, behaviors and beliefs. Connell posits four dimensions of gender relations - power, production, emotional, and culture - that organize social structures and contexts. Taken together, these dimensions define the patterns of constraints on gender practices and relations within specific contexts. This study examines how gender modifies the effect of three dimensions of household gender relations - production, power and emotional on access to healthcare.

Gendered power refers to how major household decisions and responsibilities are managed and shared. For immigrants, gendered power within the household is renegotiated and reconstructed upon migration and is influenced by the larger social contexts of incorporation

revealing more complexity to decisions, burdens of responsibility, and their implications. Dynamics of power are in flux and must be understood in the context of changing gender relations in the home country, migration decisions, dynamics of family separation and reunification, social networks, and access to resources.

In a qualitative study of Mexican immigrant families, Hondagneu-Sotelo (1994) found despite a division of labor within the home where women did most of the housework, there was more egalitarian decision making within these same homes in regards to finances, legal issues, migration and children's needs. Within the constraints of adapting to a new society and reconstructing their households in settlement, immigrant women and men saw the needs and benefits of sharing power and women actively participating in decision making in areas where they previously had limited power.

This negotiation of power reflects multiple structural changes within and outside the household that also interact with the gendered division of labor, culture and emotional dimensions found in the household (Brines 1994; England and Farkas 1986; Lundberg and Pollak 1996). For example, an increase of immigrant women working outside the home and contributing to household finances may increase women's negotiating power on some areas of the household, like obtaining health insurance, but not in others, as gender relations along other dimension of production, emotion and culture greatly influences help-seeking constrains and motivation.

Even if immigrant men have more relative power and status compared to immigrant women, they also experience a significant loss in societal status and power when they enter the U.S. where they often become, for the first time, a racialized minority and categorically unequal because of legal status. This loss in social status on multiple areas may have lessened their

negotiating power and authority, as well as forge new ways to construct power and masculinity within a new contexts, including the household (Batnitzky et al. 2009; Walter et al. 2004).

Finally, immigrants often settle in places that are unfamiliar, at best, and, hostile, at worst. Even with family and friend networks to assist in navigating a new society, the risks and outcomes of decisions may be harder to assess. Within these contexts, more egalitarian gender relations in power may be the best strategy for some immigrant households to address new challenges and unknown risks in the receiving society.

However, having responsibility for household management or economic decisions does not always reflect the benefits of greater power, but more responsibility may reflect a greater burden. In households with financial strain, the responsibility of work in and outside the house, financial management and other household decisions can be tenuous and burdensome. This can led to much more role-related strain within the household and social stressors leading to increased mental and physical health issues (Thoits 2010).

Shared power in decision making affects access to healthcare in multiple ways. In a household that shares decision making, men and women may both benefit in terms of overcoming reluctance to seeking healthcare. If women are more likely to access healthcare because of individual-level enabling or need factors, their decision making influence may positively influence men's help seeking behaviors. Moreover, more shared decision making may offer opportunities for men and women to better exchange resources from their respective networks, and encourage each other to seek help. Women's networks that tend to have more information about health and human service institutions may be better informed to identify trustworthy places for healthcare. Couples that share power may make better decisions about

when and if to pay for services, and be more mutually invested in finding additional healthcare options for the entire family.

For many immigrant men, their ability to provide financial and social resources to their family may not match their expectations before immigration, thus impacting their assumed role in the household and beliefs of masculinity and power. Moreover, the immigration experience often contributes to a plurality of gender and emotional expression that does not conform to hegemonic forms of masculinity in their country of origin or destination. Away from gender-affirming institutions and community in their country of origin, they must find ways to cope to a new environment with new hardships (Montes 2013). Immigrant men's reluctance to seek healthcare may not be about performing stoic forms of masculinity, but may actually indicate vulnerability and loss of power to fulfill their family and community roles. This lesser ability to command male authority and status may result in lessening their ability to act on their own health needs (Cabassa 2007).

Gendered production refers to the division of labor outside and inside the household. Labor force participation allows for more independent access to economic resources and the ability to pay for healthcare insurance, but it also adds to more strain and stressors that impinge on family and community responsibilities, and prioritization of health and self-care. In the past few decades, women in the U.S. and in sending countries have greatly increased their participation in the paid market place, but workplace conditions for women have become more precarious due to immigrant and economic policies (Donato et al. 2008).

In most households, immigrant and non-immigrant, domestic labor continues to be mainly performed by women, even when women are actively participating in the labor force. Multiple studies of immigrant families found that the variation in the gendered division of

household labor is structured by immigration and settlement processes such as the period of immigration, whether men or women migrate alone or with family, who migrates first, the reason for immigration, and the type of support networks existing in the place of settlement (Parrado and Flippen 2005; Parrenas 2002). For example, in a study of Mexican immigrant families, Hondagneu-Sotelo (1994) found Mexican immigrant men were more likely to participate in household labor when they migrated before there were established immigrant enclaves (before 1965), or immigrated on their own into male dominated immigrant networks.

Household division of labor facilitates immigrant men and women's access to healthcare in complex ways along areas of paid and unpaid labor. Both men and women who participate in the labor force have an increased likelihood of gaining income and private health insurance, important enabling resources for themselves and their family members to access healthcare. Moreover, immigrant men and women who work outside the home also have more diverse social network contacts in which to exchange information about where and how to obtain healthcare services, who is a trustworthy and culturally competent provider, and how to navigate the healthcare system.

Alternatively, women's higher burden of paid and unpaid household labor (i.e. household chores) may leave them with less time to prioritize their own needs for healthcare or be more selective on which health conditions they are willing to seek help. On the other hand, other domestic tasks that intersect with cultural and emotional dimensions of gender such as childcare and being the role as parent or spouse may facilitate help-seeking and increase exposure to health access opportunities through their children's healthcare and educational needs.

When focusing on household production, it is important to acknowledge economic models of the household. In new home economic models of comparative advantage, household

production is specialized to maximize utility function for the entire family, not just the individual. The gender division of labor is a result of this maximizing production (Becker 1993). This perspective would predict an overall increase in access to healthcare to maximize family health and well-being, even if there were differences between men and women. While compelling, this model does not explain the men's lower likelihood of accessing healthcare when they are the sole provider for the family, or women's higher likelihood of accessing healthcare regardless of their role in production for married or single-headed households. Moreover, Connell's multi-dimensional theory of gender relations acknowledges that household relations varies along multiple dimensions and that production will interact with power and culture, and emotion relation to affect outcomes.

Gendered emotional relations refers to emotional or sexual attachments, and gendered cultural relations refers to symbolic meanings and representations. In Connell's theory, she addresses emotional and cultural relations as distinct dimensions (2009). In this study, I conceptually combine these two dimensions to discuss how emotional support and strain and cultural conflict are demonstrated in the affective relationships that emotional caregiving responsibilities, and how gendered forms of caregiving, support and strain affect access to healthcare. Caregiving, like household chores, is a form of unpaid household labor, but unlike other forms of production, caregiving has a much stronger emotional, cultural and family relations components.

In immigrant households, caregiving and emotional support is still strongly gendered with women managing many of the physical and emotional support labor of immediate and extended family. However, there have been important immigrant and acculturation-related changes to gender and caregiving within immigrant families. Multiple studies of immigrant and

transnational families have found that men's level of caregiving varies with how much immigration has affected the structure of the family and family networks within sending and receiving countries (George 2005; Guttman 2006; Parrado and Flippen 2005; Pessar and Mahler 2006). Families in which immigration occurs in stages are more likely to have men take on more caregiving responsibilities. This occurs both in the country of origin when women immigrate first, or in the country of settlement if there are few kin networks. Without female kin networks to provide care giving, a few studies have found that men also take on more of a caring giving role with the children (Guttman 2006; Hondagneu-Sotelo 1994; Parrenas 2002). When families immigrate together into established enclaves, reunited after separation, or new families are formed in the U.S., immigrant men and women often return to traditional caregiving roles.

Immigrant men's lesser use of healthcare may reflect similar patterns for all men, but the explanation for their reluctance for help-seeking may not be the expected strong stoic reasons reflecting "hegemonic" forms of masculinity. For example, given fewer options for affordable healthcare, immigrant men may not use healthcare because they wish to prioritize limited resources for women and children. Motivations for help-seeking (or not) can stem from more caregiving or provider notions of masculinity, than just displaying strength and stoicism as reflected in forms of hegemonic masculinity (Galdas et al. 2005; Montes 2013).

For immigrant women, the caregiving role within the family is the most common explanation for women's higher rates of accessing healthcare. Men, who are cared for by women in their family, may not see the immediate need to go to the doctor. Women, who are more likely to care for others and engage in affective relationships, may increase their access because they have more enabling resources such as exposure to medical institutions through their care of

others, and the emotional associations, both positive and negative, to kin work (Dossa and Coe 2017).

Women may also experience increased healthcare need that stem from the stressors of holding multiple caregiving roles for children, their spouse and elderly family members in addition to other work and domestic responsibilities. The caregiving role also facilitates exposure to a wider range of institutions of incorporation and knowledge on how to best navigate the healthcare system. In turn, local outreach efforts to increase awareness of eligible health and human services are also placed in caregiving spaces (clinics, schools, grocery stores) and specifically target women and children such as pre-natal care, early breast cancer detection, food and nutrition programs, and school meal subsidies. Interaction with this targeted outreach and the provision of related services builds trust, knowledge and competency among caregivers to navigate systems and services.

Strains and stressors also stem from the constraints and responsibilities of work, family conflict, and not being emotionally supported by a spouse/partner. Emotional strain can take a mental and physical toll on both men and women, but women may be more affected since they may be taking on other caregiving roles. Increased role-related stress and strain (Thoits 2010) has deleterious effects on health and many increase the need to seek medical help.

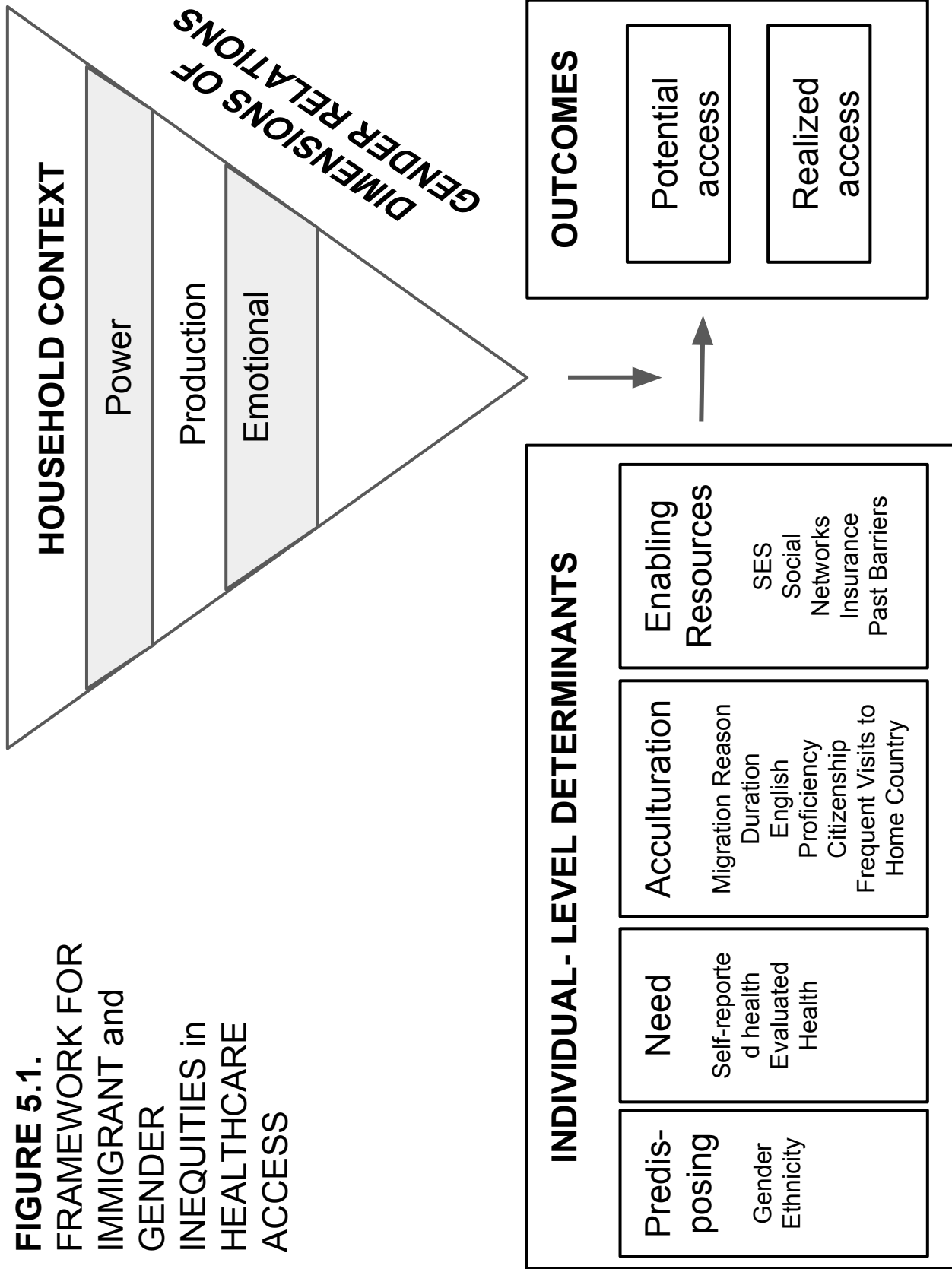
Hypotheses

To answer my research questions on the interaction between gender and dimensions of household relations on access to healthcare, this paper uses the theoretical framework discussed in detail in Chapter Two. The framework integrates three components, an individual-level model of healthcare use (Andersen 1995; Davidson et al. 2004), contextual analysis of the household

