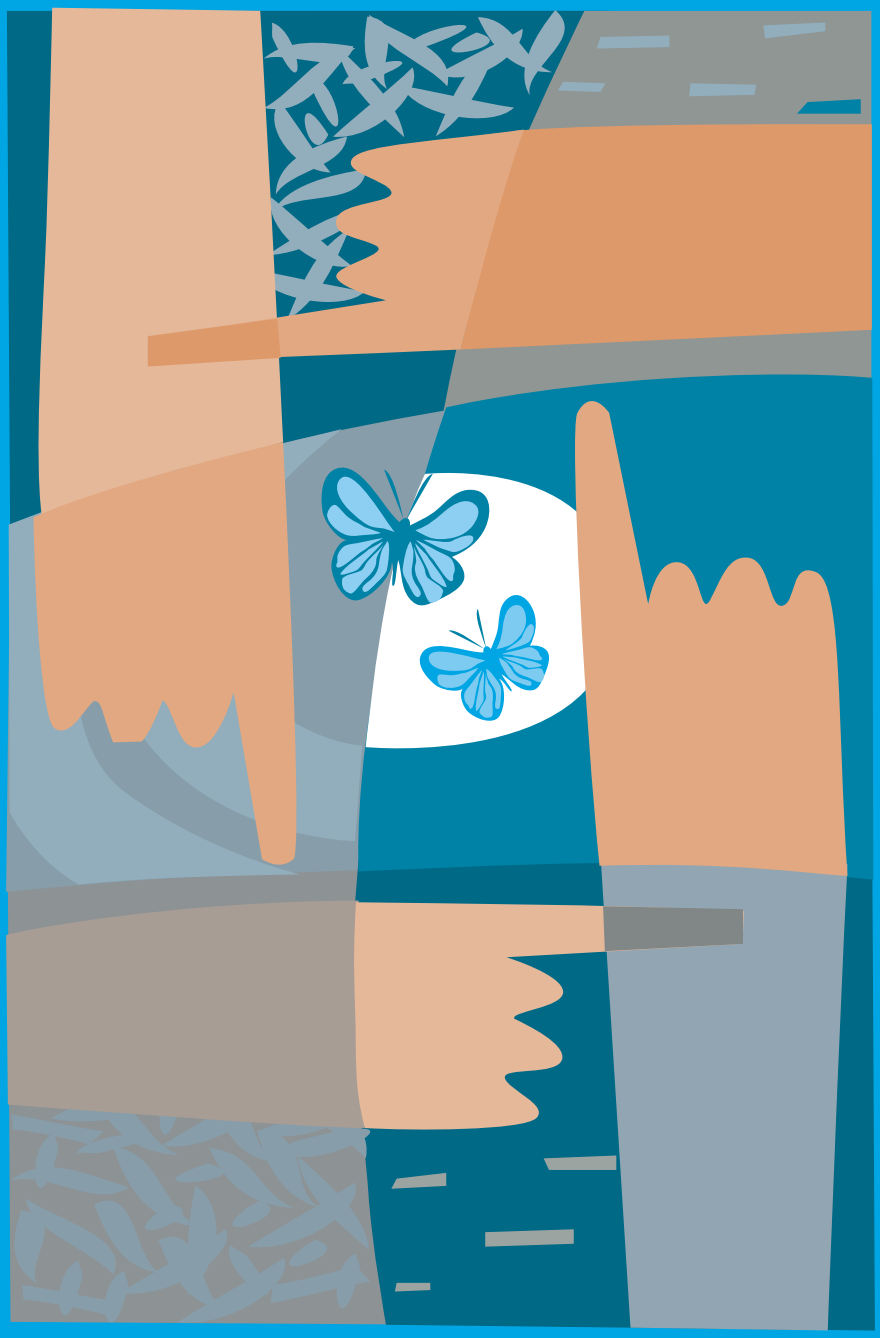
Migration & health

Mexican Immigrant Women in the U.S.



INSTITUTO DE LOS MEXICANOS EN EL EXTERIOR

CONAPO

SEGOB

SALUD

MÉXICO 2010

GOBIERNO FEDERAL

MAHRC MIGRATION AND HEALTH RESEARCH CENTER University of California

Health Initiative of the Americas Iniciativa de Salud de las Américas

School of Public Health UNIVERSITY OF CALIFORNIA, BERKELEY

UCLA CENTER FOR HEALTH POLICY RESEARCH

Bixby Center for Global Reproductive Health

UNFPA

Migration and Health

Mexican Immigrant Women in the U.S.

Aknowledgements

This document was produced through the binational collaboration of the National Population Council of the Government of Mexico and the University of California and coordinated by Paula Leite and Xóchitl Castañeda. Its publication was supported by the Mexican Health Secretariat, the Institute for Mexicans Abroad and the United Nations Population Fund.

This volume is the result of contributions by the following people:

National Population Council of the Government of Mexico (CONAPO)
Paula Leite, Director, Socio-Economic Studies and International Migration
Ma. Adela Angoa, Assistant Director, Socio-Economic Studies and International Migration
Alma Rosa Nava, Head of Department of Socio-Economic Studies
Luis Acevedo, Consultant
Carlos Galindo, Consultant
Rodrigo Villaseñor, Consultant
University of California, Berkeley, School of Public Health
Xóchitl Castañeda, Director, Health Initiative of the Americas (ISA)
Sylvia Guendelman, Professor of community health and human development
Emily Felt, Public policy analyst (ISA)
Magdalena Ruíz Ruelas, Analyst (ISA)
University of California, Los Angeles, School of Public Health
Center for Health Policy Research
Steven P. Wallace, Associate Director
University of California, Davis and Berkeley campuses
Migration and Health Research Center (MAHRC)
Marc Schenker, Director
University of California, San Francisco
Bixby Center for Global Reproductive Health
Claire Brindis, Professor

Design and layout
Maritza Moreno, CONAPO
Myrna Muñoz, CONAPO
Editing
Armando Correa, CONAPO
Susana Zamora, CONAPO
Guillermo Paredes, Consultant
Rosalba Jasso, Consultant
English translation
Suzanne D. Stephens

© Consejo Nacional de Población
Hamburgo 135, Colonia Juárez,
C.P. 06600 México, D.F.

Migration and Health. Mexican Immigrant Women in the United States
First edition: October 2010

ISBN: 970-628-959-3

The reproduction of this document for non-commercial purposes or classroom use is allowed, provided that the source is cited.

Printed in Mexico

Content

Foreword / 5

Chapter I

Characteristics of Adult Mexican-born Women in the United States / 7

Chapter II

Coverage and Type of Health Insurance / 17

Chapter III

Disparities in Access to Medical Insurance at the State Level / 25

Chapter IV

Use of Health Care Services / 33

Chapter V

Health Conditions / 37

Conclusions / 47

Foreword

Mexican migration to the United States was traditionally work-based and predominantly male. Women migrated as a result of their husband's or partner's decision to emigrate or to achieve family reunification. Nowadays, the role of Mexican women is no longer restricted to family companionship, in the absence of autonomy or self-determination. They have increasingly become incorporated into migration dynamics for the purpose of securing their own employment.

A great deal of what is said about the disadvantaged condition of the Mexican immigrant population in terms of access to health in the United States combines information for both sexes from national data sources. However, women have different experiences, as well as different health needs and vulnerabilities. It is essential to understand biological, gender, environmental, social, cultural and economic differences between men and women, that influence their health status, their search for health care, and their utilization patterns.

With this in mind, the National Population Council (CONAPO) and the University of California, through various campuses and centers, prepared this report with the support of the Mexican Health Secretariat. As in all immigration issues, bi-national collaboration is not only essential to achieving desired changes, but should also be seen as a shared responsibility.

This study aims to increase our overall understanding of health determinants, access and use of health services, and the health conditions of adult Mexican-born women in the U.S. It relies on a comparative perspective with U.S.-born, non-Hispanic white and African-American women and immigrants from other countries.

This report includes five chapters. The first one provides a description of the characteristics of adult Mexican-born women living in the U.S., together with a brief analysis of some social determinants of health. The second chapter analyzes the level and type of health insurance coverage of Mexican-born women ages 18 to 64 in comparison with other population groups. It also describes the profile of Mexican immigrant women who face the greatest risks due to their being uninsured. The third chapter incorporates an analysis of ethnic/racial disparities in access to health insurance. It begins by examining the state policies that affect immigrant populations' access to public health programs and benefits. This is followed by an analysis of the non-insurance index among Mexican immigrant and the scope of the differences in relation to U.S.-born, non-Hispanic white women. The fourth chapter analyzes the different experiences of immigrants in their use of health care services. To this end, a series of indicators including routine health care use, type of services sought, and timeliness of health care are examined. The fifth chapter examines the health conditions of Mexican immigrant women through selected aspects, such as self-perception of their health status, disease prevalence, risky health habits and mother and child health.

The analysis relies on estimates by the National Population Council (CONAPO), based on the *Current Population Survey*, the *American Community Survey*, the *National Health Interview Survey*, the *Hispanic Healthcare Survey*, and vital statistics provided by the *National Center for Health Statistics*. State legislative activity analysis is based on information from the *National Conference of State Legislatures.*

We hope that the information presented here will contribute to the development of public policies that will improve the health and quality of life of Mexican-born women living in the U.S.

José Ángel Córdova Villalobos
Health Secretary

Félix Vélez Fernández Varela,
Secretary General of
the National Population Council

Xóchitl Castañeda
Director, Health Initiative of the Americas,
Berkeley School of Public Health,
University of California

Chapter I. Characteristics of Adult Mexican-born Women in the United States

This chapter provides evidence of the growing importance in the United States of the Mexican female population aged 18 to 64 in both absolute and relative terms. It also deals with certain aspects of their familial and socio-economic structure that determine the context in which their health practices are carried out.

Since social inequities in the U.S. are based on race/ethnicity, the analysis of Mexican immigrant women in the U.S. follows classic studies on integration. The principal reference used is the U.S.-born white population, given its advantageous socio-economic position. In order to have more parameters for a comparison of the scope of the differential between the various populations, another two groups were considered: one with immigrants, comprising the set of immigrants of other nationalities, with distinctly more favorable integration indicators than that of Mexicans; and one with U.S.-born women, including African-Americans, who have high indices of marginalization.

Scope and socio-demographic profile

Mexican women: the largest female immigrant contingent in the United States

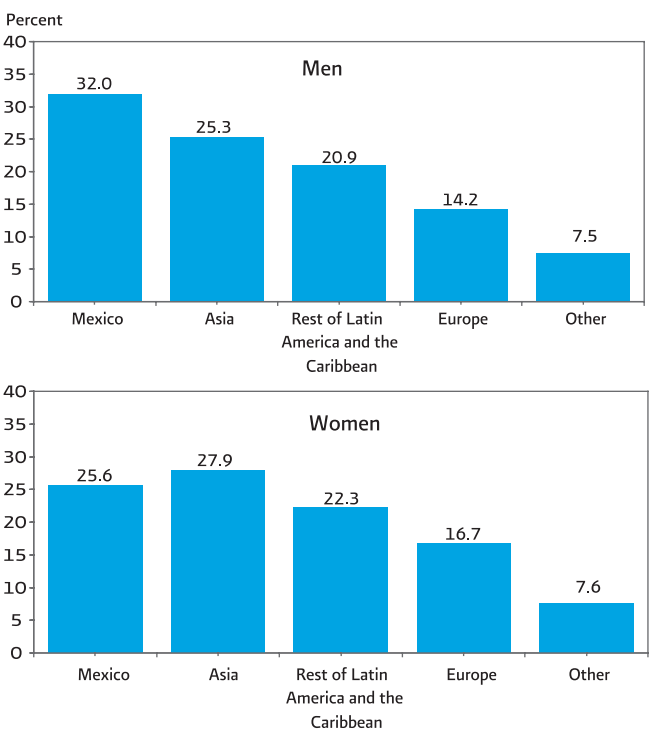
As has been widely documented, Latin American and Caribbean countries with geographical proximity have been the main source of contemporary migratory patterns into the United States. Within this context, Mexico has continued to be the country that sends by far the most migrants to the U.S. Approximately 12 million Mexicans and 21 million second, third and beyond generations of Mexicans currently reside in the U.S.

In a scenario of progressive demographic ageing, Mexican immigration has significantly contributed to invigorating the U.S. demographic profile. In addition, this immigration has also impacted the growth of the U.S.-born population, through the children of Mexicans born in the U.S..

A previous report documents that one out of every four children under age 18 living in the U.S. has at least one immigrant parent, with the children of Mexicans constituting the largest group.

The Mexican population, both male and female, represents by far the largest immigrant minority in the U.S., with the male Mexican population exceeding immigrant populations from other parts of the world (Figure 1).

Figure 1. Distribution of the immigrant population residing in the United States, by sex, based on region or nation of origin, 2008

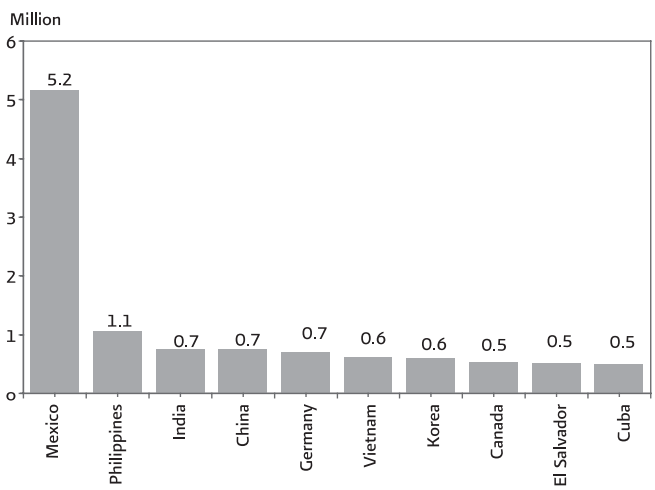


Source: CONAPO estimates based on *American Community Survey* (ACS), 2008.

The female Mexican population currently accounts for 46% of the nearly 12 million Mexican migrants living in the United States. The relative number of Mexican women living in the U.S. has not demonstrated significant variations over time, since a pattern of largely male Mexican migration has continued to prevail. In quantitative terms, however, the most substantial changes appear to have taken place in the pattern of female migration, with the growing participation of Mexican women as more active, autonomous agents in migratory processes and decreasing participation as primary companions to other immigrants.

In the main countries of origin of the female immigrant population in the United States, Mexico ranks first, with a figure that is five times higher than the Philippines, which ranks second (Figure 2).

Figure 2. Principal countries of origin of female immigrants to the United States, 2008

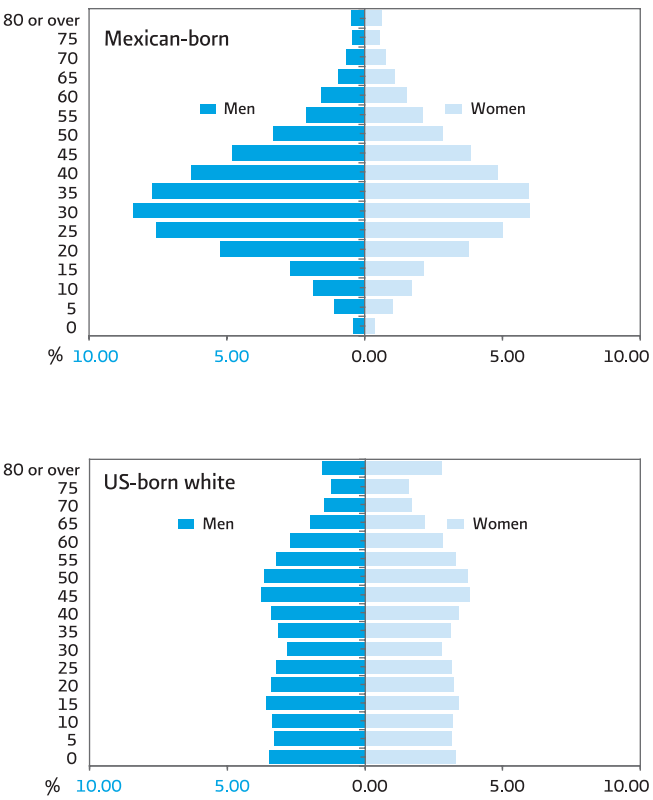


Source: CONAPO estimates based on *American Community Survey* (ACS),2008.

Mexican women are largely concentrated in the adult group

There are striking differences between the age structures of immigrant populations and U.S.-born populations. Immigrants' age composition is characterized by a broad concentration in the intermediate ages of the life cycle. This is particularly obvious in the Mexican population, where the group aged 18 to 64 —the age group selected for analysis in this study— accounts for 84% of the population (with the majority concentrated between the ages of 18 and 44) (Figure 3). This reflects the fact that it is mainly young adults who participate in migration, with only a small proportion of the younger and older population participating in such patterns.

Figure 3. Age pyramid Mexicans and white residents in the U.S., 2008



Source: CONAPO estimates based on *American Community Survey* (ACS), 2008.

Given the long history of labor migration between Mexico and the U.S., it would be reasonable to expect a larger presence of Mexican-born senior citizens. However, senior citizens only account for 7% of the Mexican immigrant population. This low percentage is closely linked to the fact that permanent migration is a relatively recent phenomenon. In previous decades labor migrants followed a circular pattern, spending only a few years in the U.S before returning to their communities of origin.

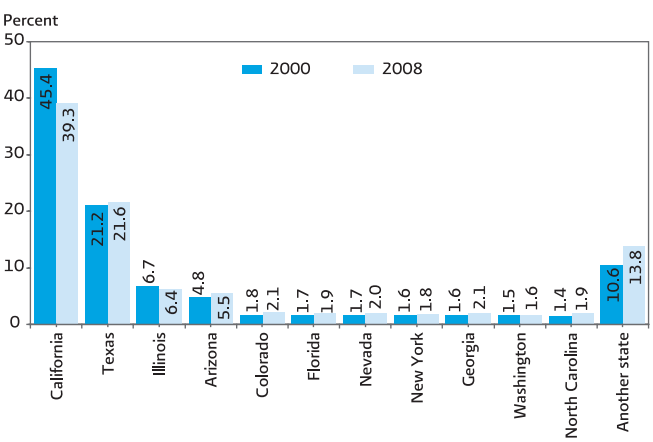
Conversely, the white U.S. population has a profile in which nearly two out of every three (60%) are concentrated in adult ages, with the population at either extreme, either under 18 (23%) or 65 and over (16%) comprising the remaining third (Figure 3). Given the aforementioned age patterns, in the following analyses, we focus on the female population aged 18 to 64.

Migratory characteristics of Mexican-born women aged 18 to 64

Female Mexican immigrants are distributed throughout the U.S.

The predominance of female Mexican immigrants aged 18 to 64 is observed throughout most of the United States, but a clear variation in time and cohort has been observed in the states receiving Mexican migration. Although California and Texas continue to be the home to the majority of Mexican-born women, other states have increased their share of this population (Figure 4).

Figure 4. Mexican-born women ages 18-64, in the U.S., percent distribution by state, 2000 and 2008

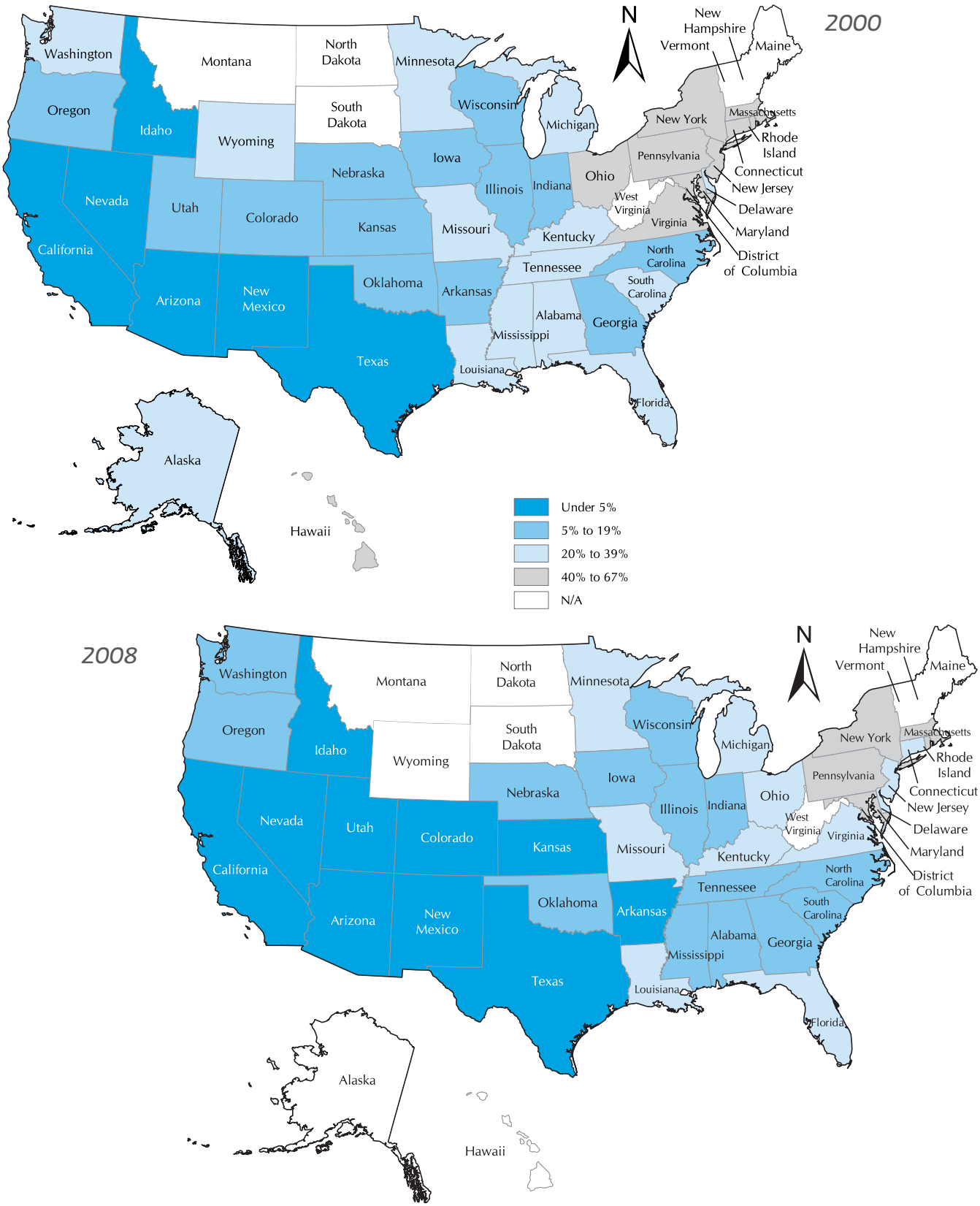


Source: CONAPO estimates based on *U.S. Census Bureau*, 5% sample from 2000; and *American Community Survey* (ACS), 2008.

The growing concentration of Mexican emigration to the United States has made their presence more visible throughout the country. Given that Mexican migration is predominantly for work, its presence in virtually all states reflects the nationwide demand in the U.S. labor market for foreign workers, specifically with Mexican characteristics. Figure 5 shows that the relative share of Mexican-born women aged 18 to 64 out of the total female immigrant population in this age group has increased dramatically in a number of diverse U.S. states.

In 2008, there were 10 states where adult Mexican women accounted for over 40% of the total number of adult immigrants. This figure is particularly high in view of the importance of a single immigrant group in comparison with all other foreign populations being measured (Figure 5).

Figure 5. Proportion of female Mexican immigrants ages 18 to 64 among all immigrants by U.S. state, 2000 and 2008



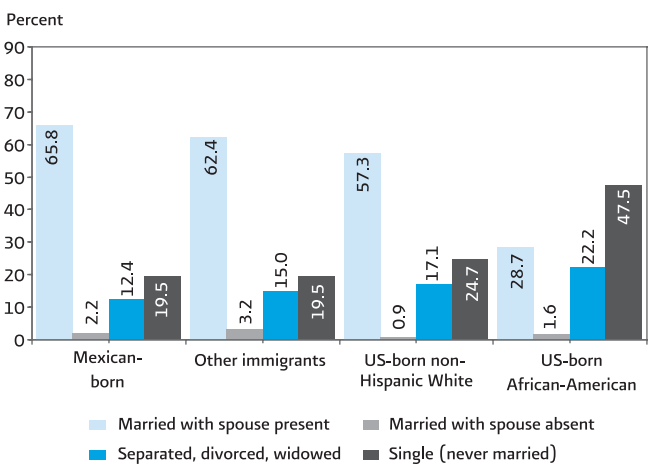
Source: CONAPO estimates based on *U.S. Census Bureau*, 5% sample from 2000; and *American Community Survey* (ACS), 2008.

Socio-demographic characteristics

Mexican-born women are more inclined to be married and to have children

Adult Mexican-born women are more likely to be married or living with their partners than any other group: two out of three are married, as opposed to one out of every three U.S.-born African-Americans (Figure 6). Conversely, reflecting their marital or co-habilitation status, in comparison with other populations, Mexican-born women are less likely to be heads of household (only 38% are heads of householder).

Figure 6. Women ages 25-64 living in the U.S. by race/ethnicity and marital status, 2009



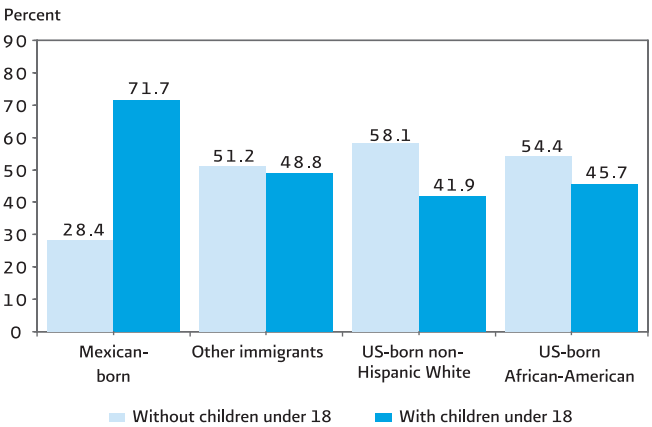
Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Women with children

In total, 72% of adult Mexican-born women have children under the age of 18, a much higher figure than women from other immigrant and U.S.-born groups (Figure 7).

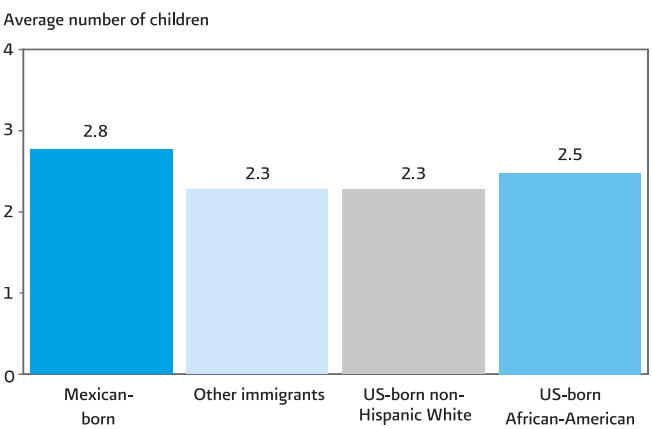
It is worth noting, however, that the great difference between Mexican-born women and other groups may partly be due to the distortion that occurs when populations with different age structures are compared. Figure 8 shows the average number of children per women for different ethnic/racial groups. This suggests that the discrepancies observed in Figure 7 are largely due to the fact that Mexican-born women are younger and are of reproductive age, thus far likelier to have children.

Figure 7. Proportion of women ages 18 to 64 living in the U.S. with/without children younger than 18 by race/ethnicity, 2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Figure 8. Average number of children for women ages 18 to 64 living in the U.S. by race/ethnicity, 2009



Source: CONAPO estimates based on *Current Population Survey (CPS)*, March 2009.

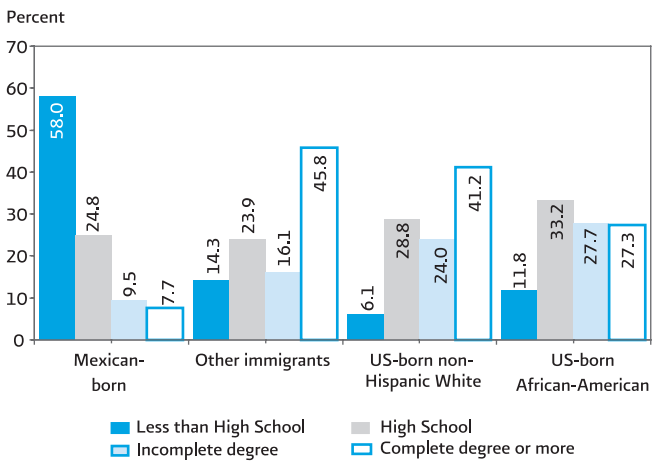
Social determinants of health

Mexican-born women are characterized by their low educational attainment and limited English proficiency

One characteristic that has prevailed among the Mexican population residing in the U.S. is their low educational attainment. This factor negatively impacts their socio-economic integration and therefore, their access to health among a number of other social, economic, and health factors. Although Mexican-born women tend to have a

higher educational attainment than their male counterparts, compared with other female populations, they are at an obvious disadvantage. The majority (58%) have less than a high school education (*High School*); whereas the proportion of other immigrants, U.S.-born, African-American and white women are far less likely to have such a limited level of education —14%, 12% and 6%, respectively. The extremely low proportion of Mexican-born women with a bachelor's or higher degree (8%), contrasts with the substantially higher levels achieved by other populations (Figure 9).[1]

Figure 9. Educational attainment among women ages 25-64 living in the U.S. by race/ethnicity, 2009

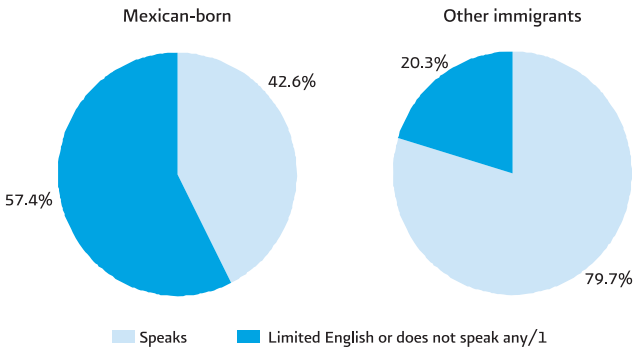


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Another aspect hindering the process of socio-economic integration of immigrant populations (particularly access to health services) is their limited English proficiency. The linguistic barrier affects nearly 3 out of every 5 Mexican-born women, whereas this ratio is 1:5 among immigrants from other countries (Figure 10). Both aspects —low educational attainment and limited English proficiency— are directly related to health literacy and problems navigating an increasingly automated health system that can only be accessed by computer.

[1] Nevertheless, in absolute terms, there are a significant number of Mexican-born female professionals: the nearly 700,000 Mexican-born women with this level of academic achievement constitute the third largest national group of qualified female immigrants in the United States, exceeded only by Indian and Filipino women.

Figure 10. English proficiency of immigrant women ages 18 to 64 in the U.S. by race/ethnicity, 2008



Note: 1/ Includes those that do not speak it well or at all.
Source: CONAPO estimates based on *American Community Survey* (ACS), 2008.

Adult Mexican-born women are characterized by having low naturalization rates

The high rates of undocumented workers and the low levels of citizenship among the Mexican population living in the U.S. create obstacles to their integration into society and restricts their access to health insurance, among other things.

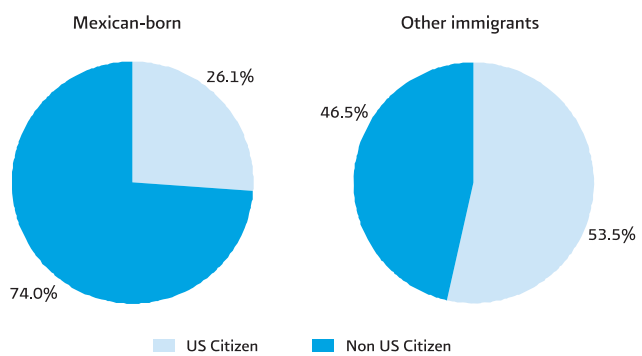
No source of nationally representative data provides an accurate estimate of the volume of undocumented migrants living in the United States. The Pew Hispanic Center estimates that there are nearly 7 million undocumented Mexicans residing in the U.S., most of whom have lived in this country for less than a decade. Although there are no specific estimates for women, this condition undoubtedly affects a significant proportion of Mexican-born women. For this group and their families, if comprehensive migratory reform is passed, (which has apparently been postponed until at a minimum 2011) it will largely define the possibility of their emerging from the shadows and aspiring to a better socio-economic level in the United States.

The *Current Population Survey* provides information on citizenship status; the proportion of the immigrant population without citizenship gives a rough idea of the number of undocumented immigrants. Not all those who are not citizens are undocumented migrants, although all undocumented workers are non-citizens. Granting citizenship constitutes an element that enhances immigrants'

integration into the receiving society, since it creates more stable immigrants, with labor and social rights, and mechanisms that facilitate and promote family reunification. In short, citizenship provides a series of rights that permit the development of human potential and participation in society similar to those of U.S.-born citizens.

Just over a quarter of adult Mexican immigrant women living in the U.S. have U.S. citizenship, despite the fact that the vast majority (over 70%) have spent over 10 years in the country. The low rates of citizenship of Mexican-born women contrasts with that of other immigrants (54%) (Figure 11).

Figure 11. Immigrant women ages 18- 64 by citizenship status by race/ethnicity, 2009

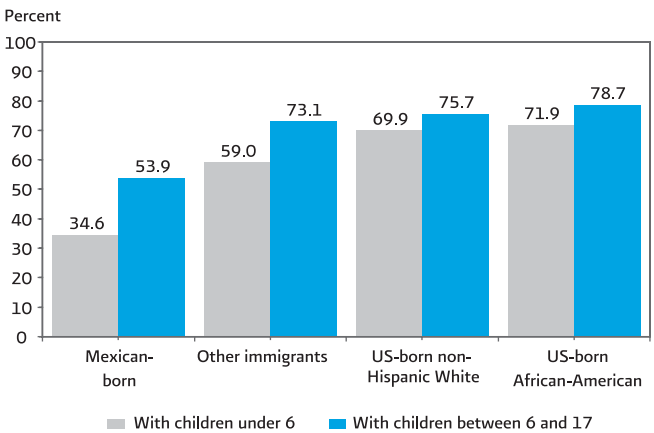


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Mexican-born women's participation in the formal work force is relatively low

Women display different patterns of entry into and permanence in the formal labor market as compared to men, largely due to the influence exerted on them by traditional roles, such as motherhood, child-raising, and housework. Analysis of the economically active female population living in the United States reveals differences between groups of different racial/ethnic origins. Figure 12 clearly shows that Mexican-born women are the immigrant group with the lowest activity in the formal labor market as compared with other immigrant groups and U.S.-born non-Hispanic white and African-American women. This situation is especially exacerbated among women with children under the age of 6. Mexican-born women probably find it more difficult to combine work and child-raising (Figure 12) as they often have limited resources to support child care as well as low levels of formal education that limit the types of jobs that they are eligible for in the U.S. labor market.

Figure 12. Labor participation rates among women ages 18-64 living in the U.S. by race/ethnicity and presence of children under 18, 2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

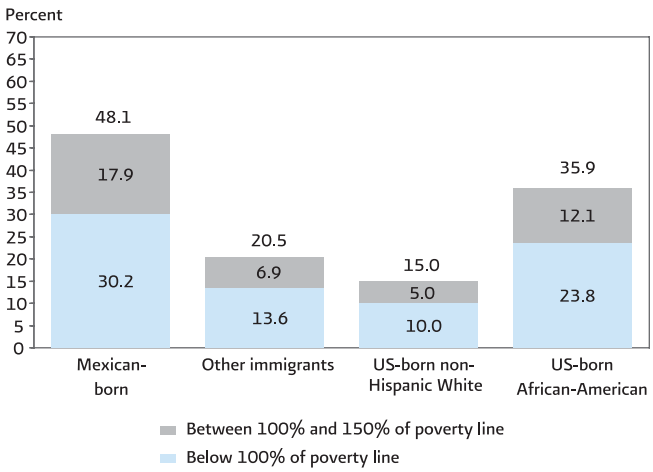
The majority of Mexican immigrant women live in low-income households

Lower access to the labor market by Mexican immigrant women, particularly in formal occupations with decent salaries and job benefits, restricts them to living in more precarious financial conditions. A total of 48% of adult Mexican women live in low-income families, in other words, in families with incomes 150% below the U.S. *Federal Poverty Line*.[2] This proportion is higher than that of African-American women (36%) and nearly three times higher than that of immigrant women from other regions and U.S.-born white women (21% and 15%, respectively). Likewise, figures on the prevalence of poverty (100% below the *Federal Poverty Line*) show that Mexican-born women are at a greater disadvantage than African-American women (30% and 24% respectively).

[2] In 2009, 100% of the *Federal Poverty Line* corresponded to $21,756 for a family of four with two children under 18.

Closing the social and economic schism between Mexican female immigrants and African-American and white women will require major investments (Figure 13).

Figure 13. Women aged 18 to 64 resident in the United States in a condition of low incomes,[1] by race/ethnicity, 2009



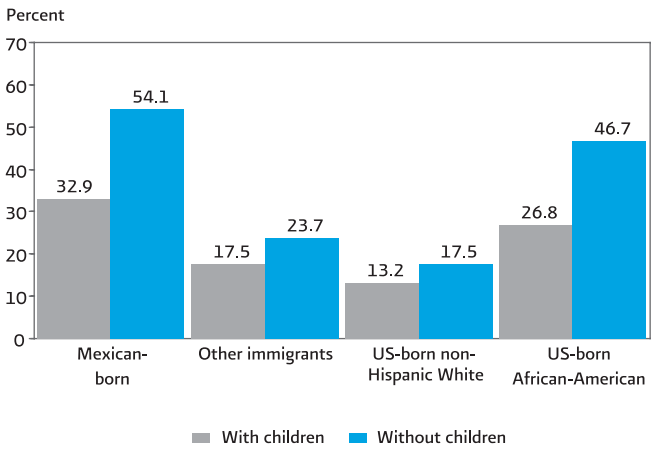
Note: 1/ Income below 150% of US Federal Poverty Line.
Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

The incidence of poverty and low income varies according to family structure. Although having children under 18 affects households' economic level across all groups, the greatest vulnerability is observed among Mexican-born women: 54% are included in the low-income category as compared to 47% of African-American women. Among other immigrants and U.S.-born white women these figures drop to 24% and 18%, respectively (Figure 14).

The lack of a father in the household noticeably affects women from all ethnic groups. Once again, however, Mexican-born women raising their children on their own are the most likely to experience financial difficulties: 78% of Mexican women in single-parent households have low incomes, a much higher figure than for other groups (Figure 15).