(Bird and Rieker 2008; Portes and Rumbaut 2006; Portes and Zhou 1993), and a structural analysis of gender relations (Connell 2009) to comprehensively examine how the interaction between gender and household gender relations facilitate or constrain access to healthcare (Figure 5.1). I posit the following hypotheses:

- H1: Households where men have most of the decision making power and economic responsibilities are more likely to have a negative effect on access to healthcare.
- H2: Households with greater female employment and female share of household chores are more likely to have a negative effect on access to healthcare.
- H3: Households with more caregiving responsibilities and emotional strain are more likely to have a positive effect on access to healthcare, and household with more spouse/partner support are more likely to have a negative effect on access to healthcare.
- H4: Gender will moderate the association between household power and access to healthcare with households where men have all of the decision making power and economic responsibilities will have a stronger negative effect on men than women.
- H5: Gender will moderate the relationship between household division of labor and access to healthcare with mixed effects. Households with a higher proportion of female employment will have a more positive effect on women's access to healthcare. In contrast, households where women do all of the household chores will have a more negative effect on women's access to healthcare.
- H6: Gender will moderate the relationship between caregiving roles with households with more caregiving responsibilities and emotional strain will have stronger positive effect on women's access to healthcare.

FIGURE 5.1.
FRAMEWORK FOR
IMMIGRANT and
GENDER
INEQUITIES in
HEALTHCARE
ACCESS



METHODS

Data and sample

The data used in this paper comes from the National Latino and Asian American Study (NLAAS), a nationally representative household cross-sectional sample of Latinos and Asian Americans (Alegria et al. 2004). NLAAS data was collected from May 2002 to November 2003 from adults from four Latino ethnic groups (Cuban, Mexican, Puerto Rican, and Other Latino), four Asian ethnic groups (Chinese, Filipino, Vietnamese and Other Asian), and a control group of non-Latino, non-Asian, white respondents. Interviews were conducted in Cantonese, English, Mandarin, Spanish, Tagalog, and Vietnamese. The weighted response rate was 65.6% for the Asian sample (n= 2,095) and 75.5% for the Latino (n=2,554) sample. This paper uses the full sample of Asians and Latinos (n=4,649). The final sample for analysis comprises of individual adult respondents who identified as immigrant (foreign-born) and in a married or cohabitating relationship with a person of a different sex (n=2,324).

The NLAAS sampling method is comprised of three components: (1) core sampling where participants were recruited with a multistage stratified area probability sampling design; (2) high density sampling where Census block groups were oversampled in areas where ethnic groups were represented in at least 5% of households; (3) second-respondent sampling to recruit participants from households with one eligible respondent. The NLAAS sampling procedure required the construction of weighting corrections to take into account joint probabilities of selection under the three components of the sampling design (Alegria et al. 2004; Heeringa et al. 2004; Pennell et al. 2004). The NLAAS sampling design requires the construction of weighting corrections that adjust for the hierarchical nature of the multistage survey design. Analyses were

done using the STATA 15 Statistical Software SVY program (StataCorp 2017), which takes into account complex survey sampling methods such as stratification, clustering and unequal weighting allows for weighting adjustments to account for the complex sampling design.

Measures

Dependent Variables

There are three dependent variables to distinguish between potential access and realized access to healthcare. Each outcome variable measures a distinct type of interaction with the healthcare system.

Has a Usual Healthcare Provider, (1=Yes, 0=No). Respondents were asked whether they had a usual provider for medical care.

This outcome of potential access measures the level of awareness of the healthcare system indicated by having a medical provider they could go to on a regular basis. Because of additional barriers to access faced by immigrants, such as availability of interpretation services and levels of cultural competency, immigrants who may have insurance to pay for services still may not have a usual place to go to for healthcare.

Use of Medical Services within the last 12 months, (1=Yes, 0=No). Respondents were asked whether they used any medical services within the last 12 months, including routine, dental/ophthalmologist, urgent or scheduled treatment or surgery.

This outcome of realized access measures the level of engagement with the healthcare system. Because it was not feasible to fully control for medical visits for reproductive needs among women, a broader measure of healthcare utilization was chosen over the more limited measure of use of routine or primary healthcare.

Number of visits within the last 12 months: Respondents were asked about the number of visits in the past 12 months to a general practitioner or other medical doctor

This outcome of realized access measures the frequency of utilization. There are no strict guidelines for frequency of healthcare utilization for the general age-adjusted population, but a yearly visit for routine or primary care for preventative reasons is a general recommendation by medical professionals. More than one medical visit within a year, after controlling for individuals with diagnosed chronic diseases, may indicate a higher exposure to conditions that affect acute mental and physical health such as stressors, infections, and injury.

Predisposing Factors

Gender, (1=Female, 0=Male).

Age, (years)

Ethnicity, (Asians: Chinese, Vietnamese, Filipino and Other Asian; Latinos: Mexicans, Puerto Ricans, Cubans and Other Latinos)

Need Factors

Need factors include two self-rated health measures and one measure of diagnosed chronic condition. Assessment of need also considers past diagnosed conditions given the tendency to over-estimate health in self-rated measures among groups who have the least access to healthcare such as immigrant men and recent immigrants.

Poor self-rated physical and mental health, (1=Poor/Fair, 0=Good/Excellent). Respondents were asked to rate their own physical and mental health on a four-point scale in separate questions.

This variable refers to whether a respondent answered poor or fair to either question.

Chronic disease diagnosis, (1=Yes, 0=No). This measure summarizes whether the respondent had at least one chronic disease diagnosis from a medical provider. Chronic diseases include heart disease, high blood pressure, asthma, chronic lung disease, diabetes, stomach or intestinal ulcer, epilepsy or seizures or cancer.

Acculturation Factors

Measures of acculturation reflect multiple processes of acculturation that include: 1) original migration decisions, 2) orientation towards the U.S.; and 3) transnational ties.

Reason for migration: job, to join family, or medical. Respondents were allowed to choose more than one response and rate how important the reason was for their decisions on a scale from 1 = very important to 3 = not very important. Responses were recoded into a dummy variable, 1 = somewhat/very important, and 0 = not important. Reasons for migration often shape the context for settlement (i.e. place, legal status) as well as level of health selectivity. Immigrants who migrate for work exhibit healthier behaviors and health statuses compared to immigrants who migrate for other reasons. This health selectivity associated with immigrants has been found to apply more to men than women because of migration reasons.

Proportion of life in the U.S. Calculated as current age minus age of migration divided by current age. The amount of time spent in the U.S. was calculated in relation to the respondent's age and age at immigration. This contrasts to studies that use measures of years in the U.S. (duration). Evidence suggests that the age of immigration is also relevant to understanding cultural change and societal incorporation. A variable measuring the proportion of life in the U.S has been used in previous studies (De Leersnyder et al. 2011; Leu et al. 2011).

Poor/Fair English proficiency. English proficiency has been found to have a significant effect on healthcare access across racial and ethnic groups and gender. Respondents were asked three questions to rate their ability to read, write, and speak English on a four-point scale ($\alpha = 0.97$) Responses ranging from poor to excellent in English proficiency, were recoded into a dichotomous variable (1 = poor/fair, 0 = good/excellent).

Citizenship status, (1 = naturalized U.S. citizen, 0 = not a U.S. citizen). Respondents were asked whether they have naturalized as U.S. citizens. It is also a measure of more established immigrants that indicate a shift in social identity towards the U.S. as well as being able to take advantage of specific rights and privileges. Citizens have more legal access to services and are also less inhibited in using public services because they are much less likely to fear being labeled a public charge (Gee et al. 2016).

Frequent visits to country of origin. Respondents were asked about their frequency in which they return to their country of origin, 1=often, 2= sometime, 3= rarely, 4=never. This variable was recoded into 1=often/sometimes, 0= rarely/never. The frequency of return visits to the country of origin indicates the maintenance of transnational ties well as additional opportunities to access healthcare that is more affordable or culturally and linguistically congruent.

Enabling Factors

Three types of factors that enable or inhibit access to healthcare are measured: socioeconomic-legal resources, past experiences of access or treatment barriers to healthcare, and types of social network support.

Education (in years)

Financial strain, (1=Yes, 0=No). Respondents were asked if they were having any difficulty in paying monthly bills.

Type of health insurance (private, public, no insurance). Health insurance is a vital resource that people gain through their employer, the state, or open market. For immigrants, health insurance is a socioeconomic-legal resource where employment status, income, legal status and duration in the U.S. determines whether a person is eligible for insurance (see Chapter Three for more details). Dummy variables were constructed on three types of insurance, private, public and none.

Number of Past Barriers to Healthcare. Respondents were asked if they experienced any past access or treatment barriers to healthcare within the last 12 months. Barriers included experiences with difficulty in getting an appointment by phone and referral to a specialist, experiences of a provider spending limited time with them during an appointment, long waits in clinic, difficulty in getting advice over the phone, not being able to get an assigned clinic, not able to get prescription to medication, and not receiving continuity of care.

Social support is an important contributor to better health and well-being. For healthcare access, supportive networks among friends and relatives can complement support received from a spouse/partner, and can affect access in both directions. Support networks are importance sources of information, resources, emotional care that can encourage seeking healthcare or be a substitute for healthcare services (i.e. mental health counseling)

Relative Support, (scale, 3-13). Respondents were asked three questions and rate their frequency of contact and levels of support with family or relatives (not including spouse/partner/children)

on a 4-point scale with 1= a lot to 4=not at all. Questions included, “How often do you talk on the phone or get together with family or relatives who do not live with you?” “How much can you rely on your relatives who do not live with you for help if you need to talk to someone about your worries?” “ How much can you open up to relatives who do not live with you if you need to talk to someone about your worries?”

Responses were recoded into a binary variable with 1=a lot/some 0=a little/not at all.

Friend Support, (scale, 5-15). Similar questions were asked about level of support with friends.

Household Gender Relations variables capture three dimensions of power, production and emotion.

Gender relations of power is measured using two variables on *decision making* and *economic responsibility* measured on a 5 point scale.

Decision making, (scale 1-5). Respondents were asked, “When it comes to making major decisions, who has the final say, you or your spouse?” 1=Respondent, 2=Both, 3=

Spouse/Partner. This questions was followed up with asking:

Do you/your partner have 1=a lot more say, 2= somewhat, or 3 a little say than you/your partner?

The variable was recoded with the gender of the respondent and the responses to the scaled questions with 3 = equalitarian share of decision making, and 1 and 5 reflecting an asymmetrical share of decision making, with 1 = female spouse/partner having a lot more say, and 5 = male spouse/partner having a lot more say.

Economic responsibilities, (scale 1-5). Respondents were asked, “When it comes to paying for household expenses – like mortgage or rent, electricity bills, who has the most responsibility?”

This variable was recoded like the decision making variable, where responses were coded with gender of the respondent and a 1-5 point scale was constructed with 3 = egalitarian share of economic responsibilities, 1 = female spouse/partner having most of the economic responsibilities, and 5 = male spouse/partner spouse/partner male spouse/partner having most of the economic responsibilities.

Gender relations of production is measured using two variables on *female household employment* and *household chores*.

Female household employment, (1=Yes, 0=No). Female household employment was coded from the sex of the respondent and their answer to questions on the employment status of themselves and their spouse/partner. This variable was coded to include any combination where the female in the household was employed (dual employed households or female sole employed households). This include part time and full time employment.

For *household chores*, (scale 1-5). A similar scale and coding for decision making and economic responsibilities variables was used. Respondents were asked. “When it comes to household chores – like cooking, cleaning, childcare, grocery shopping, who has the most responsibility?”

Gender relations of emotion is measured using four variables that capture different levels of spouse/partner, child and family dynamics of emotional support, strain that are related to help-seeking and caregiving behaviors that affect access to healthcare.

Partner support, (1=Yes, 0=No). Respondents were asked four questions on the level of emotional support they receive from their spouse/partner. “How much does your spouse/partner really care about you?” “How much does your spouse/partner understand the way you feel about

things?” “How much can you rely on your spouse/partner for help if you have a serious problem?” “How much can you open up to your spouse/partner if you need to talk about your worries?” Responses ranged from 1 (not at all) to 4 (a lot). The scale ranged from 4 – 16 with increasing numbers indicating more support, and recoded into a binary variable with scores more than 8 indicating support = 1 , and score 8 or less indicating no support = 0.

Partner strain, (1=Yes, 0=No) was measured and coded in the similar way as partner support.

Questions included “How often does your spouse/partner make too many demands on you?”

“How often does your spouse/partner criticize you? “How often does you spouses/partner let you down when you are counting on him/her? How often does your spouse/partner get on your nerves? The scale ranged from 4 – 16 with increasing numbers indicating more support, and recoded into a dichotomous variable with scores more than 12 indicating strain =1, and scores 12 or less indicating no strain = 0.

To facilitate comparability, coding for the partner support and strain measures in the same way as other studies that have used the same dataset and variable.

Child under 18, (1=Yes, 0=No). This variable measures the need for caregiving within the family indicated by having one or more children living in household under the age of 18.

Number in Household. This variable measures the extent of caregiving needed in the family.

Family cultural conflict, (scale 5-15): To address immigrant specific family dynamics, I include an acculturation-related household variable that measures emotional strain at the family level, I use part of the Hispanic Stress Inventory (Cervantes et al. 2016, 1991), the scale includes items such as “You have felt that being too close to your family interfered with your own goals”, and “Because you have different customs, you have had arguments with other members of your

family” “Because of lack of family unity, you have felt lonely and isolated. Responses ranged from 1 (hardly ever or never) to 3 (often), yielding a minimum and maximum sum score from 5-15 ($\alpha = .77$). Higher values indicate greater family cultural conflict.

Analytical Strategy

Table 5.1 provides descriptive statistics for the total sample, stratified by gender. Weighted percentage and means are reported along with results from Chi-square tests to determine whether gender differences observed were statistically significant.

Table 5.2 reports the results from a series of linear probability models that focus on the relationship between household gender relations factors and having a usual provider for medical care. Estimates and standard errors are reported. The analysis is performed in four steps. Model 1 tests the relationship of predisposing and need variables to determine their relationship to having a usual provider for medical care. Model 2 adds acculturation and enabling factors. Model 3 adds the household gender relations variables to examine their effect, controlling for all other covariates, on having a usual provider for medical care remain. Model 4 and subsequent models add gender and household gender relations interaction terms. Interaction terms are added independently to each model with statistically significant models shown. Figures of predicted probabilities are also shown to further highlight the gendered effects between covariates and healthcare access outcome. Additional analysis, not shown, are conducted with all the gender and household gender relations interaction terms in one model to measure the effect of each interaction term while controlling for all other covariates.

Table 5.3 reports the results from a series of linear probability models that focus on the relationship between household gender relations factors and having used any medical services within the last 12 months. It follows the same modeling pattern of analysis as Table 2.

Table 5.4 reports the results from a series of negative binomial regression models that focus on the relationship between household gender relations factors and the number of visits to medical services within the last 12 months. It follows the same modeling pattern of analysis as Tables 2 and 3.

Linear probability models were used instead of logistic regression models for ease of interpretation. All models were run using logistic regression to and confirmed similar results. All models used robust standard errors.

FINDINGS

Descriptive statistics

Table 5.1 provides descriptive statistics for the total sample of married or cohabitating immigrants, stratified by gender. Weighted percentage and means are reported along with results from chi-square tests to determine whether gender differences observed were statistically significant.

The rate of access is 59.34% for having a usual provider for medical care, 79.4% for having used any medical service within the last 12 months, and an average of 2.63 medical service visits within the last 12 months. Across all three outcomes, women have significantly higher rates of healthcare access compared with men. This gender pattern is consistent with past research.

Table 5.1. Descriptive Statistics for Total Sample and Stratified by Gender (Immigrants, Married and Cohabiting Sample n=2,324)

Variable	Total Sample		Men		Women		Gender Difference
	% or		% or		% or		
	Weighted Mean	SE	Weighted Mean	SE	Weighted Mean	SE	
	n=2,324		n=1,210		n=1,114		
Potential Access							
Usual Provider for Medical Care	59.34	(1.84)	51.33	(2.32)	68.06	(2.21)	***
Realized Access							
Use of any medical service within past 12 months (routine, dentist/opt, urgent, scheduled treatment/surgery)	79.4	(1.96)	71.67	(2.72)	87.8	(1.52)	***
Number of medical service visits within past 12 months	2.63	(0.09)	2.05	(0.15)	2.23	(0.14)	***
Predisposing Factors							
Female	47.92						
Age (years)	40.72	(0.58)	41.38	(0.74)	40.01	(0.57)	*
Ethnicity:							
Mexican (reference)	39.75	(4.04)	43.83	(3.8)	35.32	(4.69)	**
Puerto Rican	4.34	(0.5)	4.55	(0.56)	4.12	(0.61)	
Cuban	4.21	(0.5)	4.35	(0.55)	4.06	(0.51)	
Other Latinos	18.36	(1.82)	17.71	(2.)	19.08	(2.2)	
Chinese	10.1	(1.29)	9.14	(1.27)	11.13	(1.53)	+
Vietnamese	5.55	(0.87)	4.71	(0.78)	6.46	(1.06)	
Filipino	6.85	(0.98)	6.16	(0.98)	7.61	(1.13)	+
Other Asian	32.5	(2.74)	9.55	(1.4)	12.23	(1.66)	+
Need Factors							
Poor/Fair Self-rated physical health	26.41	(2.02)	24.9	(2.14)	28.05	(2.76)	
Poor/Fair Self-rated mental health	11.36	(1.1)	11.92	(1.63)	10.75	(1.01)	
Diagnosed chronic condition	29.64	(1.62)	28.75	(2.18)	30.62	(1.51)	
Migration & Acculturation Factors							
Reason for Immigration (Very important)							
Employment	67.67	(1.47)	71.38	(1.43)	63.63	(2.43)	**
To Join Family	49.86	(2.14)	46.21	(2.49)	53.83	(2.73)	**
Medical	13.58	(1.4)	12.9	(1.44)	14.3	(2.)	
Proportion of Life in US	42.28	(0.01)	44.52	(0.01)	39.93	(0.01)	***
English Proficiency Poor/Fair	65.9	(2.04)	64.35	(2.3)	67.59	(2.15)	+
Naturalized Citizen	37.32	(2.08)	37.78	(2.34)	36.82	(2.42)	
Visits Country of Origin (Often/Sometimes)	44.75	(1.55)	47.15	(2.61)	42.15	(1.74)	
Enabling Factors							
Education (years)	10.87	(0.23)	10.79	(0.23)	10.97	0.29	
Financial strain	42.82	(2.35)	41.17	(2.86)	44.62	(2.43)	
Health insurance status:							
Private (ref)	49.83	(2.71)	51.74	(2.7)	47.96	(3.1)	+
Public	17.75	(1.21)	13.85	(1.4)	21.98	(1.62)	***
Uninsured	32.32	(2.29)	34.4	(2.6)	30.06	(2.61)	+
Number of past barriers to medical care	0.76	(0.04)	0.666	(0.07)	0.85	(0.05)	*
Social Support Networks							
Relative Support Scale (3-15)	11.18	(0.09)	11.06	(0.11)	11.38	(0.13)	*
Friend Support Scale (5-15)	9.59	(0.07)	9.4	(0.1)	9.81	(0.1)	**
Household Gender Relations							
Decision Making (1-5)	3.32	(0.36)	3.43	(0.05)	3.19	(0.04)	***
Economic Responsibilities (1-5)	2.35	(0.04)	2.28	(0.04)	2.43	(0.05)	**
Household Chores (1-5)	3.69	(0.03)	3.59	(0.04)	3.8	0.03	***
Female Employment	51.33	(2.12)	51.31	(2.24)	51.35	(2.61)	
Children under 18	48.78	(2.09)	45.35	(2.62)	52.51	(2.3)	**
Household Size	3.25	(0.06)	3.13	(0.09)	3.38	(0.07)	*
Family Cultural Conflict (5-15)	6.16	(0.05)	6	(0.06)	6.34	0.07	***
Partner Emotional Strain	42.84	(1.64)	44.45	(2.61)	41.09	(1.21)	
Partner Emotional Support	8.26	(0.82)	5.53	(1.05)	11.24	(1.27)	**

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

The average age of the sample is 40.72 years. Mexicans (39.75%) were the largest ethnic group followed by Chinese (10.1%), Filipino (6.85%) and Vietnamese (5.55%). Other Asians (32.5%) and Other Latinos (18.36%) are also a large proportion of the sample. Mexicans are the only ethnic group with a significantly larger male population. Chinese, Filipinos and other Asians have a larger female population (p -value <0.10).

A quarter of the sample (26.41%) have poor/fair self-rated physical health, 11.36% of the sample report having poor/fair self-rated mental health, and 29.64% report having been diagnosed with at least one chronic medical condition. None of these health need factors significantly differed by gender.

Acculturation measures reflect the gendered nature of migration to and incorporation into U.S. society. On migration measures, 67.67% of the sample responded that migrating for work was very important. 49.86% responded that migrating to join family was very important. A smaller percentage (13.58%) responded that migrating for medical reasons. Reasons for migration are not mutually exclusive. As reflected in the literature, more men reported migrating for work reasons and more women report migrating to join family.

On incorporation measures, the mean proportion of life spent in the U.S. is 42.28 which reflects a more established immigrant sample in terms of duration. This contrasts with, 65.9% reported having poor/fair English proficiency and 37.32% being naturalized U.S. citizens which reflects lower levels of acculturation to the U.S. Men spent a higher proportion of their life in the U.S., and have slightly lower rates of poor/fair English proficiency compared with women. This differs from other studies which found higher rates of poor/fair English proficiency among women.

On the maintenance of transnational ties, 44.75% of respondents reported that they visited their country of origin often or sometimes. There were no gender differences with this measure.

The average number of years of education is 10.87. Almost half (42.82%) of the sample are experiencing financial strain. Almost half of the sample have private health insurance (49.83%), followed by 32.78% who are uninsured and 17.75% have some form of public health insurance. There are slightly more men among those with private insurance and the uninsured, and women comprise significantly more of those with public health insurance. These gender differences in health insurance reflect a gender and immigrant stratified labor market and its relationship to market-based health insurance and public policy programs. A third (34.78%) of the sample have experienced at least one healthcare access or treatment barrier in the past. The mean number of barriers was 0.76 with the range being between 0 and 8. More women experienced any barriers and experienced a higher mean number of barriers compared with men. The social networks are robust with high levels of relative (mean: 11.18) and friend support (mean: 9.59). As expected, women reported higher levels of relative (11.38 vs. 11.06) and friend support (9.81 vs. 9.4) than men.

Household gender relations measures are categorized along dimensions of power, division of labor and emotion. For scaled measures (1-5), lower numbers reflect asymmetrical gender relations that where women have more power and responsibility, work outside the home, and do less household work. Higher numbers reflect asymmetrical gender relations indicate men have more power, responsibility and do less household work. The median number (3) reflect an egalitarian structure. In the measurement of power relations, the mean of decision making and economic responsibility measures indicate egalitarian gender structure, with decision making

(3.32) skewing more towards men and economic decisions (2.35) skewing more towards women. Two variables have some small gender differences, with men reporting having more decision making power (3.43 vs. 3.19) and women reporting having more economic responsibilities (2.28 vs. 2.43).