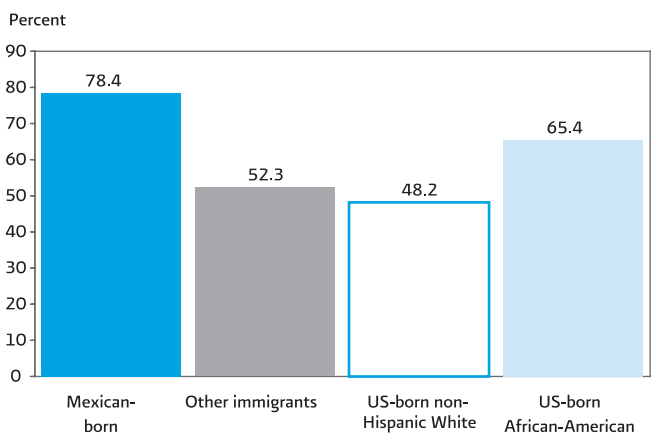
The information on the characteristics of Mexican female immigrants, analyzed in this chapter, provides the background for a better understanding of the specific needs and experiences of this population in terms of health. For

Figure 14. Women aged 18 to 64 resident in the U.S. with/without children in a condition of low incomes[1] by race/ethnicity, 2009



Note: 1/ Income below 150% of US Federal Poverty Line.
Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Figure 15. Women aged 18 to 64 resident in the U.S. with single parenthood status[1] by low incomes[2] and race/ethnicity, 2009



Notes: 1/ Single mother.
2/Income below 150% of US Federal Poverty Line.
Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

example, their high concentration in young adult ages and the characteristics of their family structure suggest the need to provider productive health and maternal and child health services. On the other hand, the crudeness of the figures analyzed evinces the low degree of integration of Mexican female adult immigrants in the U.S. compared with other immigrant and U.S.-born groups. They

are at a noticeable disadvantage regarding citizenship status, English proficiency, work performance, income, etc. These factors condition their ability to have medical insurance coverage and therefore to regularly attend health services.

Chapter II. Coverage and Type of Health Insurance

Although various factors condition regular health service use, health service coverage is undoubtedly the main means of periodically accessing medical care services in the U.S., since it provides financial access to a wide range of prevention, diagnostic and treatment services. The U.S. has one of the most unequal health provision systems in the developed world, expressed by the fact that a large percentage of the population lacks health insurance, including certain immigrant groups. The U.S. health system is based mainly on the private sector, with most health insurance being obtained through employment, while the state provides public programs that provide insurance for the most vulnerable groups that meet certain eligibility criteria. These are usually associated with income levels or, under certain circumstances, special health conditions. In the case of immigrant populations, citizenship status and length of legal residence in the country may be a factor.

The underlying inequities regarding health insurance coverage levels thus reflect and express socio-economic integration processes that vary according to race/ethnicity and citizenship status. The precarious situation and marginalization of certain immigrant and U.S.-born minorities has its correlation in higher indices of exclusion from the health system. By contrast, groups that are more economically and socially integrated have high indices of health insurance coverage.

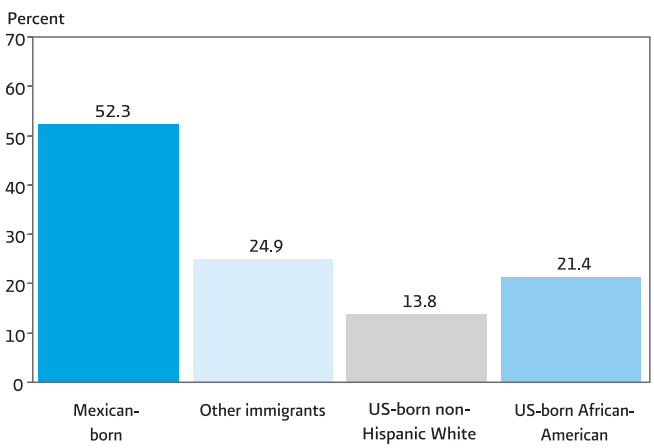
This chapter analyzes the level and type of health insurance coverage of Mexican immigrant women ages 18 to 64 in comparison with other ethnic/racial groups. It also examines the profile of those that face the greatest risk of not being insured.

Health Insurance Coverage

Over half of all adult Mexican immigrant women in the U.S. are not covered by some health insurance system

In general, Mexican-born adult women face great difficulties in gaining access to health insurance systems. Over half (52.3%) lack some type of health coverage (Figure 16). The pattern of lacking health insurance is more favorable for other immigrant and racial/ethnic groups. Only one quarter of immigrants from elsewhere in the world lack health insurance, a rate similar to that of African-American women (21%). U.S.-born white women are in a much better position, since only 14% are uninsured. These figures identify the existence of profound ethnic disparities in access to health insurance systems. Specifically, Mexican immigrant women emerge as a highly unprotected population group.

Figure 16. Women ages 18 to 64 living in the U.S. without health insurance, by race/ethnicity, 2009

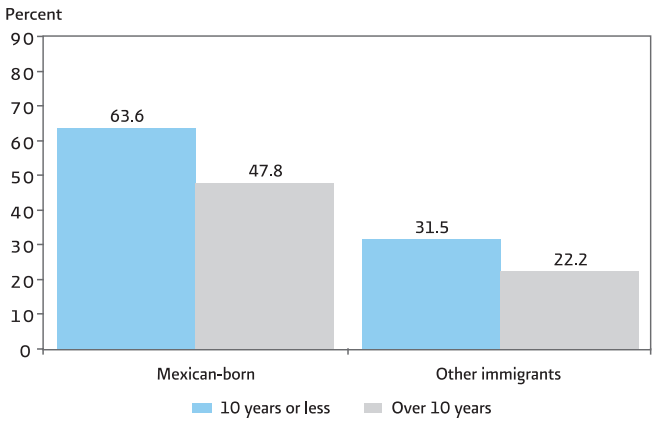


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

This situation is particularly dramatic among the most recent arrivals to the U.S., among whom there are even higher levels of non-insurance. Mexican immigrant women with fewer than ten years' residence in the U.S. have a non-insurance rate of 64%, which falls to 48% among those that have been living in the U.S. for over ten years. However, the disadvantage of Mexicans in relation to other populations persists over time. Remarkably, immigrant women from other parts of the world that have recently arrived (fewer than 10 years ago) have a higher level of

medical insurance coverage than Mexicans that have been living in the country for over 10 years (Figure 17).

Figure 17. Women ages 18 to 64 living in the U.S. without health insurance by length of residence and race/ethnicity, 2009

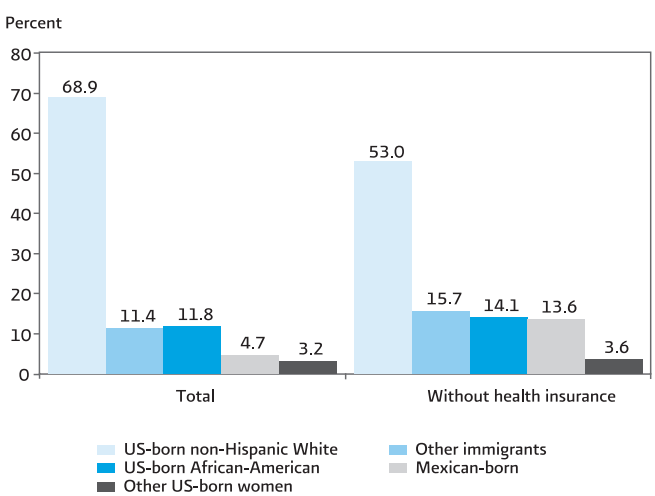


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Ethnic/racial minorities are over-represented in the universe of the uninsured female adult population

An analysis of the relative importance of each ethnic/racial group in the U.S. female populations ages 18 to 64 and their relative share of the uninsured population shows that ethnic/racial minorities face greater obstacles in gaining access to the health system. Mexican immigrant women are the most dramatic case, since they account for 5% of the female population in this age group in the country, yet account for 14% of the total number without health insurance (Figure 18).

Figure 18. Women ages 18 to 64 living in the U.S. by race/ethnicity, 2009



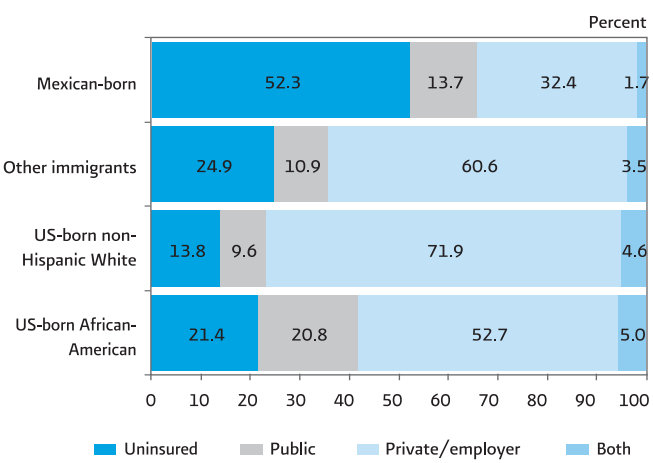
Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Type of Health Insurance

Having medical insurance depends largely on the possibility of obtaining health insurance through employment

There is a direct link between health insurance coverage and the possibility of having private medical insurance, which is mainly obtained through employment (whether one's own or that of a relative). U.S.-born white women are the ethnic/racial group with the highest level of health insurance as well as the group most likely to have medical insurance as part of their employment benefits. At the other extreme are Mexican immigrant women with the lowest indices of health insurance and the lowest likelihood of obtaining health insurance through work (Figure 19). At the same time, the lower proportion of Mexican-born women with some form of public health insurance reveals their limited access to programs designed to support low-income populations.

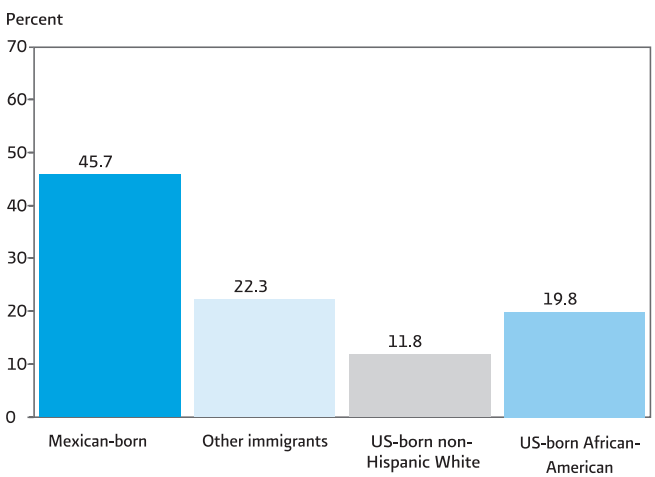
Figure 19. Women ages 18 to 64 living in the U.S. by type of health insurance and race/ethnicity, 2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

One of the factors that might explain the lower index of coverage of Mexican immigrant women is their lower work participation rate. However, an analysis of the situation of working women reveals significant disparities between the groups, since Mexican-born women are far less likely to have this job benefit. Nearly half the total number of Mexican-born female workers are uninsured, a rate that is four times higher than the rate for the white female U.S.-born labor force (Figure 20). This is closely linked to the Mexican immigrant population's pattern of labor insertion, which is strongly conditioned by their low level of academic achievement and citizenship status, expressed in a high concentration in poorly paid jobs offering limited or no job benefits. Even when this job benefit is provided by their employers, their low salaries make it very difficult for them to cover the premium.

Figure 20. Working women ages 18 to 64 living in the U.S. without health insurance by race/ethnicity, 2009

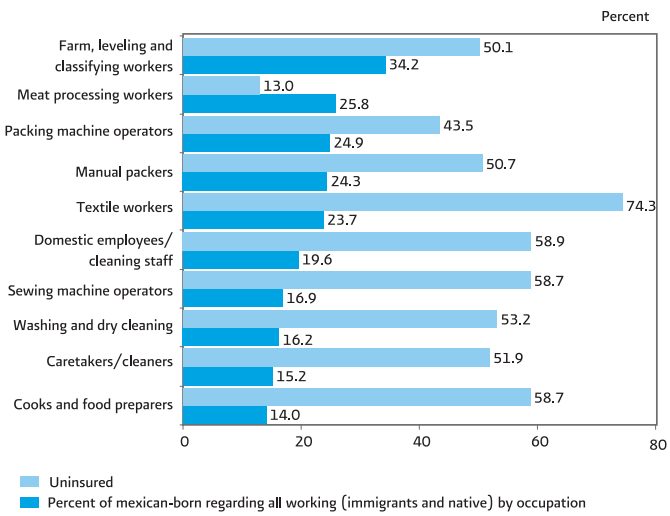


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

The concentration of Mexican female workers in hazardous exacerbates jobs their vulnerability in the face of the lack of medical insurance

The possibility of having employment-linked health insurance therefore varies by type of occupation, to the disadvantage of workers engaged in less qualified activities and the advantage of those at the top of the occupational scale. Unskilled service occupations, agriculture and industries that depend largely on Mexican female labor are very unlikely to offer health insurance as a job benefit (Figure 21). The low rates of insurance of female workers from Mexico in many unskilled occupations, some with a high incidence of occupational injuries and job-related illnesses, are extremely worrying. The least protected group is that of textile workers, three out of four of which lack health insurance coverage.

Figure 21. Proportion of Mexican immigrant women ages 18 to 64 in the U.S. without health insurance in selected occupations, 2005-2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2005-2009.

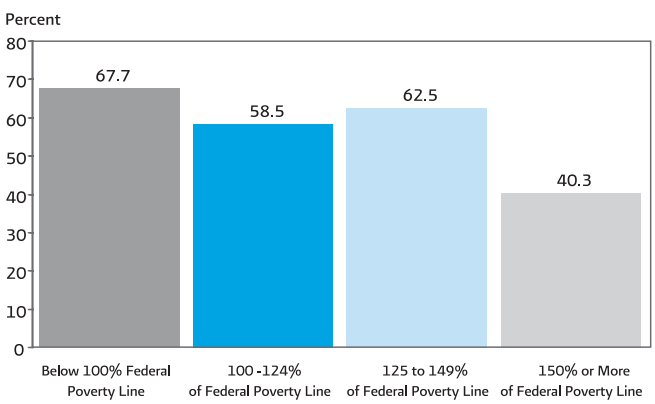
The lack of health insurance mainly affects the Mexican population with the greatest need

Groups at the greatest socio-economic disadvantage are the most likely to be excluded from the health system. In the case of Mexican immigrant women, the index of non-insurance among those living in poverty is dramatic: 68% lack health insurance. This situation is less unfavorable among those living in families with incomes over 150% above the Federal Poverty Line: fewer than half (40%) are uninsured (Figure 22). There is a counterproductive effect on health in the population when the poorest groups have to pay the most to look after their health and have to suffer the consequences of neglected health

coverage. It is not surprising, then, that Mexican-born women in this condition (many of whom are undocumented) tend to postpone diagnosis or treatment of a disease as long as possible or face serious financial crises in the event of having to go to hospital centers. That is, preventive measures that are often most cost-effective (*e.g.* vaccination, cancer screening, dental care) are neglected resulting in more expensive health care needs for diseases that develop.

Public programs designed for low-income families may help offset the weaknesses of a system that leaves health provision primarily in employers' hands. However, immigrant populations with scant resources, particularly the Mexican-born population, experience serious difficulties in gaining access to these programs, given the compulsory requirement of citizenship or a minimum of five years' legal residence.[1]

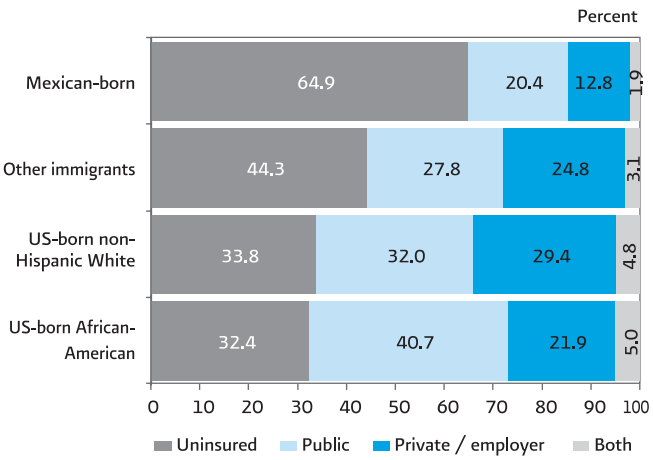
Figure 22. Mexican immigrant women ages 18 to 64 in the U.S. without health insurance by income level, 2005-2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2005-2009.

The poorest Mexican-born women have the lowest rates of access to federal programs designed to look after the health of the most disadvantaged populations (Figure 23). Approximately 22% meet the eligibility criteria that enable them to benefit from public health insurance (20% are insured by only a public program while 2% also have private health insurance). In comparison with the other ethnic/racial groups, Mexican women benefit least from public health programs, which corroborates the socio-economic and migratory disadvantages of the Mexican population living in the U.S. (Figure 23).

Figure 23. Women ages 18 to 64 living in the U.S., with low incomes,[1] by type of medical insurance and race/ethnicity, 2009



Note: 1/ Income below 150% of U.S. Federal Poverty Line.
Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

[1] The data analyzed do not as yet reflect modifications to the eligibility criteria of low-income immigrant populations for public health programs but the main obstacle faced by the Mexican population —undocumented status- continues to exist. This means that no significant variations in the results are expected.

Health System Reform in the United States

In March 2010, the U.S. Congress approved a landmark U.S. health system reform, and it was signed into law by the President. This legislation involved a major change in the current laws regarding health care coverage. Its main objectives are to: 1) expand access to health coverage for the vast majority of U.S. society, through the expansion of public medical care programs and the reduction of the cost of private medical insurance; 2) improve the public health care system by modernizing and streamlining it; and 3) reform the private medical insurance market, traditionally characterized by being expensive, restrictive and inefficient.

The provisions included in the reform will be gradually implemented over the next few years and nearly 95% of the U.S. population is expected to have medical coverage within 10 years. The most generous provisions will begin to be implemented over the next few years and it is only then that advances in the health system will be able to be evaluated. These provisions include the expansion of coverage provided by the states; the improvement of public medical care services; the reform of the private coverage market through the reduction of acquisition costs, the elimination of restrictions and rejection due to pre-existing conditions, and an improvement in the medical services provided. They will also include the implementation of a series of government supports, including tax support for the middle class, the implementation of a mandatory health insurance for virtually all the U.S. population, channeling more resources into Community Health Centers, etc.

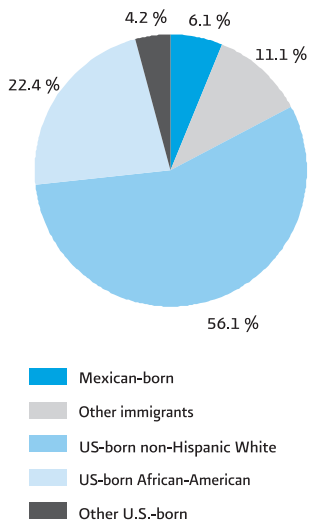
The health reform has established the basis for constructing a fairer national health system, which is an important step towards the incorporation of millions of individuals and families in the United States. This universe includes a significant number of legal residents who, after a period of legal residence of five years in the country, will be able to enjoy and benefit from the facilities provided by the government to acquire public coverage or assistance to minimize the costs of private insurance in the medium term. The reform will not cover everyone and it is estimated that between 15 and 20 million people will be excluded from the health system. This will happen to a high number of non-institutionalized individuals[1] —including U.S. citizens—, and others who, for religious and ethnic reasons, will be unable to qualify and obtain the advantages and benefits included in the reform, since they do not, for example, have a permanent place of residence. This will also be the case of at least 12 million undocumented immigrants —more than half of whom are from Mexico— who will be unable to enjoy the benefits provided by the U.S. reform and government, since there is no prior mechanism that will enable them to regularize their migratory status in the U.S. The lack of a comprehensive migratory reform that provides a solution for these millions of undocumented immigrants is an intrinsic limitation on the plan to achieve universal health care in the US.

Given the lack of political consensuses to establish the basis for a universal health system, a large package of economic assistance with annual increases for the next few years was approved that will benefit the Community Health Centers. They will continue to provide primary, preventive and ambulatory health care to virtually anyone that requires it, regardless of his or her socio-economic condition, coverage status or migratory situation. This will make it easier to increase the capacity for dealing with the public and improving the services provided by nearly 1,500 federally-approved Community Health Centers that provide services in over 3,200 communities without medical services distributed throughout all 50 states and the District of Colombia. In short, although undocumented migrants are the main group excluded from health reform, it is worth noting that in comparison with their current situation, they will improve their degree of access and medical care through these centers.

[1] Homeless persons, persons enlisted in the armed forces, migrant or seasonal workers.
Source: http://www.healthcare.gov/.

A common myth regarding Mexican migrants is that the motivation for much of the migration to the U.S. is to gain access to social benefits. The small proportion of eligible Mexican-born women ages 18 to 64 that are enrolled in the Medicaid program belies this statement (Figure 24). Although exclusion from the health system of a large sector of Mexican immigrant women has not reduced migration, which is primarily due to the desire to find employment, it has contributed to exacerbating social inequalities in health access.

Figure 24. Women ages 18 to 64 living in the U.S. affiliated with Medicaid by race/ethnicity, 2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Socio-Demographic Profiles by Type of Coverage

Health insurance coverage is strongly associated with socio-demographic profile (Figure 25). As expected, those that benefit most from public insurance are women living in the most precarious familial contexts: 71% of immigrant Mexican women live in low-income circumstances.[2] They are also younger, with lower educational achievement and the most likely to have dependent children. Conversely, most of those with private health insurance have higher incomes, higher educational attainment, higher citizenship rates and are more likely to work full time. At the same time, the most vulnerable group, which does not have health insurance, is far more likely to live in low-income circumstances than those with private insurance: nearly two out of three uninsured Mexican-born women live in low-income circumstances and therefore have very few resources for meeting their health care needs. There is a high concentration of young adult females among uninsured Mexican women, which implies a greater need for reproductive health care. However, this is unlikely to be achieved in a highly precarious context. At the same time, the majority have dependent children.

Mexican female immigrants, by far the largest foreign female contingent in the country, are characterized by a high level of exclusion from the health system. This situation is exacerbated among the poorest women, who include undocumented immigrants, the group on the lowest rung of the social ladder. Their vulnerability assumes dramatic proportions when they have accidents or become seriously ill and have to go to hospital centers.

Since the recently passed health system reform excluded the most vulnerable immigrant population, those that are undocumented, a large segment of the Mexican immigrant population, is likely to remain excluded from the system. The new reform will therefore create a new form of social inequality: one that distinguishes undocumented immigrants from all others and thereby contributes to exacerbating the impacts of segregation, discrimination and xenophobia that affect Mexican immigrants throughout the U.S.

[2] 150% below the Federal Poverty Line.

Figure 25. Mexican Immigrant Women ages 18 to 64 in the U.S. by Selected Characteristics and Type of Health Coverage, 2009

Selected characteristics	Health coverage			Total
	Public	Private	Uninsured	
Age				
18-24	14.5	8.0	13.4	11.8
25-34	25.5	23.5	34.5	29.6
35-44	27.4	30.0	29.6	29.4
45-54	15.8	27.2	15.3	19.2
55-64	16.8	11.4	7.2	10.0
Total	100.0	100.0	100.0	100.0
Income				
Below 150% Federal Poverty Line	70.6	19.3	60.4	48.7
150% and more of Federal Poverty Line	29.4	80.7	39.6	51.3
Total	100.0	100.0	100.0	100.0
Educational attainment (population ages 25 to 64)				
Less than High School	64.2	44.2	65.3	58.0
High School	21.4	28.5	23.4	24.8
Incomplete degree	10.3	13.4	6.6	9.5
Complete degree or more	4.1	13.9	4.7	7.7
Total	100.0	100.0	100.0	100.0
Citizenship				
U.S. citizen	26.0	41.0	16.8	26.1
Non-U.S. citizen	74.0	59.0	83.2	73.9
Total	100.0	100.0	100.0	100.0
With/without children under 18				
Without children under 18	25.4	34.2	25.2	28.4
Children under 18	74.6	65.8	74.8	71.6
Total	100.0	100.0	100.0	100.0
Family structure with children under 18				
Single mother	31.8	9.9	17.7	17.4
Both parents	68.2	90.1	82.3	82.6
Total	100.0	100.0	100.0	100.0
Type of working day				
Works full time	39.7	69.7	47.9	55.9
Works part time	36.4	22.0	34.0	29.4
Unemployed	23.9	8.3	18.0	14.7
Total	100.0	100.0	100.0	100.0

Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2009.

Chapter III. Disparities in Access to Medical Insurance at the State Level

Health insurance coverage varies significantly at the state level, which is closely linked to the enormous diversity of state policies. Within this context, immigrants' degree of access to public health programs targeting low income groups also varies substantially. Most health care programs available at the state and even local level are partly or largely financed by federal government funds, such as Medicaid and CHIP. While those funds include specific federal rules about eligibility and benefits, states and localities often have discretion over a variety of eligibility rules.

For example, federal rules and guidelines determining qualification for and access to many public advantages and benefits offered by the U.S. government demand at least 5 years' legal residence in the country. Some states,[1] however, require at least one of these 5 years' legal residence to have been within their jurisdiction. Likewise, the states can also stipulate socio-economic evaluations, visits to inspect the applicant's dwelling or the exhaustive checking of personal information included in the application form. Consequently, a person qualifying for a medical treatment program in a certain state would not qualify in other states in which qualification criteria were stricter.

This chapter attempts to add a new dimension to the analysis of ethnic/racial inequities in access to medical insurance coverage: the state dimension. Political discussions and decisions at the state level, in issues such as medical insurance coverage, medical care costs, medical infrastructure, medical insurance at work and reproductive health have a significant impact on women's access to and experience of the health system. That is why it is important to go beyond national statistics to the state level to acquire a better understanding of existing inequities in health issues. This chapter begins with a brief evaluation of the laws passed during the recent period defining immigrants' rights and public benefits, which affect Mexican immigrant women's access to health. It also examines the index of non-insurance among this group and analyzes the scope of the differences in relation to U.S.-born white women.

State authorities are defining their own immigrant policies and the rights/benefits of immigrant populations

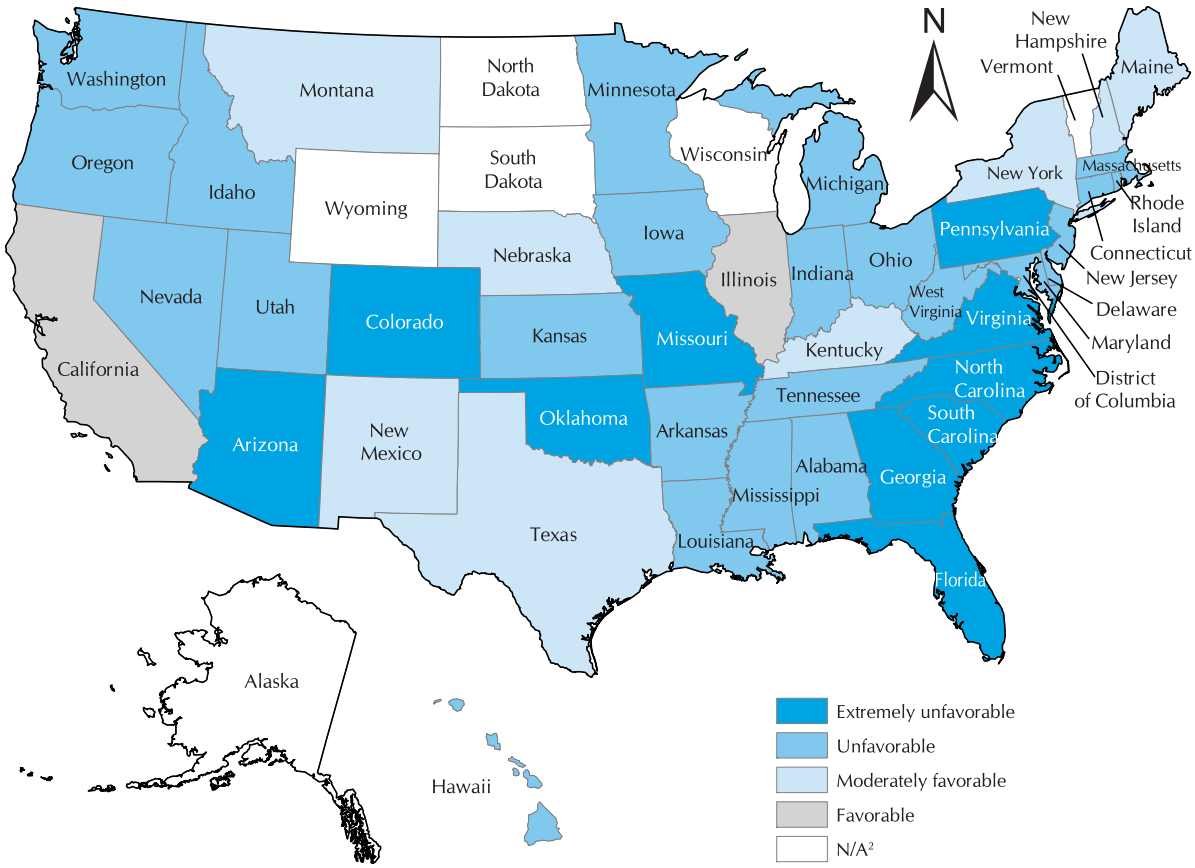
Given the lack of action on immigration reform at the federal level, U.S. states are now defining their own immigration policy which, whether directly or indirectly, affects immigrant population's access to health. According to reports by the *U.S. National Conference on State Legislatures*, between 2005 and 2009, 567 state laws on immigration and immigrants were passed. These laws regulate work, access to public benefits, education, driving licenses and other identification documents, human trafficking, security and immigration controls, among other aspects.

In general, the new state regulations have created a more favorable context for the documented immigrant population. Conversely, undocumented immigrants have faced more restrictive conditions that prevent their integration: 80% of the laws related to this group were restrictive and limited their rights.

An analysis of the direction of the laws passed in recent years on unauthorized immigrants shows that they can be classified according to the degree to which they reduce their rights and restrict access to public benefits. A case in point is the legislative activity promoted in recent years in at least seven states in the United States: Arizona, North Carolina, South Carolina, Colorado, Florida, Georgia and Virginia, whose practices seek to hamper and prevent undocumented immigrants from reaching them. This contrasts with some of the laws promoted by the legislatures of the states of California and Illinois (Figure 26).

[1] For example, the state of Maine requires at least one year of legal residence within its jurisdiction.

Figure 26. State legislative activity targeting irregular immigrant population in the United States,[1] 2005-2009



Notes: 1/ Includes legislation on education, job regulations, people trafficking, issuing and use of driving licenses and identification documents, public advantages and benefits, security and law enforcement and health.

2/ N/A: States whose legislatures did not pass laws on the issue and/or not significant for irregular immigration.

Source: Drawn up by CONAPO on the basis of the annual reports by the *National Conference on State Legislature on the state legislation passed in the U.S. on immigration and immigrants*, 2005-2009.

The laws targeting undocumented immigrants regarding access to public programs and benefits are largely restrictives

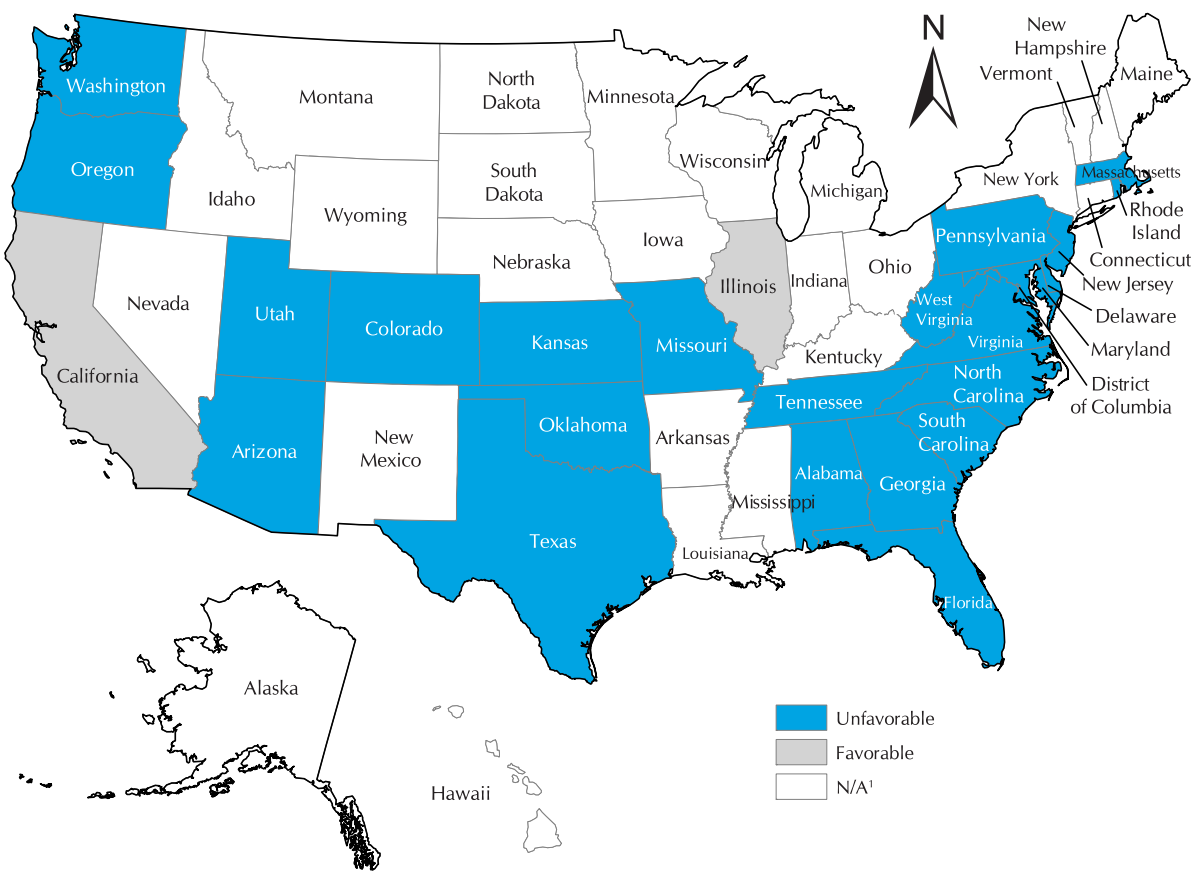
The issue of access to health, like other fundamental rights such as access to education and certain public benefits has been consistently dealt with and regulated in recent years. In the period between 2005 and 2009 alone, the legislatures of 26 state governments approved approximately 120 bills affecting immigrants in areas linked to medical care and other public services. These laws were designed to impose greater restrictions on immigrant groups in access to public programs or benefits, particularly access for undocumented immigrants. The exception to this trend is emergency medical care and the application of vaccinations and services for the detection and treatment of contagious or easily transmitted diseases.

Arizona, Colorado, Florida, Georgia, North Carolina, South Carolina and Virginia have recently passed several immigration laws that implement practices severely restricting access to the advantages and benefits provided by the state to persons without citizenship or legal residence. This includes services related to health and maintenance (Figure 27). Other states with less legislative activity have enacted similar laws as a result of specific factors at the time of this legislation. This is the case in the following states: Missouri, New Jersey, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, and Washington.

The opposite is true of the laws passed in California and Illinois between 2005 and 2009 which, for example, permit medical care for undocumented immigrants through local programs. They also channel more state funds into the Community Health Centers and Migratory Health Centers that treat anyone regardless of his or her migratory status.[2] There are also some states that have decided to use their own funds to provide medical care for certain vulnerable groups, as in the case of expectant mothers and children that do not qualify for federal programs. Examples include California and Illinois which in recent years have worked on a series of legal mechanisms to improve immigrants' living conditions, including health care (Figure 27).

Despite this discouraging scenario at the national level, it is worth highlighting the fact that a significant number of immigrants —the majority undocumented— who cannot gain access to the advantages and benefits available in the various U.S. states have benefitted somewhat from local programs.

Figure 27. State legislative activity regarding access to health services, advantages and benefits oriented towards the irregular immigrant population in the United States, 2005-2009



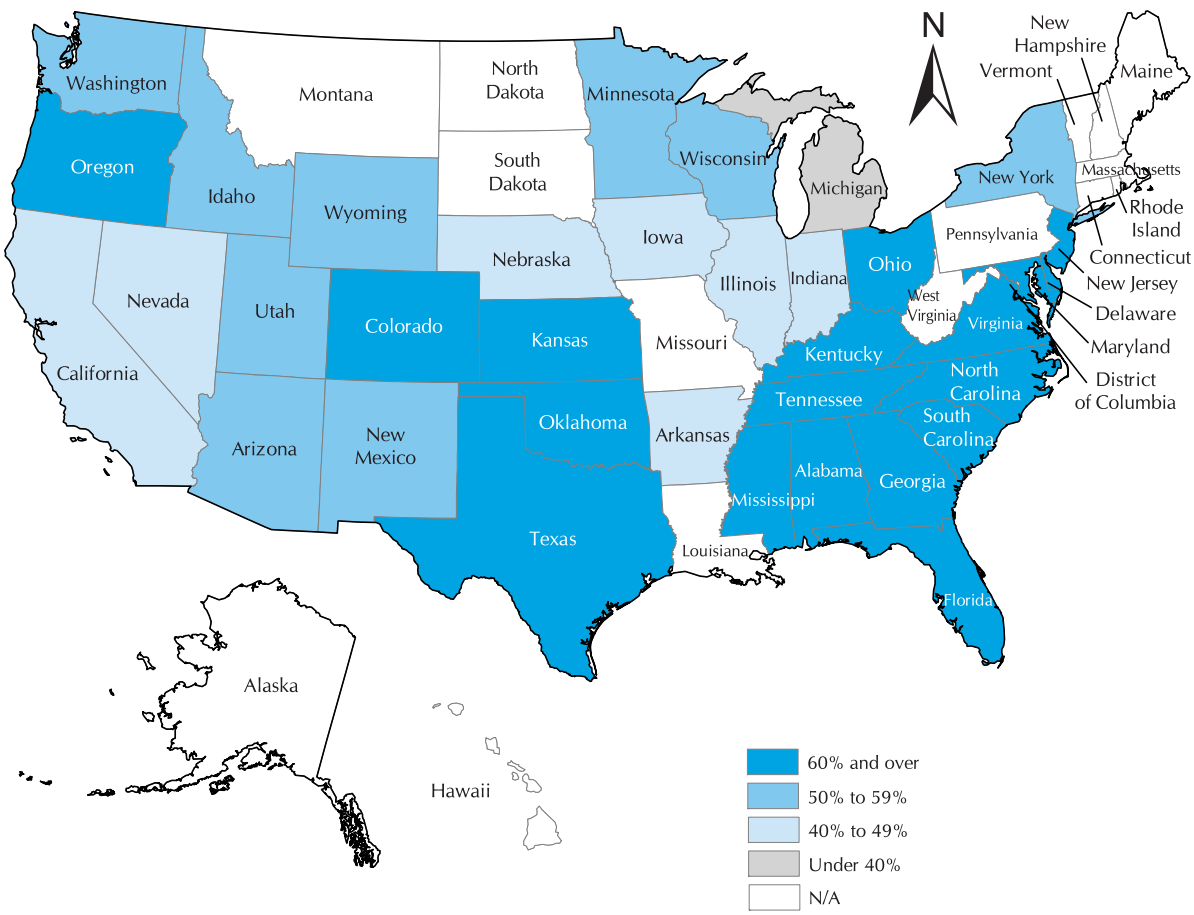
Note: 1/ N/A: States whose legislatures did not pass laws on the issue and/or not significant for irregular immigration.
Source: Drawn up by CONAPO on the basis of the annual reports by the *National Conference on State Legislature on the state legislation passed in the U.S. on immigration and immigrants*, 2005-2009.