With household gender division of labor, the mean of household chores is 3.69 indicating an egalitarian structure. The rate of household female employment is moderate at 51.33%. As expected, there are some small gender differences in reporting the gender structure of household chores, with women reporting living in households where they are doing more household chores (3.8 vs. 3.59).

With household relations of caregiving and emotional support, almost half the sample (48.78%) have at least one child under the age of 18 living with them with more women reporting having a child dependent. The household size mean was 3.25. The mean of family cultural conflict was 6.16 indicating low levels of conflict, although women reported higher mean levels than men (6.34 vs 6). There are no gender differences in partner strain with 42.84% of the sample reporting high levels of emotional strain from their spouse/partner. By contrast, only 8.26% reported receiving partner emotional support with women receiving significantly more than men (11.24% vs. 5.53%). Overall, both men and women show high levels of emotional strain from child, partner and family relations and low levels of partner/spouse emotional support. Women reported higher levels of having dependent children and experiencing family cultural conflict compared with men, but women also reported receiving higher spousal/partner emotional support.

The various dimensions of household gender relations reflect more egalitarian gender relations along decision making, economic responsibilities, female employment and household

chores than assumed by much of the immigration health literature. The findings on emotional caregiving and support also affirms past literature with women having more caregiving and emotional strain than men in terms of child and family dynamics, but receiving less strain and more support from their male spouses/partners. Gender differences in perspective of household gender relations along dimensions of power, production and emotion also point to saliency of different family roles and their relationship with stressors, the difference between having power and having responsibilities, and gendered perceptions of household management and division of labor.

Findings on Potential Access to Healthcare

Table 5.2 presents results from multivariate linear probability models on having a usual provider for medical care, a measure of potential access to healthcare. Estimates and standard errors are reported. Model 1 includes predisposing and health need factors and shows that being female, relative to male, significantly increases the probability of having a usual provider by 0.16. This positive effect of being female remains consistent across all models. Mexicans are the least likely immigrant group to have a usual place for medical care, relative to all immigrant group included in the model. These racial and ethnic differences remain throughout all models. Having poor/fair self-rated mental health significantly decreases the probability of having a usual provider for care by 0.12, relative to good/excellent self-rated mental health, and having at least one diagnosed medical condition significantly increases the probability of having a usual provider by 0.13. The effect of these two need factors remains in all subsequent models.

**Table 5.2. Multivariate Linear Probability Models
Effects of Household Gender Relations on Having a Usual Provider for Medical Care among Married/Cohabiting Immigrants**

	Model 1			Model 2			Model 3		
	Estimate	SE		Estimate	SE		Estimate	SE	
Predisposing Factors									
Female	0.16	*** (0.02)		0.16	*** (0.02)		0.16	*** (0.02)	*** (0.02)
Age (years)	0.01	*** (0.001)		0.005	*** (0.001)		0.005	*** (0.001)	*** (0.001)
Mexicans (reference)									
Puerto Ricans	0.27	*** (0.06)		0.14	* (0.07)		0.15	* (0.07)	* (0.07)
Cubans	0.11	** (0.04)		0.08	* (0.04)		0.09	* (0.04)	* (0.04)
Other Latinos	0.18	*** (0.05)	+	0.10	+		0.10	+	+
Chinese	0.15	*** (0.05)	*	0.10	*		0.12	*	+
Vietnamese	0.21	*** (0.04)		0.07			0.10	*	*
Filipino	0.19	*** (0.04)		0.08			0.10	+	+
Other Asian	0.23	*** (0.03)	*	0.08	*		0.08	*	*
Need Factors									
Poor/Fair Self-rated mental health	-0.12	*** (0.04)		-0.08	+		-0.08	*	*
Poor/Fair Self-rated physical health	-0.02	(0.03)		0.03			0.03		(0.03)
Diagnosed chronic condition	0.13	*** (0.03)	**	0.07	** (0.03)		0.07	*	*** (0.03)
Acculturation Factors									
Migration reason: to work				0.07	*** (0.03)		0.08	*** (0.03)	*** (0.03)
Migration reason: to join family				0.001	(0.02)		-0.01		(0.02)
Migration reason: medical care				-0.03	(0.04)		-0.04		(0.04)
Proportion of Life in US				0.10	*		0.11	*	*** (0.05)
English Proficiency Poor/Fair				-0.02	(0.02)		-0.01		(0.02)
Naturalized Citizen				0.04	(0.03)		0.03		(0.03)
Visits to Country of Origin				0.07	*** (0.02)		0.08	*** (0.02)	*** (0.03)

Table 5.2 (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)			0.002	(0.003)	0.001	(0.003)
Financial strain			-0.02	(0.03)	-0.01	(0.03)
Private Insurance (reference)						
Public Insurance			-0.03	(0.04)	-0.03	(0.04)
No Insurance			-0.33	(0.03)	-0.32	(0.04)

Number of past barriers to medical care			0.02	(0.01)	0.02	(0.01)
Relative Support			0.003	(0.01)	0.003	(0.01)
Friend Support			0.01	(0.005)	0.01	(0.005)
						*
Household Gender Relations						
Decision Making					-0.005	(0.01)
Economic Responsibilities					-0.002	(0.01)
Household Chores					-0.002	(0.01)
Female Employment					-0.004	(0.03)
Children under 18					0.05	(0.03)
Household Size					-0.02	(0.01)
						*
Family Cultural Conflict					-0.01	(0.01)
Partner Emotional Strain					-0.004	(0.03)
Partner Emotional Support					0.001	(0.05)
Interactions: Gender & Household Gender Relations						
Female*Decision Making						
Female*Economic Responsibilities						
Female*Chores						
Female*Female Employment						
Female*Children Under 18						
Female*Family Cultural Conflict						
Female*Partner Emotional Strain						
Female*Partner Emotional Support						
N	2,323		2,261		2,195	
R-Squared	0.1686		0.2902		0.2849	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Model 2 adds acculturation and enabling factors. With acculturation measures, migrating for work, proportion of life in the U.S. and frequent visits the country of origin increases the probability of having a usual provider for care by 0.07, 0.10, and 0.07, respectively. As expected, having no health insurance, compared with having private health insurance decreased the probability of potential access by 0.33. An increase in friend support increases the probability of potential access by 0.01.

Model 3 is the full model with the addition of household gender relations variables. Previous associations between predisposing, need, migration, acculturation and enabling factors remain. Among the household variables, household size is the only variable that has an effect. An increase in household size decreases the likelihood of having a usual provider for care by 0.02. Additional analysis on the moderating effects of gender and household gender relations on access to healthcare did not find any support. These findings reflect the need for new or diverse information that are more likely to come from friends, which has a small significant positive effect on access, than close family. Since family and relative contexts are more homogenous and more cohesive, the information they have for obtaining a health provider may be redundant. As we can see from the positive effect of friend support in which friend networks may be more effective in increasing potential access than family networks.

Findings on Realized Access to Healthcare

Tables 5.3a and 5.3.b presents results from multivariate linear probability models on having used a medical service within the last 12 months, a measure of realized access to healthcare. Like in the previous outcome, being female has a consistently significant positive effect on having used a medical service within the last 12 months. Mexicans, relative to all immigrant groups in the sample, are the least likely to have used a medical services compared to other immigrant groups. This pattern diminishes in the full model where there are almost no racial and ethnic differences in having used medical services.

In Model 2, acculturation and enabling variables are added. Migrating for work and being a naturalized citizen both have a positive effect, and migrating to join family and having poor/fair English proficiency both have a negative effect on having used a medical service. All these acculturation effects are weakly evident (p-value level <0.10) except for migrating for work reasons. Among enabling variables, socioeconomic-legal resources like insurance type and having financial strain are statistically significant.

In Model 4, the full model, when dimensions of household gender relations variables are added, the effect of acculturation and enabling variables remain and the effect of financial strain strengthens. Among the household gender variables, only having family cultural conflict, a measure of emotional gender relations, has a positive effect on having used a medical service.

While we find very few effects of household gender relations on having used a medical services within the last 12 months on the entire sample, Models 4, 5, 6 and 7 show that gender moderates the relationship between multiple dimensions of gender relations within the household. Specifically, gender interacts with dimensions of power (economic responsibilities),

Table 5.3a Multivariate Linear Probability Models
Effects of Household Gender Relations on Using any Medical Service within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.15	*** (0.02)	0.15	*** (0.02)	0.15	*** (0.02)
Age (years)	0.003	*** (0.001)	0.002	(0.001)	0.003	* (0.001)
Mexicans (reference)						
Puerto Ricans	0.15	*** (0.04)	0.05	(0.04)	0.04	(0.04)
Cubans	0.07	(0.04)	0.01	(0.04)	0.01	(0.04)
Other Latinos	0.18	*** (0.04)	0.09	** (0.03)	0.09	* (0.04)
Chinese	0.18	*** (0.04)	0.06	+	0.07	* (0.03)
Vietnamese	0.19	*** (0.04)	0.03	(0.04)	-0.01	(0.04)
Filipino	0.15	*** (0.04)	0.00	(0.04)	-0.01	(0.04)
Other Asian	0.18	*** (0.05)	-0.01	(0.05)	-0.03	(0.04)
Need Factors						
Poor/Fair Self-rated mental health	-0.13	*** (0.04)	-0.10	* (0.05)	-0.09	* (0.04)
Poor/Fair Self-rated physical health	-0.03	(0.03)	0.01	(0.03)	0.01	(0.03)
Diagnosed chronic condition	0.09	*** (0.03)	0.04	* (0.02)	0.04	* (0.02)
Migration & Acculturation Factors						
Migration reason: to work			0.05	* (0.02)	0.06	* (0.02)
Migration reason: to join family			-0.04	+	-0.04	+
Migration reason: medical care			0.01	(0.02)	0.01	(0.02)
Proportion of Life in US			-0.06	(0.06)	-0.07	(0.06)
English Proficiency Poor/Fair			-0.04	+	-0.04	+
Naturalized Citizen			0.05	+	0.05	+
Visits to Country of Origin			0.03	(0.03)	0.03	(0.03)

Table 5.3a (continued)

	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)			0.005	(0.003)	0.005	(0.003)
Financial strain			-0.04 +	(0.02)	-0.05	(0.02) **
Private Insurance (reference)						
Public Insurance			0.03	(0.02)	0.03	(0.02)
No Insurance			-0.25 ***	(0.05)	-0.24	(0.04) ***
Number of past barriers to medical care			0.02 ***	(0.01)	0.02	(0.01) ***
Relative Support			-0.004	(0.003)	-0.002	(0.004)
Friend Support			0.01 +	(0.003)	0.01	(0.004) +
Household Gender Relations						
Decision Making					0.00	(0.01)
Economic Responsibilities					0.01	(0.01)
Household Chores					-0.02	(0.01)
Female Employment					0.01	(0.02)
Children under 18					0.04	(0.03)
Household Size					0.00	(0.01)
Family Cultural Conflict					0.02	(0.01) ***
Partner Emotional Strain					-0.01	(0.02)
Partner Emotional Support					-0.04	(0.04)
N	2,323		2,261		2,195	
R-Squared	0.1455		0.2457		0.2621	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 5.3b Multivariate Linear Probability Models
Effects of Household Gender Relations on Using any Medical Service within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 3		Model 4		Model 5		Model 6		Model 7	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors										
Female	0.15	*** (0.02)	0.25	*** (0.05)	0.20	*** (0.02)	0.11	*** (0.03)	0.06	(0.05)
Age (years)	0.003	* (0.001)	0.003	* (0.001)	0.003	** (0.001)	0.003	* (0.001)	0.003	** (0.001)
Mexicans (reference)										
Puerto Ricans	0.04	(0.04)	0.05	(0.04)	0.04	(0.04)	0.04	(0.04)	0.04	(0.04)
Cubans	0.01	(0.04)	0.02	(0.04)	0.01	(0.04)	0.01	(0.04)	0.01	(0.04)
Other Latinos	0.09	* (0.04)	0.09	* (0.04)	0.09	* (0.04)	0.09	* (0.04)	0.08	* (0.04)
Chinese	0.07	* (0.03)	0.07	* (0.03)	0.07	* (0.03)	0.07	* (0.03)	0.07	* (0.03)
Vietnamese	-0.01	(0.04)	0.00	(0.04)	-0.01	(0.04)	-0.01	(0.04)	-0.01	(0.04)
Filipino	-0.01	(0.04)	-0.01	(0.04)	-0.01	(0.04)	-0.01	(0.04)	-0.01	(0.04)
Other Asian	-0.03	(0.04)	-0.02	(0.04)	-0.03	(0.04)	-0.03	(0.04)	-0.03	(0.04)
Need Factors										
Poor/Fair Self-rated mental health	-0.09	* (0.04)	-0.08	+ (0.04)	-0.09	* (0.04)	-0.09	* (0.04)	-0.09	* (0.04)
Poor/Fair Self-rated physical health	0.01	(0.03)	0.01	(0.03)	0.01	(0.03)	0.01	(0.02)	0.01	(0.02)
Diagnosed chronic condition	0.04	* (0.02)	0.04	* (0.02)	0.04	* (0.02)	0.04	* (0.02)	0.04	* (0.02)
Migration & Acculturation Factors										
Migration reason: to work	0.06	* (0.02)	0.06	* (0.03)	0.06	* (0.02)	0.06	* (0.02)	0.06	* (0.02)
Migration reason: to join family	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	(0.02)	-0.04	(0.02)	-0.04	+ (0.02)
Migration reason: medical care	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)	0.01	(0.02)
Proportion of Life in US	-0.07	(0.06)	-0.06	(0.06)	-0.07	(0.06)	-0.06	(0.06)	-0.06	(0.06)
English Proficiency Poor/Fair	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	+ (0.02)	-0.04	(0.02)
Naturalized Citizen	0.05	+ (0.03)	0.05	+ (0.03)	0.05	+ (0.03)	0.04	(0.03)	0.04	(0.03)
Visits to Country of Origin	0.03	(0.03)	0.03	(0.03)	0.03	(0.03)	0.03	(0.03)	0.03	(0.03)