Health Insurance Coverage

The lack of health insurance among Mexican women is dramatic in the states with the most recent immigration and greatest anti-immigrant activism

The highest indices of non-insurance of Mexican immigrant women occur, in order of importance, in Mississippi, Georgia, Ohio, Oklahoma, New Jersey, Colorado, Florida and North Carolina (where it varies from 80% to 65%). At the other extreme are the states of Michigan, Arkansas, Iowa, California and Illinois, where the index of non-insurance varies from 38% to 45% (Figure 28).

Figure 28. Mexican-born female population ages 18 to 64 without health insurance by state of residence in the U.S., 2005-2009

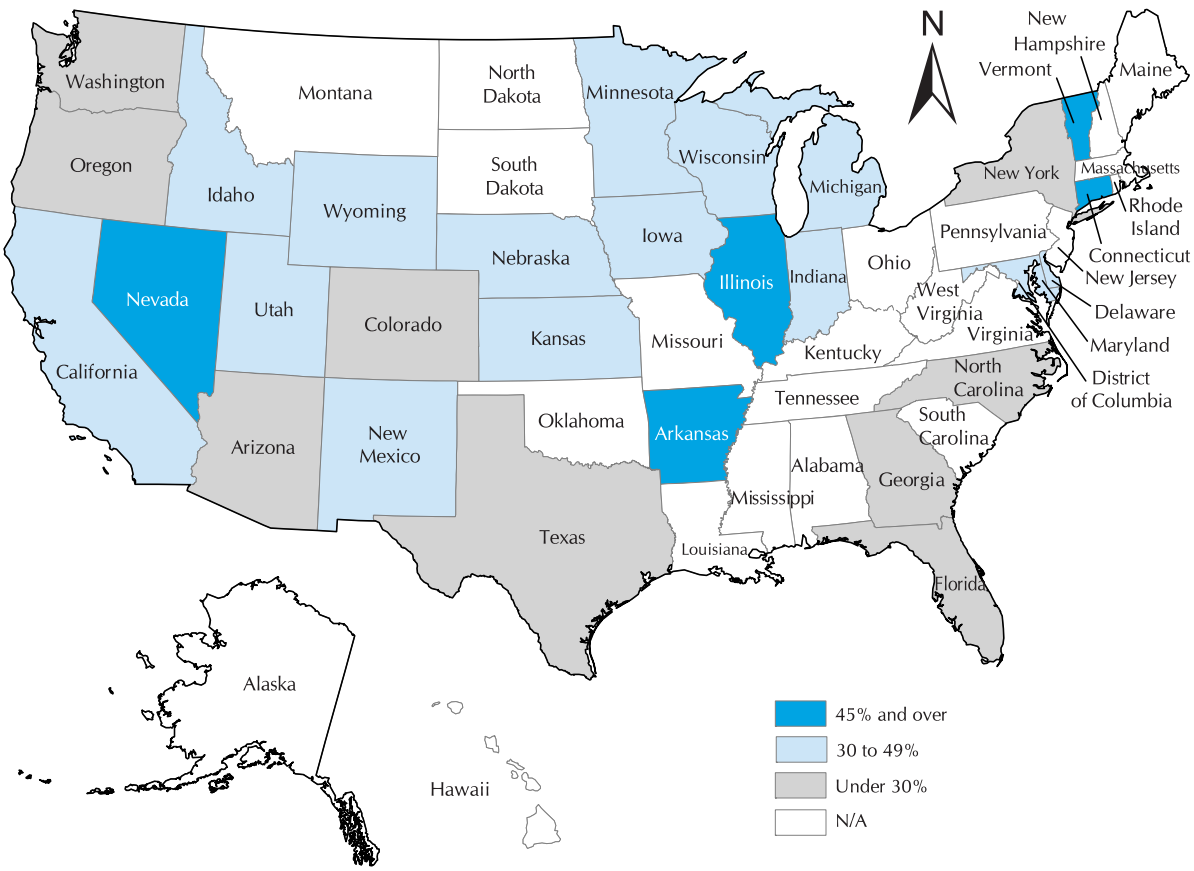


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2005-2009.

The low propensity of Mexican women to have private insurance can be observed throughout the U.S.

As noted in the previous chapter, the low rate of health insurance among Mexican immigrant women is linked to the lower likelihood that they will receive health insurance from their employers. Figure 29 shows that in a large number of states, where the available information is statistically significant, a small proportion of Mexican immigrant women have health insurance through employment (whether their own or a relative's). In states such as Georgia, New York, North Carolina, Colorado, Washington and Oregon, where Mexican immigration is relatively recent and therefore characterized by a large number of undocumented immigrants, this proportion is lower than 25%.

Figure 29. Mexican-born women ages 18 to 64 with private health insurance by state of residence in the U.S., 2005-2009

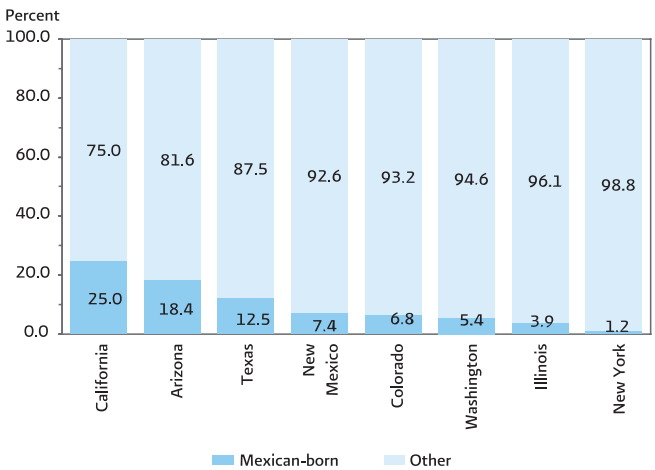


Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2005-2009.

Very few states in the U.S. have a large proportion of Mexican immigrant women within the universe of Medicaid beneficiaries. This belies the argument that immigrants in general and Mexicans in particular place a heavy burden on the welfare system. According to the available information, there are three states where this proportion is significant (Figure 30). In California they account for 25% as opposed to 18% in Arizona and nearly 13% in Texas respectively. Among the most conservative groups in these states, concerns have probably been raised about the cost of the use of this program by foreign beneficiaries, which has boosted efforts in state legislatures to restrict their rights. In California, unlike Arizona and Texas, the existence of a state legislatures that is better disposed

towards the Latino community, together with the activism of large organizations in favor of immigrants, has curbed attempts by the most conservative sectors seeking to restrict the rights of immigrants, particularly undocumented ones.

Figure 30. Distribution of female population ages 18 to 64 receiving Medicaid benefits by race/ethnicity and selected state of residence in the U.S., 2005-2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2005-2009.

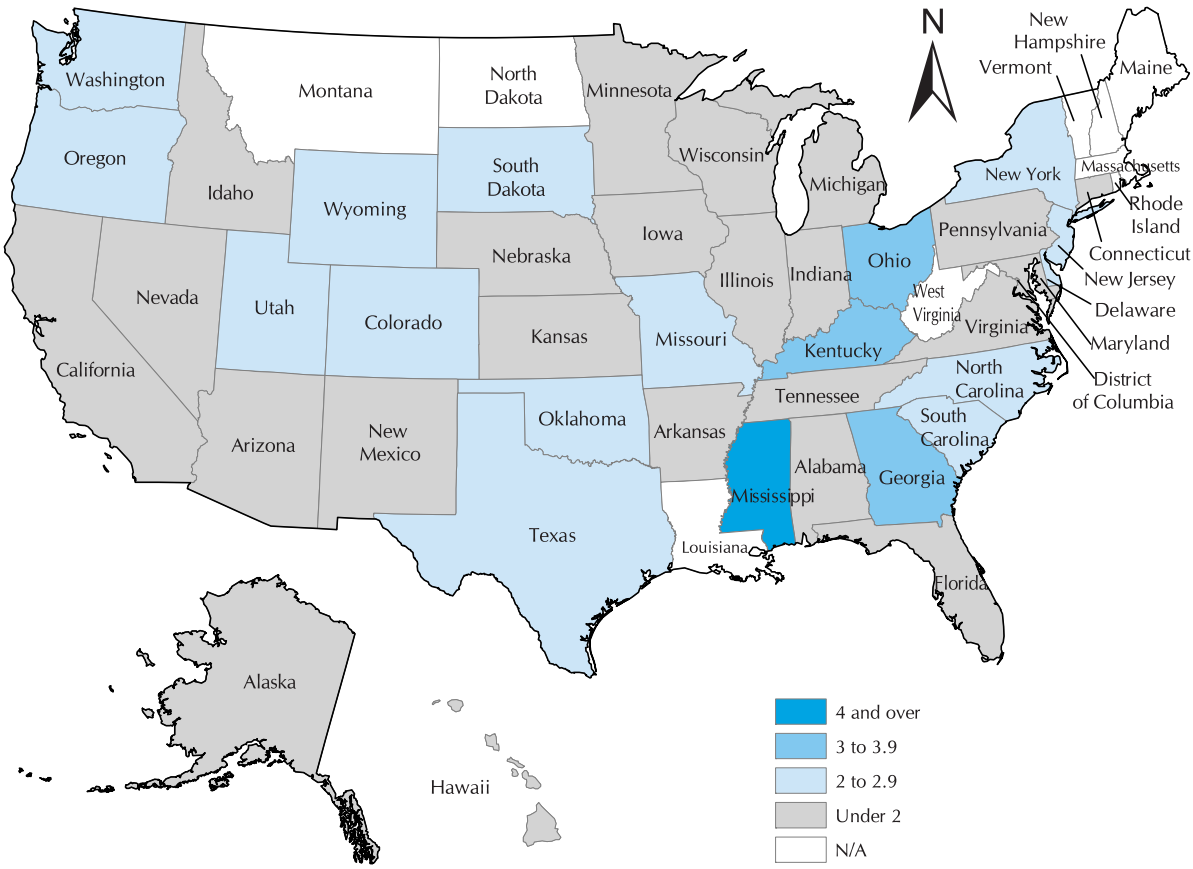
Inequities within states

Ethnic/racial inequities in terms of health insurance coverage are reproduced at the state level

The ethnic/racial disparities in access to health insurance observed nationwide are reproduced to a greater or lesser extent at the state level. Figure 31 shows the scope of these disparities within each state through an indicator showing the number of time U.S.-born white women exceed Mexican immigrant women in medical insurance coverage. A case in point is Mississippi, where white U.S.-born women have an index of coverage four times higher than that of Mexican-born women. Mississippi is followed, in descending order, by Kentucky, Georgia, Ohio, New Jersey, Colorado, Oklahoma, North Carolina and Florida, which have the highest differences in coverage between the two groups. At the opposite extreme are the District of Colombia and states such as Michigan, California, Nevada, Iowa and Illinois, where the differences between U.S.-born white and Mexican immigrant women are insignificant. A direct link can be observed then, between the index of non-insurance of Mexican women and the disparities (Figure 28) in coverage in relation to U.S.-born white women (Figure 31).

There are sharp disparities in the level of health insurance coverage for Mexican immigrant women between states. These are largely linked to the possibility of obtaining job-related health insurance. At the same time, these differences are linked to the enormous diversity of public health policies that are frequently restrictive with regard to immigrant populations. In fact, recent years have seen intense legislative activity at the state level that affects the rights granted to immigrant populations. A significant number of states have legislated to restrict access by immigrants, particularly undocumented ones, to public benefits and programs, including those related to health care. This dynamic seems to operate as yet another tool for migratory control by attempting to discourage immigration and immigrants' irregular residence, which it has patently failed to achieve. In fact, these measures merely exacerbate the inequities in health access, largely affecting Mexican women.

Figure 31. Health coverage ratio of non-Hispanic White women ages 18 to 64 in relation to Mexican immigrant women by state of residence in the U.S., 2005-2009



Source: CONAPO estimates based on *Current Population Survey* (CPS), March 2005-2009.

Chapter IV. Use of Health Care Services

Experiences in women's use of health services differ between each ethnic/racial group according to age, health needs and socio-economic, cultural, technological, linguistic and migratory factors, among others. Many women experience significant financial and logistic difficulties in obtaining timely medical care. As mentioned earlier, health insurance is the main facilitator of the timely use of health care since it provides financial access to a wide range of services for the prevention, diagnosis and treatment of disease. Conversely, the lack of health insurance is the main barrier to needed medical services. Low–income Americans, especially Mexican immigrants, are the most likely to lack health insurance.

In general, medical insurance does not cover the full cost of services, since part of the medical visit and prescription costs are paid out of pocket by the patient through co-payments and deductibles. These costs can be burdensome for low-income populations.

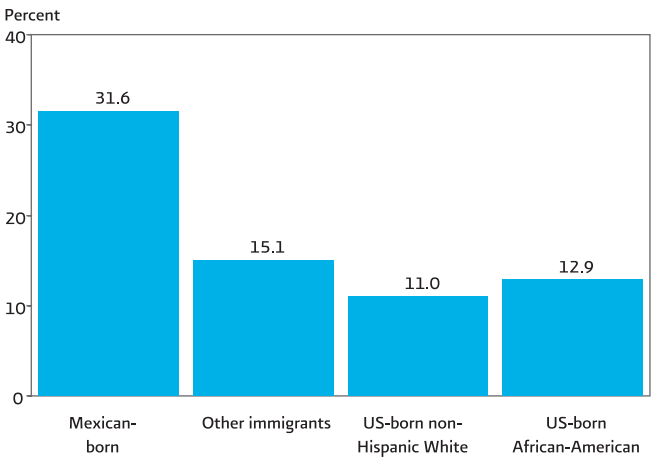
This chapter uses a comparative perspective with other ethnic/racial groups to analyze regular health service use by Mexican immigrant women, the type of services they use, and the timeliness with which they receive medical care.

Access to health care services and health insurance

Nearly a third of Mexican immigrant women in the United States reported that they did not have a usual source of care

Having periodic check-ups obviously requires having a place to go for regular health care. There are sharp discrepancies between different groups of women, with Mexican immigrants being in the position of greatest relative disadvantage: nearly a third do not have a source of regular health care. This is the case for only 15% of other immigrants and 13% and 11% of U.S.-born African-American and white women respectively (Figure 32).

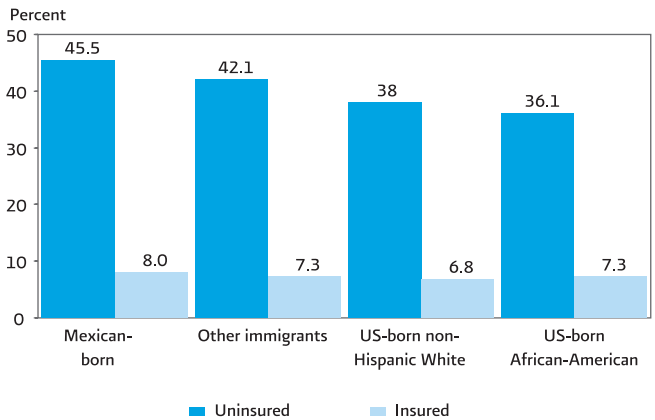
Figure 32. No Usual Source of Care by Race/ethnicity and Nativity, Women ages 18-64, U.S., 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

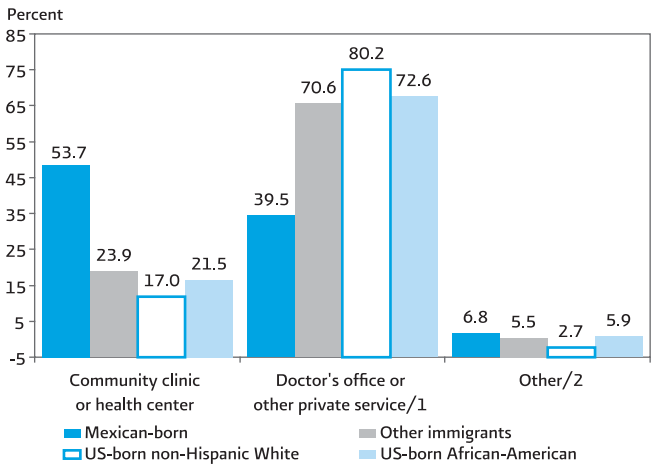
A lack of health insurance correlates with a weak link to health services. The data clearly show that persons without health insurance are more likely not to have a usual source of care. This situation is more common among Mexican-born women (46%) than among other immigrant women (42%), U.S.-born whites (38%), and African-American women (36%) (Figure 33). The lower level of having a usual source of care by uninsured Mexican immigrant women is probably linked to many factors including greater financial difficulties, linguistic and cultural barriers, and fear associated with the lack of immigration papers. Conversely, there are no significant differences in having a usual source for obtaining health services when women have health insurance, demonstrating that this is a factor that "democratizes" access to health care.

Figure 33. No Usual Source of Care by Race/ethnicity and Nativity and by health insurance status, Women ages 18-64, U.S., 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Figure 34. Type of Usual Source of Care by Race/ethnicity and Nativity, Women ages 18-64, U.S., 2007-2009



Notes: 1/ Includes Doctor's office and Health Maintenance Organization (HMO).
2/ Other includes emergency room, outpatients' department and other places.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Type of health care service

Mexican immigrant women are less likely to use private physicians

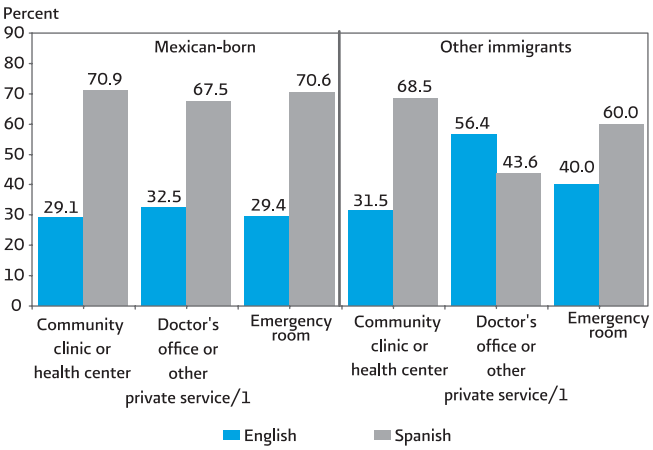
The quality of health care received is closely linked to the source of care. In principle, those seeking care from private physicians are likely to receive better care than those that who use public health centers or clinics since they are able to establish a more stable relationship with the doctor, who in turn provides more personalized care.

Half the Mexican immigrant women with a regular source of health care use public centers or clinics, a much higher proportion than that of other groups (Figure 34). Conversely, the proportion with a regular source of private medical care (40%) is significantly lower than that of immigrants from other parts of the world (71%), U.S.-born African-American (73%) and white women (80%).

It is noteworthy that public health centers or clinics are more accessible to Mexican immigrant women, not only because they cost less and are often located in immigrant neighborhoods, but also because they provide culturally and linguistically appropriate services. Data from the *Hispanic Healthcare Survey* show that in 71% of cases of Mexican immigrant women receiving care at these clinics or centers, the medical visit is conducted in Spanish. No significant differences were detected in the use of Spanish when they were seen by a doctor (68%) or in an emergency room (71%) (Figure 35). There is a clear difference, however, in relation to other Hispanic immigrant women that visit private medical care, since only 44% used Spanish during their conversations with the doctor. When it comes to choosing a private physician, Mexican immigrant women, who have a limited English proficiency, are likely to prefer health care providers that speak Spanish.

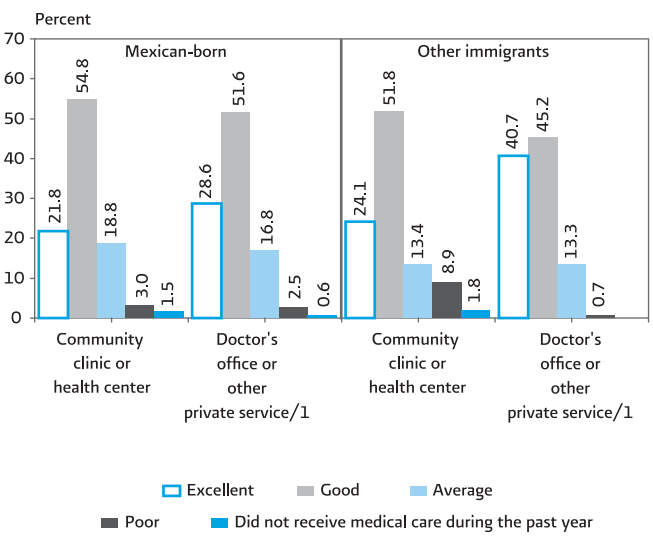
Mexican immigrant women's perception of the quality of service provided is similar for both clinics and private doctors. Of those who visited public health centers or clinics, 76% rated their care as good or excellent. At the same time, 22% regarded the quality of the care as average or poor. In the case of those that received medical care in a private doctor's office, four out of five regarded the quality of the service as good or excellent while 19% regarded it as average or poor (Figure 36).

Figure 35. Language Used in Medical Visit by Type of Usual Source of Care, Mexican-born and Other Hispanic Immigrant Women ages 18-64 , U.S., 2007



Note: 1/ Includes Doctor's office and Health Maintenance Organization (HMO).
Source: CONAPO estimates based on Pew Hispanic Center, Robert Wood Johnson Foundation, *Hispanic Healthcare Survey*, 2007.

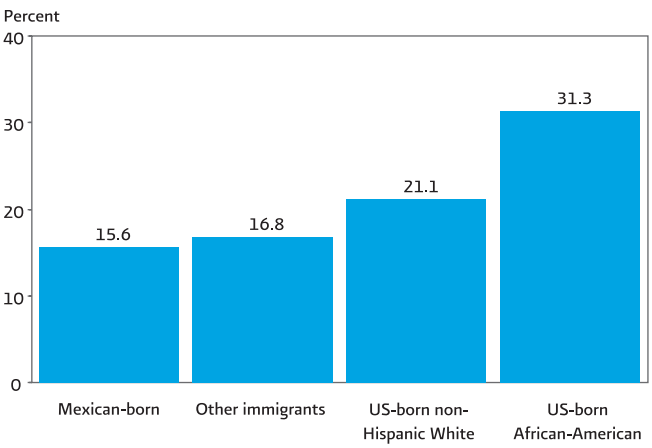
Figure 36. Perceived Quality of Medical Care by Source of Care, Mexican-born and Other Hispanic Immigrant Women ages 18-64, U.S., 2007



Note: 1/ Includes Doctor's office and Health Maintenance Organization (HMO).
Source: CONAPO estimates based on Pew Hispanic Center, Robert Wood Johnson Foundation, *Hispanic Healthcare Survey*, 2007.

It is a common myth that immigrant populations without health insurance or a regular source of medical care tend to use hospital emergency services more often. But emergency use data reveal the opposite. The use of emergency services by other immigrant/ethnic groups is up to twice the low rate of use among Mexican immigrant women (16%) (Figure 37).

Figure 37. Emergency Room Visit Past Year by Race/ethnicity and Nativity, Women ages 18-64, U.S., 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Preventive and primary health care

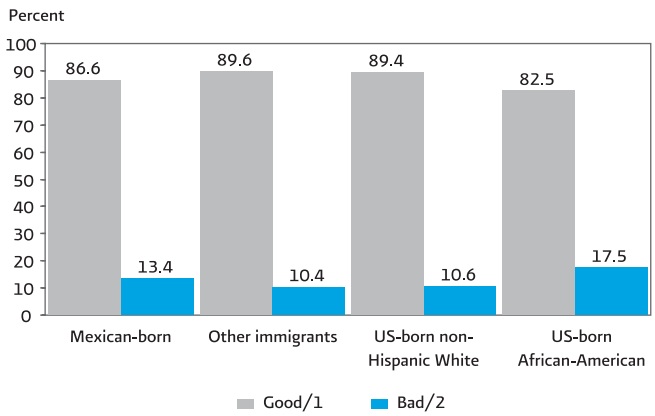
The majority of Mexican immigrant women think that they are in good health

The frequency with which adults use health care services in the U.S. is closely linked to their perception of their state of health. When people perceive their health to be fair or poor their medical visits are likely to be more frequent, and visits are more widely spaced when people perceive their health as being good, very good, or excellent. In this study, at least one medical visit every six months is regarded as the minimum necessary for those reporting an average or poor state of health.

No significant differences were detected in the perceptions of different groups of women regarding their state of health (Figure 38). Nevertheless, U.S.-born African-

American and Mexican immigrant women were more likely to regard themselves as having health problems (18% and 13% respectively, as opposed to 10% of U.S.-born whites and other immigrant women).

Figure 38. Self-Assessed Health by Race/ethnicity and Nativity, Women ages 18-64, U.S., 2007-2009

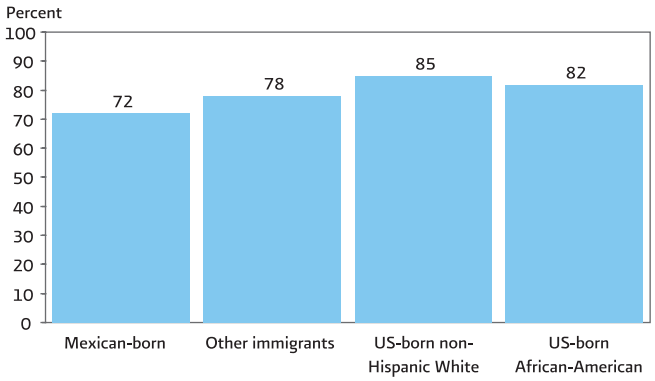


Notes: 1/ Includes the categories of excellent and good.
2/ Includes the categories of average and poor.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Uninsured adult Mexican-born women with health problems are less likely to receive timely health care

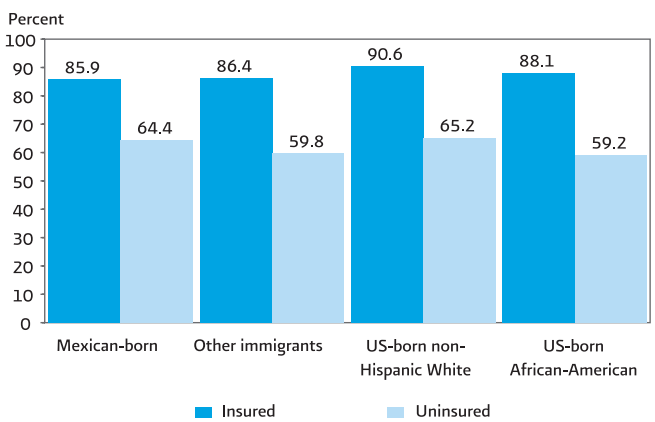
Mexican immigrant women who perceive their state of health as being fair or poor are less likely than other population groups to consult a doctor within a short period of time: approximately 72% consulted a doctor in the past six months. This figure is higher among immigrants from other countries (78%), U.S.-born African-American (82%) and whites (85%) (Figure 39). Once again, having health insurance is associated with more physician visits by women in all the populations analyzed (Figure 40).

Figure 39. Doctor Visit in Past 6 Months Among Women ages 18-64 with Fair/Poor[1] Self-Assessed Health, by Race/ethnicity and Nativity, U.S., 2007-2009



Note: 1/ Includes the categories of average and poor.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Figure 40. Doctor Visit in Past 6 Months Among Women ages 18-64 with Fair/Poor[1] Self-Assessed Health, by Insurance Status, Race/ethnicity and Nativity, U.S., 2007-2009



Note: 1/ Includes the categories of average and poor.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Mexican immigrant women are less likely to have a usual source of care or to have a timely visit to the doctor, particularly among those without health insurance. Likewise, Mexican women visit public health centers and clinics more frequently. Thus, socio-economic disparities between groups result in different health care practices, not only in terms of the regularity and timeliness of seeking services for the prevention, diagnosis and treatment of disease, but also in the degree of specialized service received.

Chapter V. Health conditions

Mexican-born women, like the majority of the U.S. female population, are mostly healthy and able-bodied. It is, however, possible to identify a pattern of health needs for this group on the basis of information on their health conditions.

This chapter constructs an approach to the health status of Mexican immigrant women living in the U.S. in comparison with the other groups of women considered in this study. To this end, it analyzes the prevalence of certain diseases, the pervasiveness of certain risky conditions and maternal and child health outcomes.

Disease prevalence

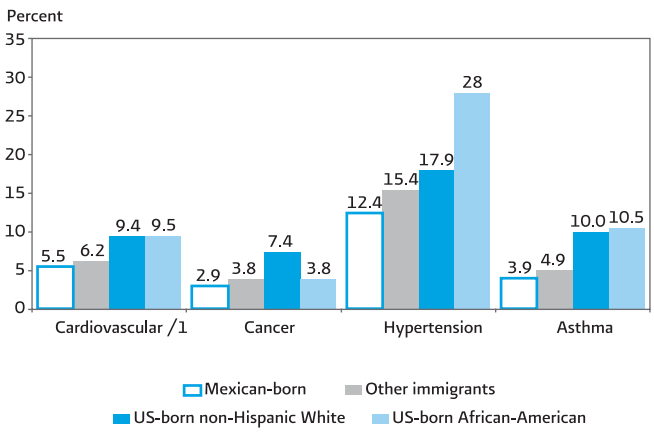
In general, immigrants are often considered to be healthier than the U.S.-born population. However, a more detailed analysis reveals considerable differences in the prevalence of certain diseases and ailments that reflect different patterns of health needs between the populations.

Mexican immigrant women generally have better overall health than other immigrant and U.S.-born women

Mexican immigrant women have better health than one would expect, given their socio-economic level and low rates of health insurance and healthcare use. Some authors refer to this as the "Immigrant Paradox" or the "Hispanic Paradox." This apparent paradox may, however, be in part due to the biases resulting from the selectivity factors among migrants and return migrants. Some researchers have even attributed it to inaccurate data.

According to data from the *National Health Interview Survey* (NHIS), Mexican immigrant women are less likely to suffer serious chronic conditions, such as cardiovascular disease (5.5%), cancer (3%), hypertension (12%) and asthma (4%) than are other ethnic or racial groups (Figure 41).[1]

Figure 41. Ailments of women ages 18 to 64 living in the U.S. by race/ethnicity, 2007-2009



Note: 1/ Includes coronary disease, angina pectoris, heart attacks and other heart diseases.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Two factors might significantly explain the low prevalence referred to earlier. First, the younger age structure of Mexican immigrant women and second, the under-registration associated with the health insurance conditions of this group. We know that the prevalence of these diseases is probably under-estimated, since populations' health is mediated by a combination of various factors which, in the case of Mexican immigrant women, is noticeably

[1] According to the World Health Organization (WHO), the main chronic diseases include cardiopathies, cerebrovascular accidents, cancer, chronic respiratory diseases and diabetes. Visual disability and blindness, hearing defects and deafness, bucodental diseases and genetic disorders are the other chronic ailments that represent a substantial portion of the world burden of disease. According to the mortality statistics of the National Center for Health Statistics, cardiovascular diseases and cancer are the first and second leading cause of death among Hispanic women in the United States.

unfavourable: high index of lack of documentation, disproportionately high incidence of poverty, low educational attainment, limited command of English and low rates of health insurance and health service use (Chapters II, III and IV).

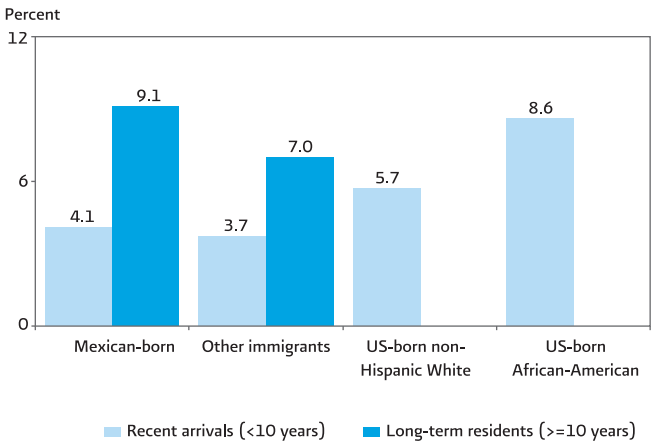
These circumstances result in underreporting of these diagnoses and thus an underestimation of the true prevalence in the population. The most disadvantaged groups find it the most difficult to visit the doctor. This increases the likelihood that the disease will only be diagnosed once they have developed serious symptoms that require medical care. Conversely, those with mild clinical symptoms or who are still at an asymptomatic stage have little incentive to visit a doctor.

Certain diseases such as diabetes, peptic ulcers and musculoskeletal diseases are frequent among Mexican immigrant women

Despite this potential underestimation of disease prevalence, Mexican-born women are more likely to be diagnosed with certain diseases. Diabetes is particularly common among Mexican immigrant women who have lived longer in the U.S. (9.1%), compared with the prevalence among non-Hispanic whites (5.7%).[2] At the same time, among recently-arrived Mexican immigrant women, only 4% report suffering from this disease (Figure 42).[3] This suggests that many factors common to Mexican immigrants in the U.S. including poor eating habits have increased the development of diabetes among this population. Indeed, this is the fifth cause of death among the Latino population living in the U.S. (both immigrant and U.S. born).

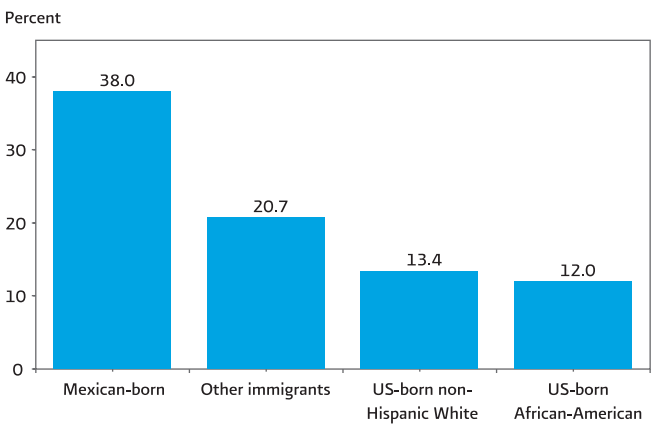
Diabetes is an extremely serious disease requiring lifelong management. Without proper treatment and control, a diabetic runs the risk of developing severe complications such as blindness, amputation of the lower limbs, and heart and kidney disorders. That is why continuous monitoring of the evolution of this disease is a crucial requirement for preventing these complications. It is therefore extremely worrisome to find that approximately 38% of Mexican-born women diagnosed with this disease lack health insurance, more than three times the figure for U.S.-born white and African-American women in this condition (Figure 43).

Figure 42. Women ages 18 to 64 living in the U.S. diagnosed with diabetes by length of residence and race/ethnicity, 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Figure 43. Women ages 18 to 64 living in the U.S. diagnosed with diabetes without health insurance, by race/ethnicity, 2007-2009

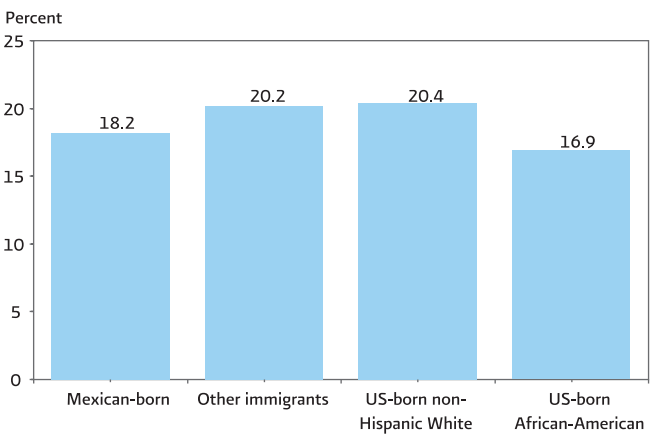


Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

[2] Immigrants with 10 years or more residence in the U.S.
[3] Immigrants with less than 10 years residence in the U.S.

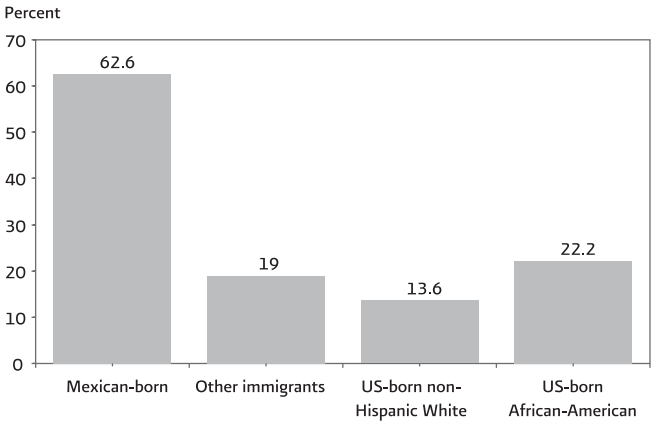
Nearly one out of every five Mexican immigrant women reports that they suffer from musculoskeletal disorders, usually associated with intense pain and the loss of physical functions, causing them difficulties in their everyday activities.[4] This same condition was reported by a similar proportion of women from the other groups (Figure 44), However, Mexican immigrant women experience far greater difficulties that other groups in receiving proper medical supervision and treatment, since 63% lack health insurance. This percentage of women without insurance is far higher than that for women from other ethnic and racial groups (Figure 45).

Figure 44. Women ages 18 to 64 living in the U.S. with musculoskeletal disorders by race/ethnicity, 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Figure 45. Women ages 18 to 64 living in the U.S. with musculoskeletal disorders and without health insurance, by race/ethnicity, 2007-2009



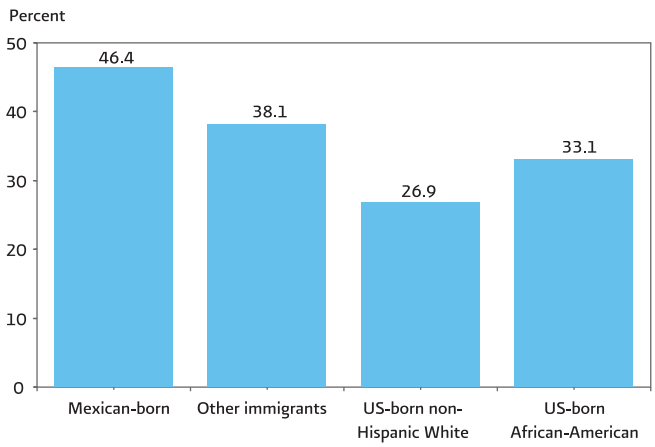
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

At the same time, Mexican immigrant women are more likely to suffer from peptic ulcers: nearly half (46%) reported suffering from some type of ulcer, whether gastric or duodenal, in the 12 months prior to the interview.[5] This proportion is much higher than for non-Hispanic U.S.-born white (27%) or African-American women (33%) (Figure 46). The most common cause of peptic ulcer is infection with Helicobacter pylori. The second leading cause is the prolonged use without professional supervision, in other words, self-medication of drugs to reduce the symptoms of inflammation, pain and fever. The latter may particularly affect Mexican immigrant women, who are less likely to have medical supervision and more inclined to self-medicate.