Table 5.3b (continued)

	Model 3		Model 4		Model 5		Model 6		Model 7	
	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors										
Education (years)	0.005	(0.)	0.004	(0.)	0.005	(0.)	0.005	(0.)	0.005	(0.)
Financial strain	-0.05	** (0.02)	-0.05	* (0.02)	-0.04	* (0.02)	-0.05	** (0.02)	-0.05	** (0.02)
Private Insurance (reference)										
Public Insurance	0.03	(0.02)	0.03	(0.02)	0.03	(0.02)	0.02	(0.02)	0.02	(0.02)
No Insurance	-0.24	*** (0.04)	-0.24	*** (0.04)	-0.24	*** (0.04)	-0.24	*** (0.04)	-0.25	*** (0.05)
Number of past barriers to medical care	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)
Relative Support	-0.002	(0.004)	-0.002	(0.004)	-0.002	(0.004)	-0.003	(0.004)	-0.003	(0.004)
Friend Support	0.01	+ (0.004)	0.01	+ (0.003)	0.01	+ (0.004)	0.01	* (0.003)	0.01	+ (0.003)
Household Gender Relations										
Decision Making	-0.001	(0.01)	-0.002	(0.01)	-0.001	(0.01)	-0.002	(0.01)	-0.001	(0.01)
Economic Responsibilities	0.01	(0.01)	0.03	+ (0.02)	0.01	(0.01)	0.01	(0.01)	0.01	(0.01)
Household Chores	-0.02	(0.01)	-0.02	(0.01)	-0.02	(0.01)	-0.02	(0.01)	-0.02	(0.01)
Female Employment	0.01	(0.02)	0.01	(0.02)	0.06	* (0.03)	0.01	(0.02)	0.01	(0.02)
Children under 18	0.04	(0.03)	0.04	(0.03)	0.04	(0.03)	-0.003	(0.03)	0.04	(0.03)
Household Size	0.002	(0.01)	0.002	(0.01)	0.003	(0.01)	0.002	(0.01)	-0.01	(0.02)
Family Cultural Conflict	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)	0.02	*** (0.01)
Partner Emotional Strain	-0.01	(0.02)	-0.01	(0.02)	-0.01	(0.02)	-0.01	(0.02)	-0.01	(0.02)
Partner Emotional Support	-0.04	(0.04)	-0.03	(0.04)	-0.04	(0.04)	-0.04	(0.04)	-0.04	(0.04)
Interactions: Gender & Household Gender Relations										
Female*Decision Making			-0.04	* (0.02)						
Female*Economic Responsibilities										
Female*Chores										
Female*Female Employment					0.06	* (0.03)				
Female*Children Under 18							0.10	* (0.04)		
Female*Household Size									0.03	* (0.01)
Female*Family Cultural Conflict										
Female*Partner Emotional Strain										
Female*Partner Emotional Support										
N	2,195		2,195		2,195		2,195		2,195	
R-Squared	0.2621		0.2657		0.2657		0.2655		0.2659	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

the division of labor (female employment), and emotions (having a child dependent and household size) on having used a medical service within the last 12 months.

Comparing the patterns associated with economic responsibility by gender, Figure 5.2 illustrates that when men or women, have almost all economic responsibilities in the household, respectively, their likelihood of access to healthcare increases. As economic responsibilities transfers more to their spouse/partner, this variable becomes less significant in determining healthcare access. When women have all the economic responsibility in their household, their predicted probability of using medical services is 0.05 greater than when all the economic responsibility in the household transfers to men. The same pattern occurs among men with a slightly larger gap, where their predicted probability of using medical services is 0.06 greater when they have all economic responsibility compared to when their spouse has all the economic responsibility.

Given women's relative higher levels of access compared to men, this pattern shows a large gender gap in the use of medical services in households where women have more economic responsibilities, and a much smaller gender gap in households where men have more economic responsibility. However this "equality" in access to health between men and women is predicated on women lowering their likelihood to men increasing their likelihood of access, which may not be the best health pattern for a population that has an overall lower prevalence of accessing healthcare compared to the U.S. born.

Model 5 shows that that female employment in the household increases the likelihood of using a medical service within the last 12 months by 0.06, and this effect is moderated by gender. Figure 5.3 illustrates that men living in households with female employment have a 0.06 greater predicted probability of having used a medical service compared to men who do not live in

households with female employment. For women who work, they have a 0.03 lower predicted probability of having used a medical service compared to women who do not work

Figure 5.4 illustrates that while men's predicted probability of access does not change with having children, women who have children have a 0.09 greater predicted probability of compared with women who do not have children living with them.

Figure 5.5 highlights the opposing gendered effect of household size on having used a medical service. As household size increases, women's predicted probability of access increases by 0.16 while men's access reduces by 0.12.

Additional analysis with all gender interactions with household gender relations included in the model show that the moderating effects of gender economic responsibilities continues have a significant effect (p-value level <0.10) on having used a medical service within the last 12 months, controlling for all other covariates.

Figures 5.2 – 5.5 Predicted Probability of Having Used a Medical Service within the last 12 months by Gender and Dimensions of Household Gender Relations with 95% confidence intervals

Figure 5.2 Economic Household Responsibilities

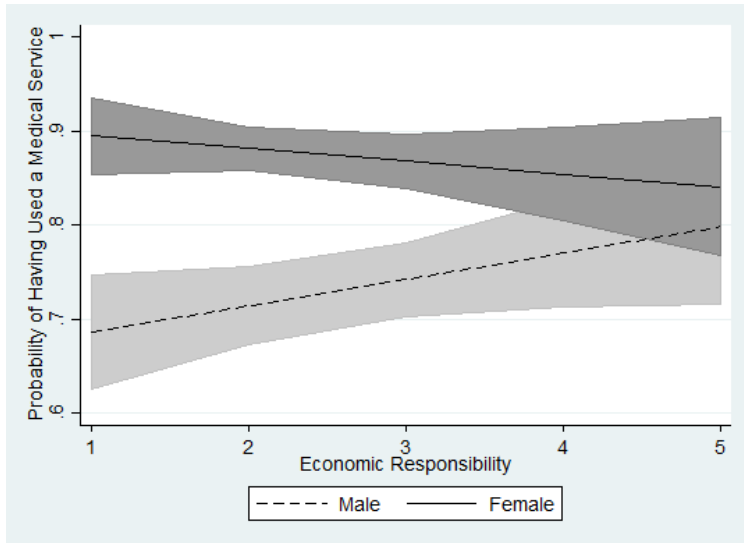


Figure 5.3 Female Household Employment

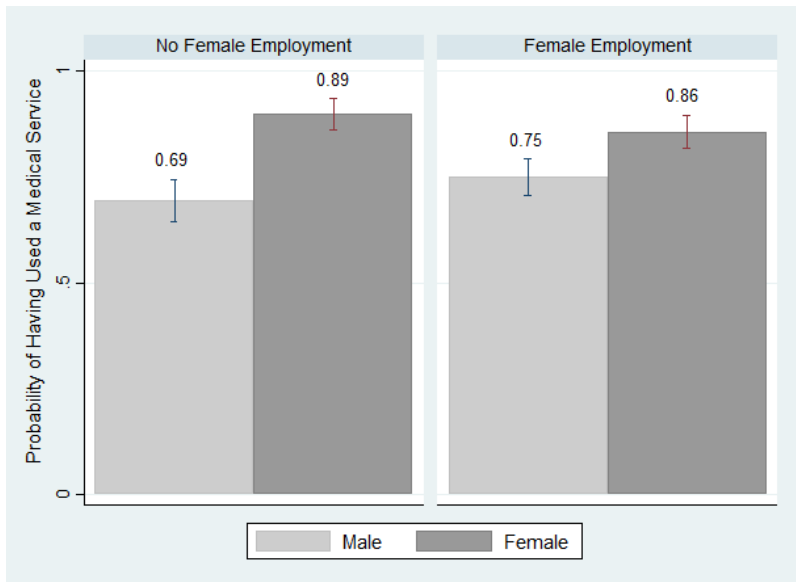


Figure 5.4 Having at Least one Child Under 18 Years Old

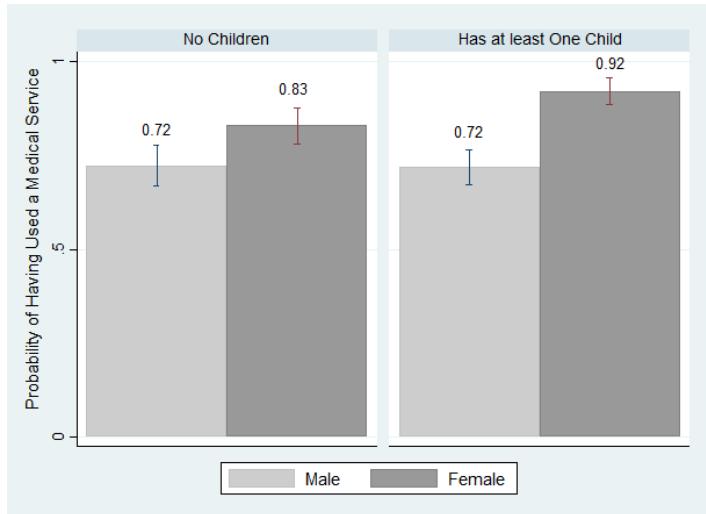
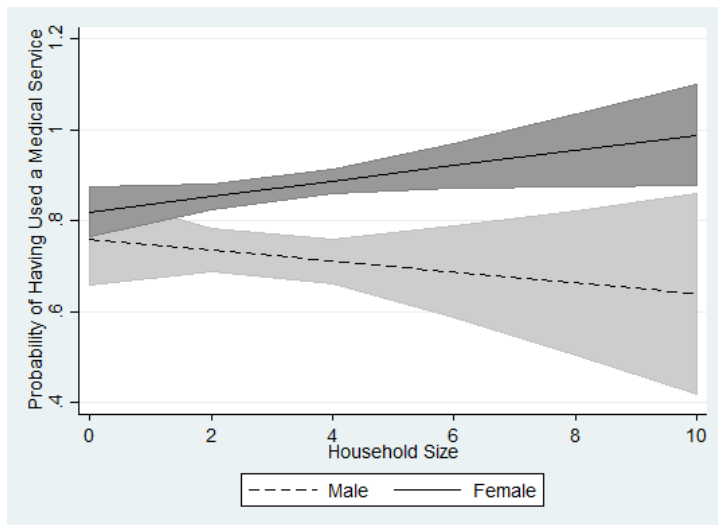


Figure 5.5 Household Size



Tables 5.4a and 5.4b presents results from multivariate negative binomial probability models on the number of visits to medical services within the last 12 months, a measure of realized access to healthcare. The coefficients in the tables represent the change in the natural log (ln) of expected number of medical visits within the last 12 months for a one-unit change in the predicted independent variable. The exponential form of the coefficient is reported in the findings.

As with the other healthcare access outcomes, being female was associated with a consistent and positive increase, with a 55% ($e^{.44}$) increase in the expected number of visits. There are racial and ethnic differences, but these diminish throughout each model. Having poor/fair self rated physical health and having a previously diagnosed chronic conditions both increase the expected number of medical visits. These health need effects remain constant across all models.

Model 2 adds acculturation and enabling factors. No acculturation factors have an effect on the number of medical visits. Compared with having private insurance, having public insurance increases the expected number of visits by a factor of 1.32 ($e^{.28}$) and having no insurance reduces the expected number of visits by a factor of 0.63 ($e^{-.46}$). Again, it is important to note the increase of access to care with public insurance, relative to private insurance.

Model 3, the full model, adds the household gender relations variables. Having children and experiencing increased family cultural conflict increases the expected number of visits by a factor of 1.36 and 1.03 number of visits, respectively. Experiencing partner/spousal support significantly decreased the expected number of medical visits by a factor of 0.72.

Even though economic responsibilities did not have an effect in the full model (Model 3), the significant interaction between gender and economic responsibilities indicates its relationship

Table 5.4a Multivariate Negative Binomial Models
Effects of Household Gender Relations on the Number of Medical Visits within the last 12 months among Married/Cohabiting Immigrants

Variable	Model 1		Model 2		Model 3	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.44	*** (0.09)	0.43	*** (0.07)	0.46	*** (0.08)
Age (years)	-0.003	(0.003)	-0.01	* (0.002)	-0.003	(0.002)
Mexicans (reference)						
Puerto Ricans	0.36	(0.25)	0.11	(0.22)	0.14	(0.21)
Cubans	0.22	* (0.1)	-0.02	(0.1)	0.03	(0.11)
Other Latinos	0.30	*** (0.1)	0.13	(0.1)	0.19	+ (0.1)
Chinese	0.56	*** (0.14)	0.25	+ (0.13)	0.31	* (0.13)
Vietnamese	0.30	*** (0.1)	0.00	(0.11)	0.04	(0.12)
Filipino	0.16	(0.13)	-0.08	(0.14)	-0.01	(0.15)
Other Asian	0.32	*** (0.1)	0.00	(0.1)	-0.02	(0.1)
Need Factors						
Poor/Fair Self-rated mental health	-0.17	(0.15)	-0.12	(0.17)	-0.11	(0.16)
Poor/Fair Self-rated physical health	0.16	+ (0.09)	0.17	* (0.07)	0.16	* (0.07)
Diagnosed chronic condition	0.42	*** (0.11)	0.34	*** (0.1)	0.34	*** (0.09)
Migration & Acculturation Factors						
Migration reason: to work			-0.09	(0.07)	-0.09	(0.07)
Migration reason: to join family			-0.06	(0.07)	-0.09	(0.06)
Migration reason: medical care			0.09	(0.14)	0.02	(0.13)
Proportion of Life in US			-0.02	(0.21)	0.00	(0.19)
English Proficiency Poor/Fair			0.00	(0.1)	-0.01	(0.09)
Naturalized Citizen			0.12	(0.1)	0.10	(0.09)
Visits to Country of Origin			-0.02	(0.06)	-0.04	(0.06)

Table 5.4a (continued)

	Model 1	Model 2	Model 3
	Estimate	Estimate	Estimate
Enabling Factors			
Education (years)		0.02 +	0.02 +
Financial strain		-0.06	-0.07
Private Insurance (reference)			
Public Insurance		0.28 **	0.24 **
No Insurance		-0.46 ***	-0.45 ***
Number of past barriers to medical care		0.06 **	0.08 ***
Relative Support		0.02	0.02
Friend Support		-0.02	-0.02
Household Gender Relations			
Decision Making			-0.03
Economic Responsibilities			-0.02
Household Chores			-0.03
Female Employment			-0.09
Children under 18			0.31 ***
Household Size			-0.05
Family Cultural Conflict			0.03 *
Partner Emotional Strain			0.10
Partner Emotional Support			-0.33 ***
Intercept	0.46	0.65	0.59
Dispersion Parameter	0.46	0.75	0.73

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

Table 5.4b Multivariate Negative Binomial Models
Effects of Household Gender Relations on the Number of Medical Visits within the last 12 months among Married/Cohabiting Immigrant

Variable	Model 3		Model 4		Model 5	
	Estimate	SE	Estimate	SE	Estimate	SE
Predisposing Factors						
Female	0.46	*** (0.08)	0.73	*** (0.14)	0.34	*** (0.09)
Age (years)	-0.003	(0.002)	-0.003	(0.002)	-0.002	(0.002)
Mexicans (reference)						
Puerto Ricans	0.14	(0.21)	0.14	(0.21)	0.14	(0.22)
Cubans	0.03	(0.11)	0.03	(0.11)	0.03	(0.11)
Other Latinos	0.19	+ (0.1)	0.19	+ (0.1)	0.18	+ (0.1)
Chinese	0.31	* (0.13)	0.31	* (0.13)	0.31	* (0.13)
Vietnamese	0.04	(0.12)	0.04	(0.12)	0.03	(0.12)
Filipino	-0.01	(0.15)	-0.01	(0.14)	-0.03	(0.15)
Other Asian						
Need Factors						
Poor/Fair Self-rated mental health	-0.02	(0.1)	0.00	(0.1)	-0.03	(0.1)
Poor/Fair Self-rated physical health	-0.11	(0.16)	-0.08	(0.16)	-0.09	(0.16)
Diagnosed chronic condition	0.16	* (0.07)	0.15	* (0.07)	0.16	* (0.07)
Migration & Acculturation Factors						
Migration reason: to work	0.34	*** (0.09)	0.34	*** (0.09)	0.34	*** (0.09)
Migration reason: to join family	-0.09	(0.07)	-0.08	(0.07)	-0.08	(0.07)
Migration reason: medical care	-0.09	(0.06)	-0.09	(0.06)	-0.08	(0.07)
Proportion of Life in US	0.02	(0.13)	0.02	(0.13)	0.02	(0.12)
English Proficiency Poor/Fair	0.00	(0.19)	0.00	(0.19)	0.00	(0.19)
Naturalized Citizen	-0.01	(0.09)	-0.02	(0.09)	-0.02	(0.09)
Visits to Country of Origin	0.10	(0.09)	0.11	(0.09)	0.09	(0.09)
	-0.04	(0.06)	-0.03	(0.06)	-0.03	(0.06)

Table 5.4b (continued)

	Model 3		Model 4		Model 5	
	Estimate	SE	Estimate	SE	Estimate	SE
Enabling Factors						
Education (years)	0.02	(0.01)	0.02	(0.01)	0.02	(0.01)
Financial strain	-0.07	(0.08)	-0.06	(0.08)	-0.08	(0.08)
Private Insurance (reference)						
Public Insurance	0.24	(0.1)	0.23	(0.1)	0.22	(0.1)
No Insurance	-0.45	(0.15)	-0.46	(0.15)	-0.47	(0.15)
Number of past barriers to medical care	0.08	(0.03)	0.08	(0.03)	0.08	(0.02)
Relative Support	0.02	(0.01)	0.02	(0.01)	0.01	(0.02)
Friend Support	-0.02	(0.02)	-0.02	(0.02)	-0.02	(0.02)
Household Gender Relations						
Decision Making	-0.03	(0.04)	-0.04	(0.03)	-0.03	(0.03)
Economic Responsibilities	-0.02	(0.03)	0.04	(0.03)	-0.02	(0.03)
Household Chores	-0.03	(0.03)	-0.03	(0.03)	-0.03	(0.03)
Female Employment	-0.09	(0.08)	-0.09	(0.08)	-0.08	(0.08)
Children under 18	0.31	(0.11)	0.31	(0.11)	0.18	(0.12)
Household Size	-0.05	(0.03)	-0.05	(0.03)	-0.05	(0.03)
Family Cultural Conflict	0.03	(0.02)	0.03	(0.02)	0.03	(0.01)
Partner Emotional Strain	0.10	(0.08)	0.10	(0.08)	0.11	(0.08)
Partner Emotional Support	-0.33	(0.09)	-0.29	(0.09)	-0.33	(0.09)
Interactions: Gender & Household Gender Relations						
Female*Decision Making						
Female*Economic Responsibilities			-0.11	(0.05)		
Female*Chores						
Female*Female Employment						
Female*Children Under 18					0.26	(0.13)
Female*Household Size						
Female*Family Cultural Conflict						
Female*Partner Emotional Strain						
Female*Partner Emotional Support						
Intercept	0.59	(0.39)	0.47	(0.42)	0.68	(0.39)
Dispersion Parameter	0.73		0.72		0.72	

+p<0.10, *p<0.05, **p<0.01, ***p<0.001

with the expected number of visits is similar to the predicted probability in use of medical services within the last 12 months (Table 5.5b). Figure 5.6 also illustrates when men or women have economic responsibility in the household, respectively, their number of medical visits is higher compared to when they have less economic responsibilities.

As in the other realized access outcome, Model 5 shows that having at least one dependent child in the household does not have an effect on the entire sample, but that the effect of children on the number of medical visits differs for men and women. Figure 5.7 illustrates a similar pattern found in the outcome on usage of medical service. Men's number of medical visits does not change with having children, while women's predicted number of medical visits greatly increases by 1.45 when they have at least one child in the household.

Additional analysis with all gender interactions with household gender relations included in the model show that the moderating effects of gender economic responsibilities, and having a child under the age of 18 continue have a significant effect (p-value level <0.10) on having used a medical service within the last 12 months, controlling for all other covariates.

Figures 5.6 – 5.7 Predicted Expected Number of Medical Visits within the last 12 months by Gender and Dimensions of Household Gender Relations with 95% confidence intervals

Figure 5.6 Economic Household Responsibilities

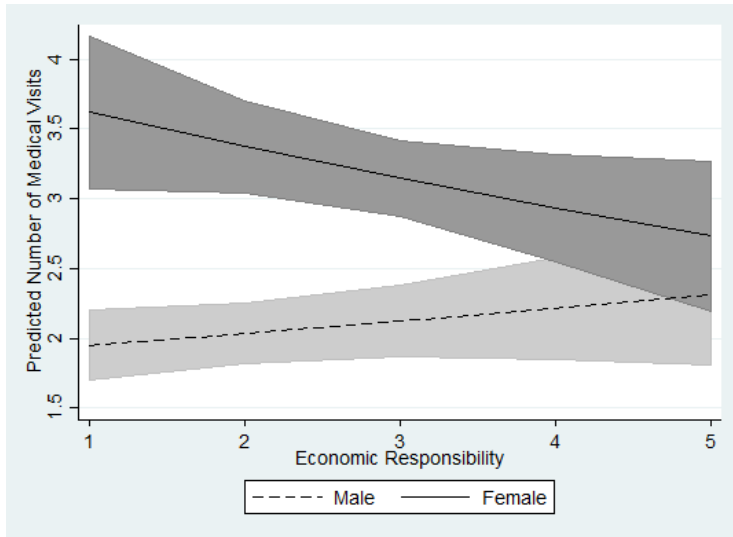
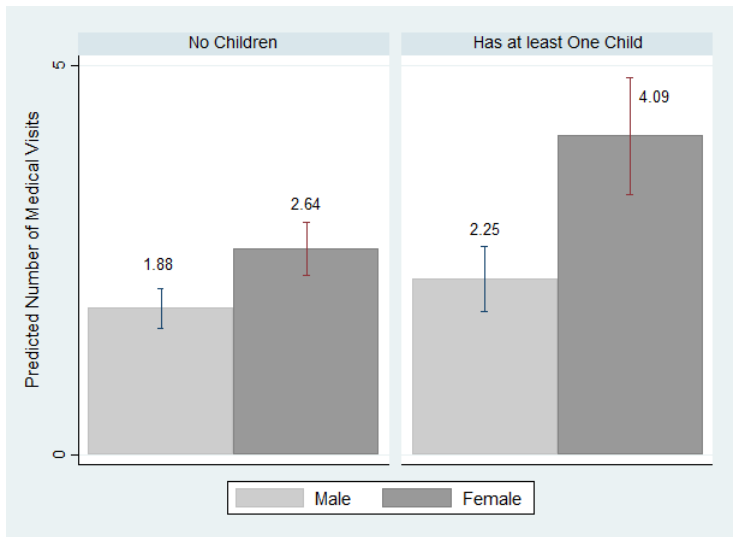


Figure 5.7 Having at Least one Child Under 18 Years Old



CONCLUSION and DISCUSSION

In contrast with much of the assumptions in the gender and immigrant health literature, the descriptive findings in this study showed egalitarian gender relations along multiple dimensions of the household including decision making, economic responsibilities, female employment and household chores. The findings on emotional caregiving and support affirmed that immigrant women have more caregiving responsibilities and experience emotional strain from family cultural conflict than men, but women also received more emotional support from their male spouses/partners.