[4] Musculoskeletal diseases are chronic degenerative pathologies that seriously affect people's ability to work or carry out their everyday activities. They sharply reduce their quality of life (lumbago, peri-articular rheumatism around the articulation or disorders that affect the soft tissue in various parts of the body, arthrosis, inflammatory arthritis, bone disease and diseases of the connective tissue).

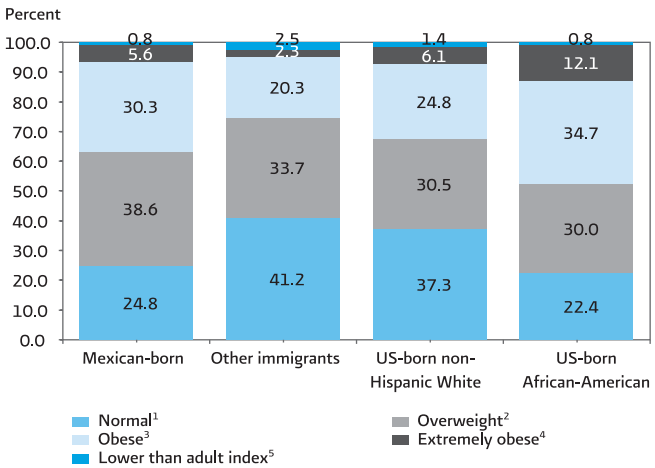
[5] A simple definition of peptic ulcer is that it is a disease of the digestive apparatus expressed through a wound in the mucus covering the stomach or duodenum.

Figure 46. Women ages 18 to 64 living in the U.S. diagnosed with peptic ulcers, by race/ethnicity, 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Figure 47. Women ages 18 to 64 living in the U.S. by body mass index categories and race/ethnicity, 2007-2009



Notes: 1/ Index between 19 and 24; 2/ Index between 25 and 29; 3/ Index between 30 and 39; 4/ Index of 40 and over; 5/ Index below 19.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

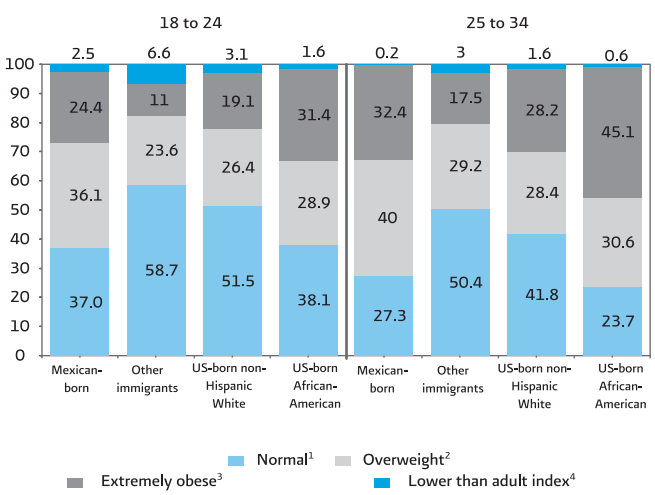
Prevalence of risk factors for disease

Certain individual risk factors or behaviors, such as obesity, lack of physical activity, and tobacco and alcohol consumption, account for a substantial amount of the risk for several chronic diseases. Various studies document lower alcohol and drug consumption among Mexican immigrant women, which is thought to be partly as a result of the protective effect of strong family and community links in Mexico.

Mexican immigrant women, together with U.S.-born African-American women, are far more likely to suffer some disorder related to being overweight (74% and 79% respectively). The problem of obesity among Mexican immigrant women is less severe than among U.S.-born African-Americans. Among Mexican immigrants, obesity and extreme obesity have lower reported prevalences than among U.S.-born African-Americans (30% and 6% versus 35% and 12%, respectively) (Figure 47).

It is of concern that overweight and obesity affect Mexican immigrant women at early ages: 61% of those ages 18 to 24 and 72% of those ages 25 to 34 suffer from this problem, which are far higher proportions than those of other immigrants and non-Hispanic U.S.-born whites (Figure 48).

Figure 48. Women ages 18 to 34 living in the U.S. by body mass index categories and race/ethnicity, 2007-2009



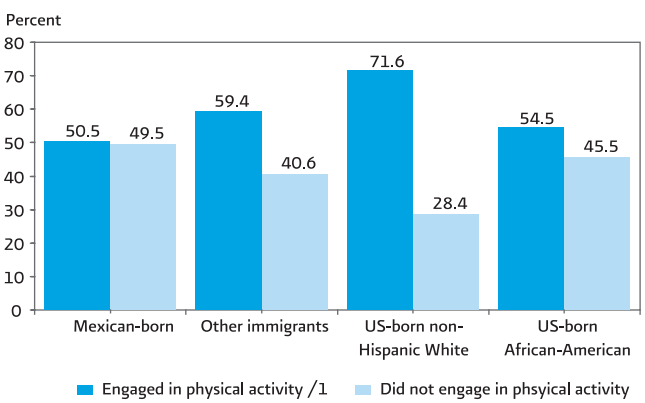
Notes: 1/ Index between 19 and 24; 2/ Index between 25 and 29; 3/ Index between 30 and over; 4/ Index below 19.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

These findings show that interventions to reduce overweight among these young women are crucial to preventing future adverse long-term effects on their health (diabetes, cardiovascular diseases, hypertension).

Mexican-born women are more prone to physical inactivity in leisure-time than other women

In general, physical activity in leisure-time is widespread among adult women in the United States. However, according to available information, regular, structured physical activity is not an important part of the lives of half the Mexican female immigrant population (49%), representing an additional risk factor for cardiovascular disease. The second most sedentary group are U.S.-born African-Americans (45%), with non-Hispanic U.S.-born whites at the other extreme (28%) (Figure 49).

Figure 49. Women ages 18 to 64 living in the U.S. by engagement in leisure-time physical activity and race/ethnicity, 2007-2009

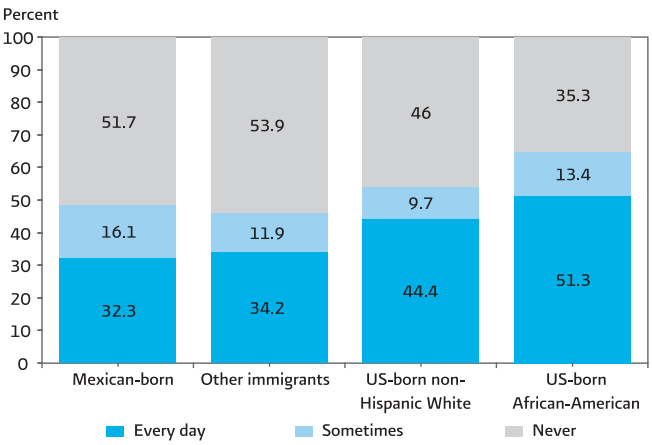


Note: 1/ Includes those that engage in vigorous or moderate physical activity or resistance training at least once a week.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

A significant proportion of Mexican immigrant women reported smoking every day

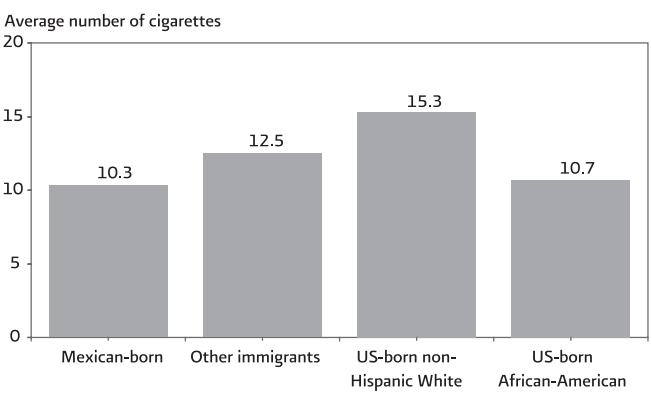
Smoking is more widespread among U.S.-born Americans than among immigrants. In fact, immigrant women are very likely to be never smokers: 52% of Mexican-born women and 54% of other immigrant women reported never having smoked. However, nearly a third of Mexican immigrant women in this sample reported smoking every day (32%), a similar proportion to that of other immigrant women and significantly less than that of U.S.-born women (Figure 50). In comparative terms, these Mexican-born women, who are regular smokers, smoke fewer cigarettes on average than non-Hispanic U.S.-born whites and other immigrant women (Figure 51).

Figure 50. Women ages 18 to 64 living in the U.S. by frequency with which they smoke and race/ethnicity, 2007-2009



Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Figure 51. Average number of cigarettes smoked by women ages 18 to 64 (regular smokers) living in the U.S. by race/ethnicity, 2007-2009



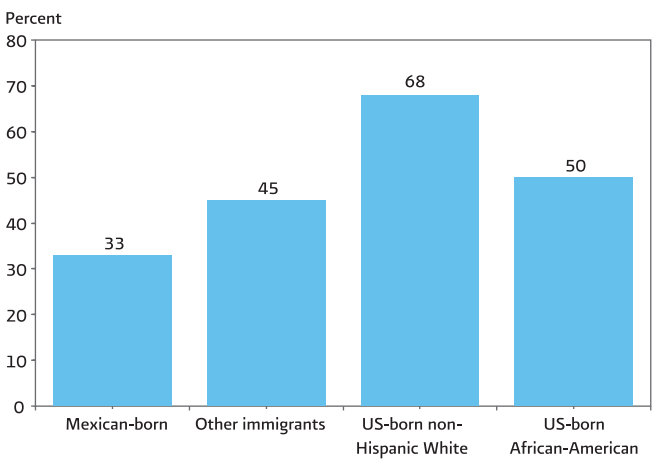
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Data on smoking vary greatly. For example, only 5-10% of recent Mexican immigrant women in rural areas are current smokers. Unfortunately, this prevalence increases with time lived in the U.S., and the prevalence may be four-times as great among women who immigrated at a young age or were born in the U.S.

Mexican immigrant women are more likely to consume less alcohol

According to the NHIS, in comparison with other groups, Mexican immigrant women report having drunk less alcohol in the year prior to the interview (33%). U.S-born white women are at the other extreme, since two out of three report drinking alcohol (see Figure 52).

Figure 52. Women ages 18 to 64 living in the United States that drank alcohol on at least one day in the year prior to the interview, by race/ethnicity, 2007-2009

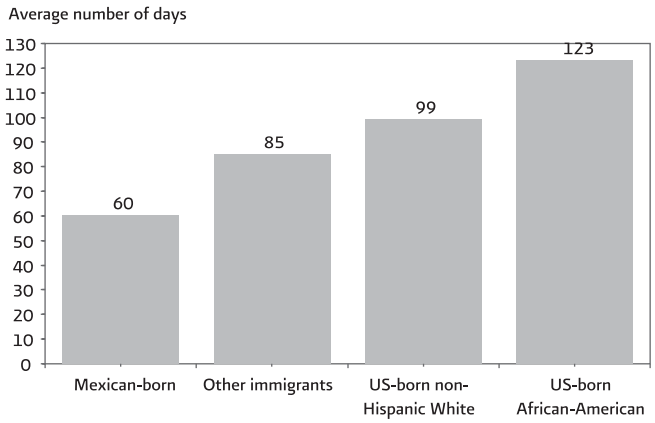


Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

Alcohol consumption itself is not harmful. In the field of research, theses maintaining that moderate drinking may have positive effects on health have gained ground. Conversely, excess[6] consumption may have negative repercussions on health. It is important to determine whether the Mexican immigrant women that reported drinking do so in excess. The data reveal a low average number of days of excess consumption among Mexican immigrant women (60) regarding women from other groups (85 other immigrants, 99 U.S.-born non-Hispanic whites and 123 U.S.-born African-Americans) (Figure 53).

[6] 5 or more drinks a day.

Figure 53. Average number of days on which women ages 18 to 64 years in the U.S. drank excessively[1] in the year prior to the interview, by race/ethnicity, 2007-2009



Note: 1/ Consumption of 5 or more portions a day.
Source: CONAPO estimates based on *National Health Interview Survey* (NHIS), 2007-2009.

It is important to note that risk behaviors may vary greatly between urban and rural populations, with social class and with degree of assimilation of the population.

Maternal and child health

Maternal and child health among the Mexican immigrant population can be examined using U.S. vital statistics.[7]

In general, Mexican immigrant women are not at a disadvantage in comparison with other groups regarding the likelihood of developing diseases during pregnancy, or adverse birth outcomes (Figure 54). Indeed, they have a lower rate of low and very low birthweight babies than the comparison groups. In other words, Mexican-born

[7] The estimates in this section are drawn up on the basis of information on births in the U.S. Vital Statistics for 2007 available at http://www.cdc.gov/nchs/data_acess/Vital StatsOnline.htm. The information presented only reflects the events registered through comparable or homogenized documents. It does not consider cases in which uncertified information appeared. The states that have unified their registration documents are: California, Colorado, Delaware, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Nebraska, New Hampshire, New York state, except New York City, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, and Wyoming. These 22 states account for 53% of all births in the U.S. For the purposes of this study, it is useful that these states contain two of those with the highest concentrations of Mexican population (California and Texas).

Figure 54. Percentage of births occurring in the U.S. by selected characteristics of the mother by race/ethnicity, 2007

Selected health characteristics	Mother's race/ethnicity				Total
	Mexican	Other immigrants	Non-Hispanic U.S.-born white	U.S.-born African-American	
Risky illnesses during pregnancy					
Hypertension associated with pregnancy	2.30	2.54	4.47	4.69	3.86
Childbirth characteristics					
Poor presentation during childbirth (breech Barth)	5.89	5.27	5.60	4.54	5.45
Birthweight					
Very low weight (< 1500 grs.)	1.01	1.28	1.20	3.27	1.48
Low weight (< 2500 grs.)	5.89	7.52	7.32	14.41	8.19
4 kg or over	8.14	6.62	9.08	3.80	7.67
Apgar before 5 minutes 1_/					
0-3 (poor)	0.45	0.41	0.42	1.03	0.50
4-6 (intermediate)	0.75	0.76	1.11	1.66	1.06
Congenital anomalies					
Anencephaly 2_/	0.02	0.01	0.01	0.01	0.01
Meningomyelocele/ Spina bifida 3_/	0.01	0.01	0.02	0.02	0.02
Cleft palate/hare lip	0.06	0.05	0.09	0.04	0.08

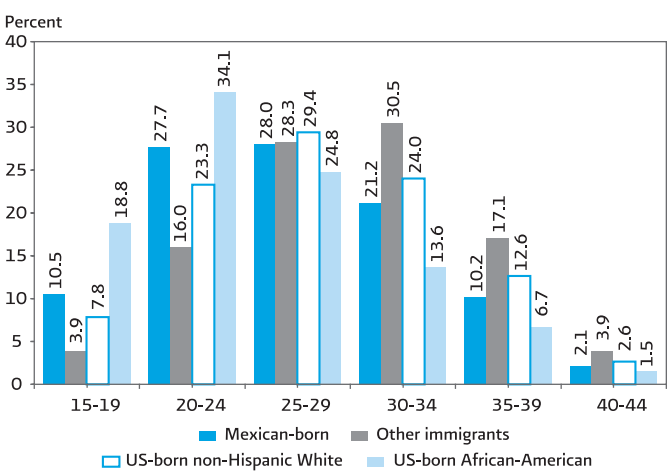
1-/ Medical examination conducted for quick assessment of newborn babies' physical condition after childbirth to determine the immediate need for any additional treatment or medical emergency. A score of seven over a minute after Barth is usually taken to mean that the baby is in good health, a score of between four and six indicates that the baby needs special attention immediately, a score lower than four many require advanced medical care and emergency measures.
2_/ Lack of much of the brain and Skull.
3_/ Birth defect in which the spinal column and the spinal canal do not close before Birth. This disorder is a type of spina bifida.
Source: CONAPO estimates based on *National Center for Health Statistics, Vital Statistics, Births*, 2007.

mothers do not seem to have special problems giving and preserving life. Such results also agree with the general concept of "migrant paradox", however, it would be desirable to have certified data for all states in the American Union, in order to sustain this hypothesis.

Mexican-born women tend to become mothers at earlier ages

Early motherhood, regardless of the population involved, marks the start of greater responsibilities and a limitation in work opportunities. Mexican immigrant women tend to have children at the second earliest age, after U.S.-born African-American women. Conversely, other groups of women tend to postpone pregnancy until a later age. Nearly 40% of Mexican-born women that gave birth in 2007 were under 25 years of age, a much higher proportion than among non-Hispanic U.S.-born women (Figure 55).

Figure 55. Distribution of women giving birth in the U.S. by age, 2007



Source: CONAPO estimates based on *National Center for Health Statistics, Vital Statistics, Births*, 2007.

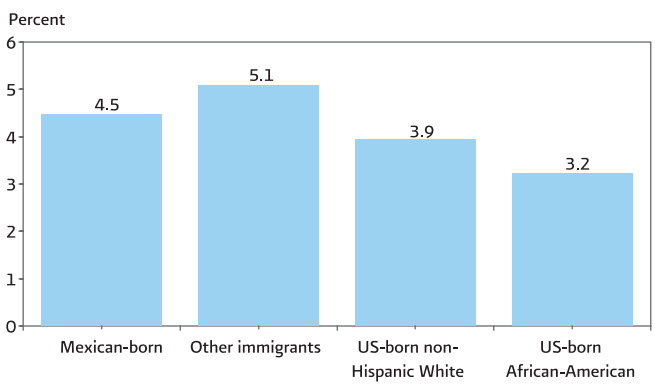
Early motherhood among the Mexican population, which is associated with limited economic, social, educational and work conditions, could be a factor in perpetuating these adverse factors.

Risk factors during pregnancy

Mexican-born women have a tendency to develop diabetes during pregnancy

Mexican and other immigrant women are more likely to develop diabetes during pregnancy (gestational diabetes). In these cases, health care during pregnancy is crucial to control glucose and avoid additional complications. Health care should be associated with several behaviors including eating a healthy diet and taking medication where necessary (Figure 56).

Figure 56. Births in the U.S. to women diagnosed with pregnancy-linked diabetes by mother's race/ethnicity, 2007

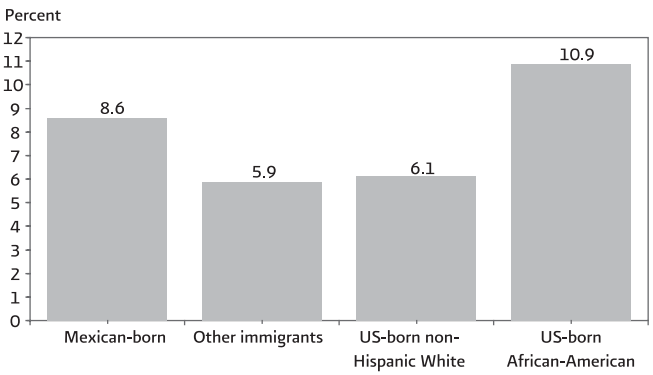


Source: CONAPO estimates based on *National Center for Health Statistics, Vital Statistics, Births*, 2007.

Mexican women are more likely than other groups to have insufficient weight gain during pregnancy

Low maternal weight gain during pregnancy may be problematic for both the mother's and the baby's health.[8] Nearly 9% of Mexican-born mothers reported a weight increase during pregnancy of less than 11 lb, a higher proportion than that of other immigrant women and of non-Hispanic U.S.-born whites (Figure 57). Higher rates of teenage pregnancy may contribute to this outcome, as may other factors.

Figure 57. Births in the U.S. by mother's weight increase during pregnancy (under 11 lb.) by mother's race/ethnicity, 2007



Source: CONAPO estimates based on *National Center for Health Statistics, Vital Statistics, Births*, 2007.