The findings on the effects of household gender relations on access to healthcare support the hypothesis that emotional gender relations involving more caregiving responsibilities and emotional strain are more likely to increase access to healthcare, and more emotional support is more likely to decrease access to healthcare (H3). We found these effects in the two realized access outcomes, with family cultural conflict increasing the likelihood of having used a medical services and the number of visits, and spousal/partner support having a strong negative effect on the number of medical visits within the last 12 months.

While there was no support for the effect of household gender relations of power and production on the entire sample (H1 and H2), there was a relationship between gender, multiple dimensions of gender relations and realized healthcare access outcomes. Specifically, gender moderated the effect of female household employment, having children under the age of 18, and household size (H4 and H5).

As hypothesized, having children and increasing household size had a much larger positive effect on women's realized access to healthcare, while men's access remained stable or

decreased (H6). Households with female employment slightly decreased women's access to healthcare and slightly increased men's access to healthcare (H5). It was hypothesized that female household employment would increase women's healthcare access due to more enabling resources, but the findings showed a small decrease in access among women and no change among men.

The findings supported the hypothesis that there would be a relationship between gender, economic household responsibility, a measure of gender relations of power, and healthcare access (H4), but not in the expected direction. It was hypothesized that gender would moderate the relationship between economic responsibility and access, with increasing men's economic responsibility affirming the assumptions that "women go [to the doctor] and men stay home" (Gorman et al 2016). The results indicate is that gender relations of power in the household modified the relationship between gender and access to healthcare. Comparing the patterns associated with economic responsibility by gender, the study found that when men or women, had almost all economic responsibilities in the household, respectively, their likelihood of access to healthcare increased. However, when they transferred economic responsibility to their spouse/partner, their likelihood of accessing healthcare decreased. This is the same pattern of decline/increase across gender, with men's likelihood of accessing healthcare declining more than women when they had less economic responsibility.

Overall, the effects of gender, household gender relations and immigrant access to healthcare highlight that multiple dimensions of gender relations in the household differently affect immigrant men's and women's access to healthcare. Having children and increasing household size had a positive effect on women's access to healthcare, while men's access changed very little or declined. Having a gender asymmetrical structure of economic

responsibility increased healthcare access for the spouse who had almost all the economic responsibility, and decreased as the responsibility transfers to the spouse/partner. Female employment had a slightly negative effect on women's healthcare access and no change in access for men.

The variation of gender relations within the immigrant household and the effects of access to healthcare highlight the limitations of assumptions that conflate multifaceted immigrant relations inside and outside of the household to simple racial, cultural and gender stereotypes such as the tradition-modern gender paradigm used to describe immigrant gender relations. In light of the study's findings that point to more egalitarian gender relations along power, production and emotions is additional evidence to critique the all too common approach to gender in the immigrant health literature. While some of the seminal work in the migration and gender literature have found similar patterns of gender relations within immigrant households using qualitative or mixed methods (Espiritu 1999; Hondagneu-Sotelo 1994; Menjívar 2000; Pessar 1999), the knowledge and insight into immigrant's lives and their navigation of the complex process of acculturation, have been for too long overlooked by the immigrant health literature.

To explain some of the gendered effects of multiple levels of emotional relations and caregiving on access to healthcare, I draw from the sociological literature on gender, stress and mental health to highlight the relationship between gender, marital and family roles. I use the framework to conceptualize access to healthcare as a coping resource in response to stress and strain. In studies of non-immigrant populations, marriage is equally protective from daily stressors and being a spouse has similar positive meanings for men and women. However, men and women have slightly different meanings attributed to being a parent and a worker, and more

importantly, men and women respond to similar stressors with different coping practices, and utilize different social support networks (Simon 1995b, 1997; Thoits 1995). There is also literature contesting the theory that there are differing specific gendered responses to stressors that lead to more internalizing mental health among women and more externalizing anti-social behaviors among men (Hill and Needham 2013). Moreover, very few of these theories on gender and stress have been thoroughly tested on racial, ethnic and immigrant populations.

Why are immigrant women's help-seeking behaviors, like accessing healthcare, more affected by household gender relations and family dynamics, relative to men? People make sense of social roles through its ability to affirm identity, uphold cultural values, fulfill social expectations and meet personal needs. Multiple roles – spouse, parent, worker – can create role strain but they can, under different combinations and contexts, also provide an affirming social identity that is culturally valued. In a study on meanings attached to family roles, Simon (1997) mainly found positive meanings attributed to spousal, parent and worker roles among men and women. Though, women had more negative meanings (i.e. frustration, pain and sacrifice) attributed to being a parent, which increased when women also worked. The positive attributions of being a spouse are reflective in this study's larger effects of spousal support than spousal strain on access to healthcare for both men and women, even though the prevalence of spousal support was considerably lower than spousal strain.

The more negative meanings to being a parent and a working parent among women may also be reflected in the study's findings on increased healthcare access among women who have children and large families, and no change or decreasing access among men who have the same roles and responsibilities. For women, if their caregiving responsibilities are associated with more emotional strain, their increased exposure to the healthcare system and other systems of

care such as the education system via the parental responsibilities of caregiving allows them to use healthcare as a viable outlet, among many, for support with stressors and other health risks. In contrast, among men who are actively caregiving for their dependents, they may not have as many negative meanings attached to being a parent or a working parent, therefore may not feel the need for support through healthcare. When strained, as highlighted in the Chapters Three and Four, men are more likely to go to seek-help through sources of support outside of the immediate family which includes friends and community. These theories of gendered responses to stress and gendered influences on help-seeking have yet to be thoroughly examined with immigrant populations who face additional contextual constraints of acculturation and discrimination.

The strong positive effect on accessing healthcare when having almost all the economic responsibility in the household for both men and women can be explained in three ways. First, is a resource argument, where having more economic responsibility means exercising more authority into the allocation of discretionary household funds. This may mean more resources for the person in power to use for their own needs, such as healthcare costs that are not covered under insurance.

Second, is a social stress and coping argument where responsibility is distinguished from power. In this study, the variable on decision making which also measures power did not have a significant effect on access to healthcare for men or women, while other variables related to different types of responsibility, like having a child, and household size did have a positive and gendered effect on access to healthcare. While managing the household expenses is a position of power and authority, it also can be a burden and a source of strain. In households where economic responsibility has a gender asymmetric structure, carrying the sole burden to pay the

rent, have enough food and keep the electricity on can lead to increased stress and strain, especially in households with limited finance and other enabling resources.

When the economic responsibilities are not shared, then the other spouse may not be a reliable source for support, therefore the need for men and women to seek help outside the household or family which includes the doctor. Further research into how gender interacts with different kinds and levels of household responsibilities may bring more insight into the motivations for help-seeking.

Three, is a gender role explanation related to material provision. Similar to the Gladas (2007) finding that the masculinity of South Asian men differed from White men (re: hegemonic masculinity) which greatly affected their help-seeking strategies. When experiencing heart attack symptoms, South Asian men had more social expectations to seek help to maintain their role as providers for the family. Accessing healthcare with little hesitation was appropriate, especially given that being a racial minority meant their options were more limited and that risks of not being able to provide for their families was greater. Being a responsible provider has different meanings attached with social identity, internal and external to the household, and provide different motivations for help-seeking behavior. Being more responsible for the economic well-being of the family, immigrant men may see that the risks of not seeing a doctor outweigh any hesitations. This sense of responsibility may even increase among immigrants living under more hostile contexts of reception. This is affirmed by the study's findings on household gender relations where family responsibility regarding finances, childcare and female employment was moderated by gender.

Limitations

The findings in this study should be considered with some limitations. First, the cross-sectional nature of the NLAAS dataset limits the ability to address issues of causality. Although the Andersen model suggests that specific factors contribute to healthcare access, less has been studied on the relationship between enabling factors using a multi-dimensional analysis of gender and household gender relations on access to healthcare.

Second, the data is from 2002 to 2003. It is unclear to what extent these findings would generalize to the present time. NLAAS is the only nationally representative dataset with large samples of Latino and Asian immigrants that includes the key variables on multiple healthcare access outcomes and multi-dimensional measures of enabling, acculturation and household gender relations. Research on more recent data and using longitudinal data would be important to replicate and extend this analysis.

Third, the generalizability of the findings to the present time is especially relevant after the implementation of the Affordable Care Act (ACA) made significant changes to the U.S. healthcare system. The ACA increased, mainly through socioeconomic mechanisms related to health insurance and the expansion of the healthcare safety net, potential and realized access for the entire country, including immigrants. However, the ACA did not change many of the legal restrictions placed on immigrant access to healthcare. Undocumented immigrants continue to be ineligible for any form of federal subsidy or program for health insurance coverage. They must continue to rely on the local and state based safety net that varies considerable by county and state. Moreover, recent documented immigrants must still wait for five years to receive any form of public assistance such as Medicaid. Eligible immigrants still risk being labeled a public charge

that would jeopardize their eligibility for further services and their application for citizenship. Thus, ACA policies may increase or decrease the level of healthcare access with more extreme differences along legal status, but the gendered pattern of healthcare access associated with household gender relations should remain similar. Given the large impact of ACA on the U.S. healthcare system, it is important to use updated data to measure the extent of its impact on gender and immigrant access to healthcare.

Policy and programmatic interventions targeting salient gendered household roles and facilitating family responsibilities could increase access to healthcare. For women, maintaining and increasing their level of healthcare access is important given the relative low levels of access of immigrants compared with the U.S. born. To increase immigrant women's healthcare access, programs could include affirming women with their multiple roles as caregivers and economic providers and emphasize that accessing healthcare is an integral part of ensuring family well-being. A structural intervention could include integrating care for young children with parents through family medicine practices within inclusive safety net services (i.e. no legal restrictions) instead of age-based medical services (i.e. pediatrics and internal). This could include clinics asking about booking an appointment for the parent along with a well-child check up. This way, two appointments are made back-to-back and the parent and child can get time with the provider. Another way to encourage women who do not have children, or men, in general, to provide incentives for new referrals for both the patient who refers a relative and the provider who opens up their panel for family members. Incentives for patients could include community recognition of their support, a future discount or coupon for services or equipment, or even a gift card. For the provider, incentives can also be professional recognition or progress on performance measures, as well as more patient time for referrals.

For men, increasing their low levels of access should be a priority. Programs targeting men's role as providers for their families and stewards for their communities could be effective in increasing access. Since men's access to healthcare is more responsive to community and institutional factors and being an economic provider for their family seems to be a salient role that facilitates help-seeking, bringing the doctor to places they value and affirm these roles may be important to increasing access. Health clinics should closely partner with community organizations and mobile clinics should be placed close to job sites, transit centers and other hubs where men congregate to/from work to make it easier for them, as individuals or with friends and colleagues, to access healthcare.

In conclusion, this study's preliminary evidence on the differing effects of gender on the relationship between multiple dimensions of household gender relations and access to healthcare. It highlights the theoretical and empirical importance of examining gender and access to healthcare using a contextual analysis that allow for the integration of structural theories of gender to better examine the multi-dimensional effects of gender on healthcare access.

CHAPTER SIX

CONCLUSION

Healthcare is a central societal institution and goes unrecognized as a domain of immigrant incorporation. For a person or a community to achieve the highest state of complete physical, mental and social well-being, including the absence of disease or infirmity, the healthcare systems, organizations and providers must address its role in contributing to and alleviating social and health stratification and stigmatization of various vulnerable groups in society. Moreover, healthcare is a deeply gendered institution that differentially distributes health-related resources, knowledge and power in complex ways. Evidence has established that immigrants access healthcare at considerably lower rates than non-immigrants, and that men, regardless of race, nativity, culture and socioeconomic status, are much less likely to seek help via the healthcare system than women. Ongoing efforts to increase access to healthcare through health coverage reform, expansion of the safety net and increased language access, highlight the continued importance for, and struggle of, addressing gender and immigrant barriers to healthcare.

This dissertation sought to better understand how gender structures the different opportunities and ways immigrant men and women access healthcare by investigating the effects of acculturation, social and material resources, and household gender relations. We already know that immigrant men are less likely to access healthcare than immigrant women. We cannot just assume that men are reluctant to access healthcare, and women are not, but that there are different structural factors that facilitate and constrain gendered help-seeking and access to healthcare. I aimed to build on previous knowledge by addressing the structural contexts of

immigration and gender to capture the distinct processes and pathways that lead to healthcare access. With my findings, I put forth research, policy and program recommendations that illuminate the urgency and feasibility of alleviating immigrant and gender inequities in access to healthcare.

This examination into the effect of gender on immigrant access to healthcare differs from previous studies because of the structural and multi-dimensional approach to gender and immigration. Measuring the effects of multiple dimensions of household gender relations, multiple dimensions of acculturation and different types of social and material resources on access to healthcare highlighted the intersecting, varied and complex pathways and relational dynamics of gender and immigration.

The three empirical analyses examined the gendered routes immigrant men and women take to access to healthcare by assessing both potential and realized access outcomes: having a usual provider for care, having used any medical service within the last 12 months and the number of medical visits in the last 12 months. Because immigrants have lower rates of access to healthcare compared to the U.S. born, examining multiple outcomes that have different meanings and functions allows for a broader investigation into help-seeking and healthcare access.

OVERALL FINDINGS

The three empirical chapters sought to examine what kind of gender effect was associated with acculturation (Chapter Three), social and material enabling resources (Chapter Four), and dimensions of household gender relations (Chapter Five) and immigrant access to healthcare. The results from the papers can be summarized in the following three patterns which highlight

the condition of gender relations within immigrant households and the distinct gendered routes to help-seeking via access to healthcare.

Household gender relations along multiple dimensions more egalitarian than assumed

The findings showed more egalitarian relations in immigrant household than previously assumed in the literature. Egalitarian gender relations occurred along household dimensions of decision making, economic responsibilities, female employment and household chores. This finding underscores the importance of including multi-dimensional measures of gender and gender relations.

Household and Family Attachments: Facilitators of Immigrant Women's Help Seeking

Across all three empirical papers, the findings showed that immigrant women's likelihood to access healthcare was associated to responsibilities, support and strain that occurred within the context of the household or within the network of immediate family and relatives. In Chapter Five, results indicated that when immigrant women had more household responsibilities in the areas of economic responsibility, caring for dependents, and tending to overall family needs, they were much more likely to access healthcare. This may be motivated by a sense of family responsibility where they need to stay healthy as part of staying responsible, or that caregiving and responsibility carries with it excessive strain, or both. In Chapter Four, results showed support networks had an effect on immigrant women's access to healthcare but the direction depending on social network type. Spousal/partner emotional support consistently

decreased access to healthcare for both immigrant men and women indicating a possible source for coping with stressors and strain. For women, support from relatives was more effective in increasing access to healthcare. This may indicate that relatives are trusted sources of diverse information and they may also be sources of encouragement to go seek professional medical help. Consistent with the influence of household dynamics on immigrant women's access, results from Chapter Three found that family cultural conflict was one of the only household stressors that had a positive effect on access for both men and women.

Community and Institutional Attachments: A Route for Immigrant Men's Help-Seeking

In contrast, men's increase in access healthcare was attributed to sources external to the household and family. Friends, community and institutions all facilitated help-seeking for immigrant men. Findings in Chapter Three showed that the higher social status, identity and privileges associated with being a naturalized citizenship and making frequent visits to the country of origin increased men's access to healthcare. In Chapter Four, results indicated the only type of support that had a positive effect on immigrant men was friend support. Friend support networks, which are more voluntary, more diverse and less cohesive than family networks, may play an important facilitator of information and encouragement. In Chapter Five, when men had all the economic responsibility for their household, their level of access to healthcare was at its highest. Access levels declined as more power was transferred to their spouse/partner. Other roles indicting household responsibility that were more internal to the family such as childcare did not have an effect on men's access to healthcare. Like immigrant

women, immigrant men's probability of access also decreased when they received spouse/partner emotional support.

The most paradoxical finding was that relationship between having experienced barriers to healthcare and access to healthcare. Chapter Four results indicated that for men, their probability of help-seeking increased as the number of barriers increased. Barriers had an opposite effect on women's access. This finding merits further investigation into the type and level of healthcare barriers that may facilitate or hinder immigrant men's access to healthcare.

THEORETICAL IMPLICATIONS and FUTURE RESEARCH

Social Roles and Responsibilities

The findings in the three empirical papers highlight the importance of social roles as a source of strain, positive identity and responsibility, all of which can be motivating factors for seeking help via healthcare. The complexity of family roles is that they are both a source of positive support as well as strain. To better explain the findings related to social roles within the family, I used theories of stress coping and social support from the field of sociology and mental health. However, there are other frameworks to examine the relationship between gender, social role and help-seeking such as from the gender literature on power and division of labor, and the social welfare literature on parenthood, marginalization and health behaviors. Future research on immigrant populations should address the complex relationship between role, strain and responsibility and health behaviors through these different mechanisms.

Social Status and Identity: Variations in Masculinity

The findings highlight that masculinity and femininity in relation to social roles does matter among immigrants, but they are neither the hegemonic forms of White masculinity, or racialized stereotypes found in the traditional-modern gender paradigm. Instead, the findings point to a need to rethink the relationship between masculinity and femininity, social roles and help-seeking that takes into consideration the immigrant-related determinants of status such as the contexts of reception, racial and ethnicity, alternative forms of masculinity, and transnational interactions.

Healthcare as part of a Social Network of Support

Healthcare is a specialized resource for support, care and medical intervention. The empirical chapters of this dissertation only examined formal systems of care, but there are systems of care and support that are just as important for health and well-being such as healthcare systems in the country of origin, alternative and traditional forms of medicine, and the networks of social support of family, friends and community. Conceptually, help-seeking should not just be limited to “seeing a doctor” but be considered part of a network of care that immigrants must navigate to find the help that want and need. Most likely, healthcare is not the first source in which someone goes for help, nor it is the cheapest, or most culturally and linguistically competent. As we can see from the study, other sources of care, information and support are important to and facilitate immigrant men and women help-seeking. Help-seeking should not be solely framed as a just an independent rational choice that directly goes from identified health need to the doctor. Instead healthcare should be placed as part of social network structure or pathway that facilitates or hinders help seeking (Pescosolido 1992).

Contexts Matter: Household and Family Boundaries of Influence

The theoretical framework used in the dissertation is focused on the context of the immigrant household. We found clear gendered boundaries of influence in help-seeking in which women were much more influenced by relations within household and family networks, and men were much more influenced by relations outside household and family networks. This emphasized the need for a contextual analysis on subsequent studies on gender and immigrant access to healthcare. Further analysis using contextual analysis should examine if there are other similar gendered demarcations along local communities, institutions and healthcare, public attitudes and safety net policies.

Egalitarian Relations *and* Gendered Pathways

We found evidence that household gender relations along multiple dimensions were more egalitarian *and* that multiple dimensions of gender relations had a differing effect on men's and women's access to healthcare. These findings highlight that gender similarities along dimensions of household relations, can also mean that the ways immigrant men and women seek help can still differ. These findings affirms the importance of measuring gender as an individual-level variable, as a dimension of relations within a specific context, and in multiple dimensions of gender relations within a study to better understand how gender shapes and structures health and health behaviors. Moreover, the findings are a caution to the use of the traditional-modern gender paradigm. Future research on gender, immigrant and racial and ethnic health should utilize these strategies and incorporate gender theory into the framework. In addition to studies on more diverse populations, there is an increasing call among gender and healthcare scholars to conduct

more validated rigorous gender comparative studies, with same conditions or symptoms, to further test common assumptions that men and women express their level of self-rated needs and access help differently. As we can infer from the studies in this dissertation, there are multiple types of sources that immigrant men and women access for help that include, but are not limited to, medical services.

POLICY and PROGRAM RECOMMENDATIONS

Goal: Increasing Immigrant Men's Access to Healthcare

Immigrant men's responsiveness to institutions and factors external to the household underscores the importance of constructing policy and program interventions to address important markers of social identity, attachment and belonging, and role and status. To increase immigrant men's access to healthcare, policy and program changes should focus on socio-economic resources like health insurance and social capital resources of friends and community. For men's access, increased access to public health insurance was predicted to make the most gains. Inversely, decreased access to healthcare (being uninsured) was predicted to make the most losses for men. If the aim is to decrease the gender gap in insurance coverage among legibility immigrants, targeted outreach and programming towards immigrant men is necessary.

The research on the positive effects of social support on health is well established, and programs have utilized these social capital effects through program such as "promotores" or community health workers. However, many of these interventions have centered immigrant women and their networks. Few interventions, published or not published, have fully involved immigrant men as leaders, community helpers or lay health advisors in a similar way. Such as

approach that utilizes men's networks, their notions of masculinity, and their coping skills should be designed, implemented and evaluated.

Moreover, compliance with language access laws is still paramount in ensuring access to healthcare for all immigrants. Language access for Mexicans is especially important because despite being the largest immigrant group with multiple generations living in established enclaves and Spanish-language media, Mexicans continue to have lower levels of healthcare access, lower levels of English proficiency and lower levels of naturalization compared with other immigrant groups (Passel 2007). It is important to emphasize that the results point to the importance of language access compliance not only occurring within the exam room between the patient and provider, but as a clear marker of institutional identity between the local clinic and the immigrant community.

For men, increasing their low levels of access should be a priority. Programs targeting immigrant men's role as providers for their families and stewards for their communities could be effective in increasing access. Since immigrant men's access to healthcare is more responsive to community and institutional factors and being an economic provider for their family seems to be a salient role that facilitates help-seeking, bringing the doctor to places they value and affirm these roles may increase access. Health clinics should closely partner with community organizations, and mobile clinics should be placed close to job sites, transit centers and other hubs where men congregate to/from work to make it easier for them, as individuals or with friends and colleagues, to access healthcare.

Goal: Maintaining and Increasing Immigrant Women's Access to Healthcare

Policy and programmatic interventions targeting salient gender roles in the household and facilitating family responsibilities would increase immigrant women's access to healthcare. For women, maintaining and increasing their level of healthcare access is important given the relative lower levels of access of immigrants compared with the U.S. born. To increase immigrant women's healthcare access, programs could include affirming women with their multiple roles as spouses, caregivers and economic providers and emphasize that accessing healthcare is an integral part of ensuring family well-being. A structural intervention could include integrating care for young children with parents through family-based medical services within inclusive safety net services (i.e. no legal restrictions) instead of age-based medical services (i.e. pediatrics and internal). This could include clinics asking about booking an appointment for the parent along with a well-child check up. This way, two appointments are made back-to-back and the parent and child can get time with the provider.

Another way to encourage women who do not have children, or men, in general, to provide incentives for new referrals for both the patient who refers a relative and the provider who opens up their panel for family members. Incentives for patients could include community recognition of their support, a future discount or coupon for services or equipment, or even a gift card. For the provider, incentives can also be professional recognition or progress on performance measures, as well as more patient time for referrals.

A communication intervention to increase knowledge and messaging could target relatives and extended family's influence over women's access to healthcare. Messaging should focus on specific types of symptoms or conditions where immigrant women are less likely to go

for medical services such as neo-natal care, pap smears, mental health, sexually transmitted diseases and domestic violence.

CONCLUDING REMARKS

Immigrant men and women have different processes and routes in which they use to seek help and access healthcare opportunities. These findings reflect immigrant women's responsiveness to the responsibilities, strain and support internal to the household and family networks. Immigrant men were more responsive to factors external to the household and family including friends, communities in the U.S. and abroad, and societal institutions. Additionally, immigrant men's response being more elastic compared with immigrant women, where their levels of access increased or decreased much more to facilitating or hindering factors. These distinctions are important to identify clear and feasible policy and programmatic interventions since the responsiveness to external factors found among immigrant men also indicates that they may be more responsive to multiple levels of policy interventions at the community, culture, institutional and legal levels.

I refer back to the image in Chapter Two of the poster put up after the passing of the 2016 travel ban declaring the clinic follows the long U.S. tradition of welcoming immigrants, refugees and asylees. This clinic mainly provides healthcare to the uninsured, undocumented and a wide range of vulnerable populations and wanted to convey with the poster that the health clinic knows that its role in the community is more than just providing medical services in the exam room. I hope the findings in this study encourages clinics to develop stronger relationships with immigrant communities and families, and have tailored policies and programming that addresses the gendered routes to healthcare among immigrants. This would enable immigrants to be better

integrated into the policy and missions of healthcare organizations and providers, and at the same time, enable immigrants to better integrate help-seeking and healthcare into their lives.

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