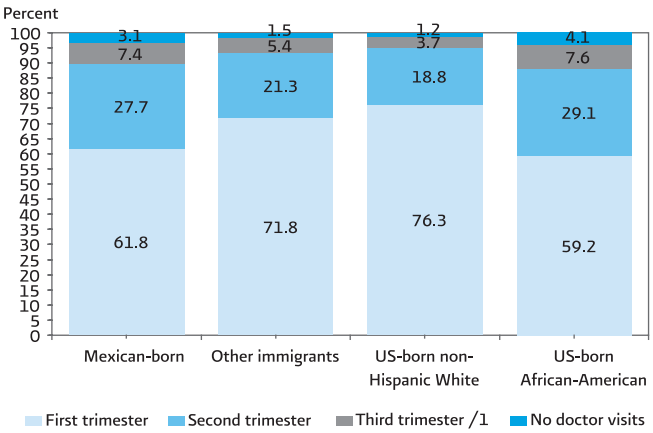
Health care during pregnancy

Antenatal care is important to the health of both the pregnant mother and the baby. Mexican-born mothers are less likely to receive antenatal care in the first trimester of pregnancy (62%) than other immigrants (72%) and U.S.-born whites (76%). U.S.-born African-American women fare worst in this context since only 59% receive health care during this period (Figure 58). Likewise, 7% of Mexican immigrant women that gave birth began receiving health care during the last months of pregnancy while 3% did not visit a doctor during their entire pregnancy. These figures are lower among other immigrant women, 5% and 2% respectively and 4% and 1% among U.S.-born whites.

Mexican immigrant women have a lower prevalence of chronic diseases such as cancer, hypertension, asthma and cardiovascular illnesses, but the prevalence of these diseases may increase with time since immigration. The women are more likely to suffer from diabetes and peptic ulcers. As for risk factors, Mexican immigrant women have strikingly high rates of overweight and obesity. An-

[8] The Institute of Medicine of National Academies (IOM) makes recommendations on weight gain of women during pregnancy and provides that the minimum is eleven pounds and up to 40 pounds (Institute of Medicine, 2009).

Figure 58. Births in the U.S. by trimester when doctor's visits started and mother's race/ethnicity, 2007



Note: 1/ Also includes those that went beyond the third term of pregnancy.
Source: CONAPO estimates based on *National Center for Health Statistics, Vital Statistics, Births*, 2007.

other closely related factor is the lack of regular, structured physical activity in Mexican-born women's lives. This type of risk factors fits with the greater prevalence of diabetes yet contrasts with the lower prevalence of cardiovascular diseases and hypertension. Cigarette smoking rates are low among many Mexican immigrant women, but increase with time since immigration. This represents a dramatic risk for increased chronic disease in future years.

It is important to see whether there is a systematic bias in reporting rates for chronic disease among Mexican immigrant women. This could be due to underdiagnosis, linked to low health insurance coverage or other factors.

There is no significant disparities between populations regarding the prevalence of illnesses during pregnancy, or the incidence of congenital anomalies in newborns. Recent immigrants have lower rates of low-birthweight babies, but this difference disappears after 5 years living in the U.S. However, Mexican immigrant women are obviously more vulnerable to adverse outcomes of pregnancy because of their lower rate of access to prenatal care.

Conclusions

Inequities in health access in the United States reflect and reinforce broader social and economic disparities based on race/ethnicity and citizenship status. This document highlights the disadvantaged position of Mexican-born women in comparison with immigrants of other nationalities and U.S.-born, non-Hispanic Whites and African-Americans.

Mexican immigrant women are an important demographic group in the U.S. This country is currently home to five million Mexican-born women, constituting by far the largest female immigrant group (five times larger than the second largest, Filipina immigrants). Mexican immigrant women account for more than 40% of all immigrant women in at least ten states and are therefore mothers of a large number of U.S.-born children.

Mexican immigrant women tend to be younger than those in other ethnic or racial groups. They are also more likely to marry and start families at young ages, making them responsible for the care of small children. Mexican-born women share the same disadvantages as their male counterparts regarding citizenship status, limited English proficiency, and low educational attainment. In comparison with other U.S.-born women, Mexican immigrants are at a disadvantage regarding health insurance (over half do not have this benefit) and tend to receive less medical and health care when they need them. Indeed, Mexican-born women are also at a disadvantage in comparison with immigrant women from other parts of the world, who have almost the same health insurance rates as U.S.-born women (although these other immigrant women, particularly recent arrivals, are also in a relatively vulnerable position).

Mexican-born women's disadvantages regarding health access can be attributed to their citizenship status and occupational and socio-economic conditions. In particular, employed Mexican-born women work disproportionately in poorly-paid jobs (particularly in the service sector) where they are less likely to receive health insurance as a job benefit. Even those entitled to health insurance face problems, since Mexican immigrant women are more likely to have to survive on low incomes, meaning that they are often unable to afford the premiums to obtain insurance, and even with insurance, they may not be able to afford the deductibles and copayments. In addition, jobs with poor benefits often lack paid sick leave benefits, meaning that the women also lose a day's pay when they seek medical care for themselves or their children.

Mexican-born women's greater vulnerability regarding health insurance and services is reinforced to varying degrees at the state level. This is closely linked to the different job opportunities and employment standards across states, and the enormous variation in public health policies and programs at the state and local levels.

Despite these disadvantages, analysis of the illnesses diagnosed among Mexican-born women reveals a lower prevalence of chronic diseases, such as cancer, hypertension, asthma and cardiovascular diseases in comparison to women belonging to other ethnic or racial groups. It is worth noticing, that, in some cases, lower prevalence might be associated with the younger age-structure of Mexican-born population. Conversely, data shows that Mexican-born women are more frequently diagnosed with diabetes and peptic ulcers. This epidemiological situation is consistent with the published scientific literature. Nevertheless, the data are not conclusive and more detailed studies are required before a higher incidence of certain illnesses can be ruled out.

The discovery of a higher prevalence of diabetes and peptic ulcers among Mexican migrant women logically leads to concerns about health care access among women suffering from these diseases. If we only consider women in the U.S. that contract these two illnesses, we find once again that Mexican immigrant women are more likely to lack the health insurance needed to facilitate health care. This result shows that Mexican women with health problems, including both curable illnesses (such as peptic ulcers) and chronic illnesses (such as diabetes) face greater barriers to curing their diseases or at least to improving their quality of life in regards to their health.

As for risk healt factors, Mexican immigrant women have strikingly high rates of overweight and obesity. Another closely related factor is the lack of regular, structured leisure-time physical activity in Mexican-born women's lives. These types of risk factors fit in with the greater prevalence of diabetes, yet contrasts with the lower prevalence of cardiovascular diseases and hypertension. This inconsistency makes it essential to determine whether Mexican immigrant women actually suffer certain diseases less frequently, or whether there are problems of under-diagnosis that are caused by low health insurance coverage, health literacy problems, and/or difficulties navigating an increasingly complex and automated health system.

For example, according to NHIS data used in this report, Mexican-born women report a noticeably low frequency of arthritis diagnoses, which is consistent with other research. The same source, however, includes specific questions for detecting undiagnosed ailments. In particular, this survey examines whether persons suffer from musculoskeletal problems (whether rheumatic or movement-related) that restrict their everyday activities. The answers to this particular question showed that Mexican-born women suffer this type of ailment as often as other women in the U.S., raising doubts about the low diagnosis of arthritis. This result raises doubts regarding the "immigrant paradox", whereby these women are assumed to enjoy excellent health.

In regards to maternal health, the data fail to show significant inequalities for Mexican migrant women regarding risks and health problems during pregnancy, or the incidence of congenital anomalies in their babies. These results agree with the general concept of the "immigrant paradox", but it would be desirable to have verified documentation for all the U.S. states. Regarding medical services, the data reveal Mexican–born women's vulnerability, given the lack of antenatal care.

Within this general context, the recently passed U.S. health care reform legislation will have a likely positive impact on legal Mexican immigrant women (both permanent residents who have been in the U.S. at least five years and those who have obtained citizenship). They are likely to benefit from at least three different provisions. First, Mexican immigrant women will benefit from the provisions designed to increase the eligibility threshold of federal health care programs (Medicaid) that benefit low-income populations. Second, federal subsidies to assist low-income individuals purchase health insurance will benefit the many immigrants who are in low-wage jobs where the employer is unlikely to offer health insurance benefits. And third, the expansion of community health centers will improve the availability of services, especially as most community clinics emphasize family and maternal care.

Although the reform is obviously a great step forward, it fails to eliminate the inequity based on the citizenship status of the resident population, since it continues to exclude undocumented immigrants and the most recent legal permanent residents. Those groups will have to rely primarily on the community health center system which provides primary care to everyone, regardless of immigration status. In general, President Obama's health care reform package can be regarded as a significant improvement. Nevertheless, efforts are still underway to achieve equitable health access in which people's right to these services will be guaranteed, regardless of their citizenship status.

This struggle to achieve the right to health, particularly for Mexican immigrant women, is crucial to the future of the U.S. The aging of the population, accompanied by other demographic changes, constitutes a key concern associated with the future sustainability of the health system and the welfare of all its inhabitants. It is estimated that by 2050, Hispanics or Latinos will comprise a third of the U.S. population. Therefore, it is in the best economic and social interests that Mexican-born women gain access to the American healthcare system, and to the benefits derived from regular medical supervision.

Lastly, we hope that this document will contribute to frame the debate on health access within a perspective of social justice and human rights. In terms of social justice, the wealth and well-being of the U.S. has historically been built and will continue to be largely built on the social and economic contributions of immigrant groups. And it is also true that women have always played a key role in supporting their families and communities. Given these factors, it is a matter of concern that Mexican immigrant women should be among the most disadvantaged groups in the U.S.

It is generally acknowledged that migration phenomena should imply shared responsibilities among participating countries. Thus, Mexican and American governments should explore the possibility of implementing a binational medical insurance program in order to provide immigrants with full medical attention. This shared insurance could also contribute to the process of immigrant integration to American society, promoting more favorable legal conditions, and thereby reducing their current status of vulnerability.

The feminization of the migratory phenomenon has proved the need to empower Mexican-born women so that, among other things, they will be able to demand and obtain the right to health access that is currently denied them. Given the crucial role of women in our societies, obtaining this right will also have a direct effect on helping their communities of 'origin' and 'destination' to progress. That is why we state that in many respects, Mexican immigrant women's health will be of growing importance to the determination of the nation's health.

References

Abraído-Lanza, Ana F. Bruce P. Dohrenwend, Daisy S. Ng-Mak, J. Blake Turner, "The Latino Mortality Paradox: A Test of the 'Salmon Bias' and Healthy Migrant Hypotheses", *American Journal of Public Health,* vol. 89, issue 10, 1999, p. 1543-1548.

ACS, *Cancer Facts and Figures for Hispanics/Latinos 2006-2008,* Atlanta, American Cancer Society, 2006.

Andreeva Valentina A., Jennifer B. Unger, Mary Ann Pentz, "Breast Cancer among Immigrants: A Systematic Review and New Research Directions", *Journal Immigrant Minority Health,* vol. 9, issue 4, 2007, p. 307–322.

Cara V. James, Alina Salganicoff, Megan Thomas, Usha Ranji, Marsha Lillie-Blanton, *Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level,* Menlo Park, CA, The Henry J. Kaiser Family Foundation, 2009.

Cara V. James, Megan Thomas, Marsha Lillie-Blanton, *Key Facts. Race, Ethnicity and Medical Care,* Menlo Park, CA, The Henry J. Kaiser Family Foundation, 2007.

CDC, *National Center for Health Statistics. VitalStats,* Washington, Center for Disease Control and Prevention: http://www.cdc.gov/nchs/vitalstats.htm.

CDC, *National Health Interview Survey. Microdata, 2007, 2008* and *2009,* Washington, Centers for Disease Control and Prevention: http://www.cdc.gov/nchs/nhis/nhis_2009_data_release.htm; http://www.cdc.gov/NCHS/nhis/nhis_2008_data_release.htm; http://www.cdc.gov/NCHS/nhis/nhis_2007_data_release.htm.

Charles, Camille Z., "The Dynamics of Racial Residential Segregation", *Annual Review of Sociology,* vol. 29, 2003, p. 167–207.

CONAPO, 2008, *Migración y Salud. Latinos en los Estados Unidos,* Mexico, National Population Council 2008.

Hayanga, Awori Jeremiah, Heather E. Kaiser, Rakhi Sinha, Sean M. Berenholtz, Marty Makary, David Chang, "Residential Segregation and Access to Surgical Care by Minority Populations in US Counties", *Journal of American College of Surgeons,* vol. 208, issue 6, 2009, p. 1017–22.

Health Care (web site), Washington, Department of Health and Human Services, 2009: http://www.healthcare.gov/

Horner, Marie-Joseph *et al., SEER Cancer Statistics Review, 1975-2006,* Bethesda, National Cancer Institute, 2009.

Institute of Medicine, National Research Council, *Weight Gain During Pregnancy: Reexamining the Guidelines*, Washington, The National Academies Press, 2009.

Jasso, Guillermina, Douglas S. Massey, Mark R. Rosenzweig, James P. Smith, "Immigrant Health-Selectivity and Acculturation", Anderson, Norman B, Rodolfo A. Bulatao, Barney Cohen (eds.), *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life,* Washington, National Academy Press, 2002, p. 227–266.

John, Esther M., Amanda I. Phipps, Adam Davis, Jocelyn Koo, "Migration History, Acculturation, and Breast Cancer Risk in Hispanic Women", *Cancer Epidemiology Biomarkers and Prevention,* vol. 14, issue 12, 2005, p. 2905–2913.

Keegan, Theresa, Esther M. John, Kari M. Fish, Theresa Alfaro-Velcamp, Christina A. Clare, Scalett L. Gómez, "Breast Cancer Incidence Patterns among California Hispanic Women: Differences by Nativity and Residence in an Enclave", *Cancer, Epidemiology, Biomarkers and Prevention,* vol. 19, issue 5, 2010, p. 1208-1218.

Kittredge, Betsy Miller, "The Health Reform, The Affordable Care Act of 2010", Washington, House of Representatives, Committee on Education and Labor, 2010: http://edlabor.house.gov/blog/2010/03/affordable-health-care-for-ame.shtml.

Landale, Nancy S., Ralph S. Oropesa, Bridget K. Gorman, "Migration and Infant Death: Assimilation or Selective Migration among Puerto Ricans?", *American Sociological Review,* vol. 65, 2000, p. 888-909.

Massey, Douglas, "Five Myths about Immigration: Common Misconceptions Underlying U.S. Border-Enforcement Policy", *Immigration Policy in Focus,* vol. 4, issue 6, 2005.

NCLS, "Informe anual sobre política estatal en los Estados Unidos en materia de inmigración e inmigrantes" 2005, 2006, 2007, 2008 and 2009, Washington, National Conference of State Legislatures: http://www.ncsl.org/Default.aspx?TabId=13133; http://www.ncsl.org/Default.aspx?TabId=13137; http://www.ncsl.org/Default.aspx?TabId=13106; http://www.ncsl.org/default.aspx?tabid=13058; http://www.ncsl.org/default.aspx?tabid=19232.

NCSL, "State Immigration Related Bills", Washington, National Conference of State Legislatures, 2010: http://www.ncsl.org/Default.aspx?TabID=756&tabs=951,119,851#951.

NGA, *The Implementation Timeline of the Health Reform, Reflecting the Affordable Care Act of 2010*, Washington, National Governors Association, 2010: http://www.nga.org/Files/pdf/2010HHSIMPLEMENTATIONTIMELINE.PDF.

OA/DNC, *Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All*, Washington, Organizing for America, Democratic National Committee, 2009: http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf.

O'Brien, Kathryn, Vilma Cokkinides, Ahmedin Jemal, Cheryll J. Cardinez, Taylor Murray, Alicia Samuels, Elizabeth Ward, Michael J. Thun, "Cancer Statistics for Hispanics, 2003", *CA Cancer Journal for Clinicians*, vol. 53, issue 4, 2003, p. 208–226.

Osypuk, Theresa L., Ana V. Diez Roux, Craig Hadley, Namratha R. Kandula, "Are Immigrant Enclaves Healthy Places to Live? The Multi-ethnic Study of Atherosclerosis", *Social Science and Medicine,* vol. 69, issue 1, 2009, p. 110–120.

Palloni, Alberto, Elizabeth Arias, "Paradox Lost: Explaining the Hispanic Adult Mortality Advantage", *Demography*, vol. 41, issue 3, 2004, p. 385-415.

Passel, Jeffrey y D'Vera Cohn (2008), "Trends in Unauthorized Immigration: undocumented Inflow Now Trails Legal Inflow", Washington, DC, Pew Hispanic Center: http://www.ime.gob.mx/ime2/2008/phc_trends_unauthorized_immigration_undocumented_inflow_now_trails_legal_inflow. pdf

PHC, *Hispanic Healthcare Survey, 2007. Microdata*, Washington, Pew Hispanic Center, Robert Wood Johnson Foundation, 2007: http://pewhispanic.org/datasets/signup.php?DatasetID=10

Pinheiro, Paulo S., Recinda L. Sherman, Edward J. Trapido, Lora E. Fleming, Youjie Huang, Orlando Gómez Marín, David Lee, "Cancer Incidence in First Generation U.S. Hispanics: Cubans, Mexicans, Puerto Ricans, and New Latinos", *Cancer Epidemiology, Biomarkers and Prevention*, vol. 18, issue 8, 2009, p. 2162–2169.

Reyes Ortiz, Carlos A., Hyunsu Ju, Karlo Eschbach, Yong-Fang Kuo, James S. Goodwin, "Neighbourhood Ethnic Composition and Diet among Mexican-Americans", *Public Health Nutrition*, vol. 12, issue 12, 2009, p. 2293–2301.

Ruggles, Steven, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, Matthew Sobek, *Integrated Public Use Microdata Series: Version 5.0 (Machine-readable database)*, Minneapolis, Universidad de Minnesota, 2010, *American Community Survey. Microdata, 2008*: http://usa.ipums.org/usa/acs_2008.shtml.

Ruggles, Steven, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010. *United States Census Five Percent Sample. Microdata, 2000*, en: http://usa.ipums.org/usa/sampdesc.shtml#us2000a.

Salganicoff, Alina, Usha R. Ranji, Roberta Wyn, *Women and Health Care: A National Profile. Key Findings from the Kaiser Women's Health Survey*, Menlo Park, CA, The Kaiser Family Foundation, 2005.

Smith, David P., Benjamin S. Bradshaw, "Rethinking the Hispanic Paradox: Death Rates and Life Expectancy for US Non-Hispanic White and Hispanic Populations", *American Journal of Public Health*, vol. 96, issue 9, 2006, p. 1686-1692.

Sorlie, Paul D., Eric Backlund, Norman J. Johnson, Eugene Rogot, "Mortality by Hispanic Status in the United States", *The Journal of the American Medical Association*, vol. 270, issue 20, 1993, p. 2464-2468.

The Focus on Health Reform, Summary of Key Health Reform in White House Proposal and House and Senate Health Reform Bill's (March 2010): http://www.kff.org/healthreform/upload/7948_HR3962_HR3590_Summary.pdf.

Thomas, David B., Margaret R. Karagas, "Cancer in First and Second Generation Americans", *Cancer Research*, vol. 47, 1987, p. 5771–5776.

USCB, *Current Population Survey. Microdata.* 2005, 2006, 2007, 2008 and 2009: http://dataferrett.census.gov/

Villaseñor, Rodrigo, Luis Acevedo, "La actividad legislativa estatal vinculada con la inmigración y los inmigrantes en Estados Unidos", en *El estado de la migración. Las políticas públicas ante los retos de la migración mexicana en Estados Unidos*, México, Consejo Nacional de Población, 2009, p. 415-438.

WH, *The President's Obama Health Reform Proposal, February 2010*, Washington, The White House, 2010: http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf.