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## **A Study of Access to Support Services by Immigrant Populations in Midwestern Counties in the United States**

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3-2018

# A Study of Access to Support Services by Immigrant Populations in Midwestern Counties in the United States

SPee N. Vululleh

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Concordia University–Portland

College of Education

Doctorate of Education Program

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A Study of Access to Support Services by Immigrant Populations in Midwestern  
Counties in the United States

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Concordia University–Portland

College of Education

Dissertation submitted to the Faculty of the College of Education

in partial fulfillment of the requirements for the degree of

Doctor of Education in

Higher Education

Sally Evans, Ed.D., Faculty Chair Dissertation Committee

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Concordia University–Portland

2018

## **Abstract**

The purpose of this quantitative-descriptive study was to examine the perceptions of immigrants in Midwest counties access to government healthcare services. This study was based on the Rawls Theory of Justice and Social Stratification Theory. Immigrant perceptions were assessed using the 2001 California Health Interview Survey (CHIS). Research questions (RQ) for the study were as follows: RQ 1—What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and gender of the immigrant? RQ 2—What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and age of the immigrant? RQ 3—What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status of the immigrant? The survey was sent to 85 immigrants who quantified for the study through Qualtrics, an online survey software company. All participants were either new immigrant or US citizen immigrants, age 18 and older. To address the research questions, a two-way MANOVA and an independent sample t-test were conducted to analyze the effects on the perceptions of access to government services with respect to the gender, age and the immigration status. Although previous research indicated a lack of access immigrants have to social services, this study results showed that the participants' responses about their perceptions of access to government services were not significantly different according to gender, age and immigration status ( $p > .05$ ).

*Keywords:* immigrant status, access, government services, perception, healthcare, educational access, community resources

## **Dedication**

In loving memory of Kou Lou, my Grandma

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It is a wonderful thing to do in human history, to give an individual his flower while he is alive. Acquiring Ed. D is a process. It is never completed in isolation of support and guidance from well-meaning individuals. The professors always said, “You are not alone in your journey”. That I remember. I will be ungrateful if I don’t express gratitude to those personalities who have contributed so meaningfully to my life. It is difficult to cite all those who grace this process. However, I love to acknowledge those personalities who contributed and served as guides and supporters. Thank God, Almighty first, for keeping me from all possible dangers; helping me to be healthy throughout the doctoral journey. Neither the Ed. D nor this dissertation would have been possible without the efforts of my professors, family, and friends.

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## **Chapter 1: Introduction**

One of the major challenges immigrants are faced with is the assistance gap, which oftentimes is evident by the disparities in employment, eligibility criteria, and immigration status, age and gender (Luemu, 2015; Pereira et al., 2012). The assistance gap among immigrants in perception of access to government services results in low educational achievement and healthcare, and poor socioeconomic status. Educational achievement and good healthcare are possible predictors for future economic success (Gelatt, & Koball, 2014; Guo, 2006; Lemu, 2015). Collaboration between public and private agencies and policy makers, the key stakeholders, is needed in order to improve the lives of immigrants in regard to accessing government services (Lemu, 2015).

Language barriers, lack of knowledge about public assistance programs, and fear of adverse immigration consequences are possible factors that affect immigrant access to public benefits (Aretakis, 2011; Bustamante et al., 2012). Other major impediments to gaining assistance are cultural orientation, language difficulties, and complexity of application processes and eligibility rules (Aretakis, 2011; Guo, 2006; Pereira et al., 2012). These contributing factors to the low perception of access to public services assistance gap are just a few of the noted disparities in accessing government support (Aretakis, 2011; Gelatt & Koball, 2014). It is important to understand healthcare access and utilization for immigrants in the United States (U.S.) in order to make positive decisions for reform (Bustamante et al., 2012). The purpose of the Quantitative-descriptive survey research study is to understand the perception of access to government services on healthcare in Midwestern U.S. counties. The study also

identifies factors that reduce immigrant access to government services in Midwestern United States counties.

### **Background of the Study**

The Midwestern United States (Midwest) is one of the four geographic regions defined by the United States Census Bureau (Migration Policy Institute, 2014; Larsen, 2004). This region comprises 12 states; Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin. The U.S. Census Bureau defines the immigrant population as foreign born, which entails individuals born in foreign countries who later become U.S. citizens (Zeigler & Camarota, 2014). America's history can be traced to immigrants bringing their beliefs and traditions to a new country in search of better life (Millet, 2014).

Literature indicates that the U.S. immigrant population in 2013 was estimated at about 42.3 million of the total population of 316.1 million. There are some disparities in immigrant populations within states. In states like California, for example, the number of immigrants is as high as one out of every two residents of the state (Zong & Batalova, 2015). The population of immigrants continued to increase from 1970 to 2013- i.e., from 9.6 million (4.7%) to 41.3 million (13.1%). This continuous increase in the immigrant population in the United States suggests that policy makers and service providers need to develop or design additional strategies to improve the economic well-being (assistance services) for the immigrants (Sharmeen Shommu et al., 2016; Zong & Batalova, 2015).

## **Statement of the Problem**

Access to vital public services is greatly limited within immigrant communities (Ayon, 2014; Liao, 2015; Pandey, Cantor, & Lloyd, 2014; Sharmeen Shommuet al., 2016). Both political policy and other social factors play a major role in creating a climate and developing policy for immigrant access to healthcare, education, and other support services (Ayon, 2014; ASHE, 2013; Choi, 2013; Glick, 2010; Pandey et al., 2014; Rodríguez-Valls & Torres, 2014). The problem is that the lack of access to vital services results in poor health outcomes, low education levels, and difficulty in improving economic outcomes (Javier et al., 2010; Sharmeen Shommu et al., 2016). Researchers have acknowledged that further studies are needed to address the understanding of factors that contribute to improvement of immigrants' access to public assistance (Ayon, 2014; Choi, 2013). Understanding what factors contribute to this will aid in finding ways to improve access for disadvantaged groups.

## **Purpose of the Study**

The purpose of the quantitative-descriptive survey research study was to understand the perception of access to healthcare and government services in Midwestern US counties for immigrants. Data for this study was gathered using the California Health Interview Survey (CHIS) Adult Questionnaire (Respondents Age 18 and Older) (UCLA Center for Health Policy Research, 2001). The questions drawn from CHIS were administered or distributed to the participants through an online survey. This questionnaire included information on immigrants' demographic, status, age, gender, and access to government support. Descriptive statistics was used to describe and measure the



extent to which a relationship exists between the research variables. The results of this study can be used to inform public policy in efforts to improve immigrant access to needed government services.

### **Significance of the Study**

This study is important because government service providers may use the result of the study for creating awareness for understanding the factors, as perceived by immigrants that affect decisions to pursue adequate access to government assistance programs. The results may also be used as resource materials for researchers who might conduct studies on similar topics in the future. Benefits of the study include providing feedback on the perceptions of immigrant populations and identification of issues concerning the support they receive for services. The results of the study may be significant to service providers and leaders at the state or federal level to develop frameworks for immigrant eligibility to plan assistance services for immigrants and analyze their success in accessing healthcare (Pereira et al., 2012; Vass, 2010).

### **Objectives of the Study**

This study seeks to better understand the factors that reduce immigrant access to government services in Midwest U.S. counties. This was done in efforts to identify the system and personal factors, as perceived by immigrants, affecting access to support providers and government services. The study further examined the extent to which immigrants use government assistance in the Midwestern U.S. Counties.

### **Research Questions**

The following research questions guided the study:

RQ 1. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and gender of the immigrant?

RQ 2. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and age of the immigrant?

RQ 3. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status of the immigrant?

### **Hypotheses**

H<sub>01</sub>: There is no difference in the perception of access to government services, with respect to immigrant status and gender of the immigrant.

H<sub>a1</sub>: There is a difference in the perception of access to government services, with respect to immigrant status and gender of the immigrant.

H<sub>02</sub>: There is no difference in the perception of access to government services, with respect to immigrant status and age of the immigrant.

H<sub>a2</sub>: There is a difference in the perception of access to government services, with respect to immigrant status and age of the immigrant.

H<sub>03</sub>: There is no difference in the perceptions of access to government services, with respect to immigration status of the immigrant.

H<sub>a3</sub>: There is a difference in the perceptions of access to government services, with respect to immigration status of the immigrant.

## **Research Design**

Descriptive research design as an approach is based in a paradigm of personal interest and emphasizes the significance of how knowledge is interpreted which allows the researchers to understand and gain insights into people's experience and actions (Creswell, 2013; Fincham, & Draugalis, 2013; Lemu, 2015). The methodology was a descriptive research design for collecting data, where the scores of 85 participants located in the Midwestern United States were used in the study. A two way MANOVA and an independent sample *t*-test were conducted to analyze the study data using an alpha of 0.05 (i.e., significance level ( $\alpha$ ) = 5%). Quantitative method was appropriate for this current study because the researcher explored possible relationships between variables, based on information gathered from the respondents (Smiley, 2011; Vass, 2010). According to Vass (2010), quantitative method does not allow the researcher to manipulate the variables in the study.

## **Definition of Terms**

The following presents the operational definitions of terms used throughout in this study:

*Access:* This term is defined as immigrant ability to utilize government services in healthcare, education, and other social services that increase economic well-being (Gelatt & Koball, 2014).

*Immigrant population:* Individuals who currently live in the U.S. but were born in other countries. The definition includes immigrants in the U.S. illegally (Zeigler & Camarota, 2014).

*Immigration Status:* Immigration status for this study is defined as either immigrants or US citizens who are foreign born (Pereira et al., 2012).

*Midwestern U.S. Counties:* The counties located in the Midwest U.S. Region where the respondents were recruited for data collection purpose (Migration Policy Institute, 2014).

### **Assumptions**

This study contains several assumptions. The researcher assumes that data gathered from the literature on immigrants is reliable and accurate, and those gathered from participants are also reliable and accurate. It is also assumed that the information from the 2001 California Health Interview Survey (CHIS) Adult Questionnaire (Respondents Age 18 and Older), accurately measure the constructs. The researcher also assumes that all participants provided honest responses to the self-reported questionnaire. Another assumption is that the sample representative provided by Qualtrics Company is a valid and reliable representation.

### **Limitations and Delimitations of the Study**

The limitation for this study may be that the sample size of 85 participants and the data may not be representative of the entire population. Some participants might have not provided accurate or total information about their immigration status or healthcare. There might have been limitations since the survey was anonymous and accuracy of participant

responses was not validated. Also, other variables that may have effect on internal validity could be the truthfulness of responses given by participants. Finally, the data collected and the approach in gathering the data may influence the validity.

The delimitation might be that this study specifically included closed-ended Likert scale responses in the survey, with an additional three open-ended responses, which might make some people more willing to take and complete the survey. The inclusion criteria for this study included only immigrants over 18 years of age residing in the Midwestern United States, and the exclusion of participants who do not meet the inclusion criteria.

### **Summary**

The purpose of the quantitative descriptive survey research study is to understand the perception of access to government services on healthcare in Midwestern U.S. counties. The quantitative study design was chosen over qualitative because it is better suited for describing the correlation between several variables. A questionnaire using 5-point Likert Scale was used for data collection purpose. A two-way MANOVA and an independent sample *t*-test were employed to analyze the data using an alpha of 0.05. A benefit of the study is to provide feedback on the perceptions of immigrant populations concerning government assistance they receive. Presented in Chapter 2 is the literature review.

## **Chapter 2: Literature Review**

Access to vital public services is greatly limited within immigrant communities (Ayon, 2014; Pandey, Cantor, & Lloyd, 2014; Sharmeen Shommu et al., 2015). Social and political factors contribute to the creation of climates in the United States where communities are lacking in adequate access to healthcare, education, and other support services. Understanding which factors disconnect immigrant communities from the resources needed is essential to making changes that, on a policy level, can improve outcomes for disadvantaged groups. Rodriguez-Valls and Torres (2014) noted that concern over the problems of the immigrant population is often understated or ignored. There is a need to understand the underlying social and cultural mechanisms that drive all of these facets of poverty to aid researchers and policy-makers in better assisting immigrant communities. Lack of access to vital services in immigrant community results in poor health outcomes, low education levels; and thus, difficulty finding secure, high-paying jobs that could improve economic outcomes (Sharmeen Shommu et al., 2016).

Examined in the literature review is the body of research relating to the various barriers that U.S. immigrant population face related to accessing healthcare, education, and other social services. These issues were addressed by presenting the historical background of immigration in the United States from its founding to present day, and literature related to immigrant experiences in this country's social, economic, and cultural systems. Explored through the review is difficulties immigrants experience in reaching social parity with native U.S. citizen (Pereira et al., 2012; Upadhyaya, 2008). Some relevant topics that were discussed in this chapter include the following: theoretical

framework, barriers to immigrant healthcare and education access, education and culture, barriers to social/governmental services, community resources and implications socially and culturally. Finally, methodological concerns, a critique of the literature, synthesis of research finding and a summary of conclusions were presented. This is to establish why the research examined here is important to the formation and execution of the present study and how those issues might be better understood.

Research databases were used as sources for the research studies reviewed in this chapter. Databases include GoogleScholar, JSTOR, PsychArticles, ERIC, ProQuest Education Journal, and Education Journal Collections. Search terms used included immigrant status, immigrant access, assistance gap, immigrant culture, educational access, healthcare access, community resources, quality of life, language, culture, and government service access. Relevant studies that were included in the literature review were generated from database searches and those found suitable for the study were included in the literature review. For particularly prominent studies, GoogleScholar was used to determine whether a study had inspired any notable later-published research, and such articles were included as well.

### **Theoretical Framework**

The theoretical framework that guided this study is the Rawls's theory of justice, developed by John Rawls (1971). Another theoretical perspective that guided this study is the social stratification theory. The concept of social justice is one addressed through the centuries by philosophers. Plato, who one of the first to suggest that every society needs to place or assign its members in the rightful position to make them more

functional and to shine, was the beginning of a philosophical examination of society and how the individual ought to be treated as cognizant part of that system (Adam & Bell, 2016).

### **Rawls's Theory of Justice**

John Rawls's theory of justice was developed to examine society in terms of social justice, law, human right and benefits. Rawls (1971) believes that there is an urgent need for society to establish ground rules for its citizens or members in order to live together in harmony. The eligibility rules set as requirements for immigrant to receive assistance are meant to assist service providers and immigrants to behave and operate in an orderly manner (Pereira, 2012; Sommers, 2013). John Rawls developed the theory of justice to advocate for fairness, equal treatment and opportunity for society members in order to administer a modern social order (Garrett, 2005; Rawls, 1971). One of the most important aspects of Rawls's theory of justice is that it provides a framework that explains the significance of free and equal society, with equal opportunity and programs that benefit all its members, especially the disadvantaged members of society (Garrett, 2005). John Rawls believed that justice should come from the background where all society members must be free and equal and have a sense of justice, which allows them to accept, cooperate, or collaborate with others (Garrett, 2005). The concept of social justice is one addressed through the centuries by philosophers. Plato, who one of the first to suggest that every society needs to place or assign its members in the rightful position to make them more functional and to shine, was the beginning of a philosophical



examination of society and how individual ought to be treated as cognizant part of that system (Adam & Bell, 2016).

Every immigrant who travels to the U.S. may have his or her own goal for life to pursue prosperity (Rawls, 1971). What is good or satisfactory for one's well-being may vary from one person to another (Garrett, 2005; Rawls, 1971; Small, & Solomos, 2006). For example, an immigrant may feel satisfied to live in the U.S. for better life, to support education, healthcare or economic well-being for his or her families in their original countries (Vesely, Goodman, Ewaida, & Kearney, 2015; Vesely, 2013). Immigrants need assistance in different areas, especially in healthcare and education, but have language difficulties and lack of information about support opportunities (Ford, 2013; Garrett, 2005; Lemu, 2015; Vesely, 2013; Yang, 2010). Despite the fact that the theory of justice encourages equity in society, it has been noted that cultural differences may influence one's perception about social justice (Adam & Bell, 2016; Jost & Kay, 2010; Sommers, 2013). Furthermore, the theory does not provide or specify whether people will respond to inequity by actively changing the circumstances to maintain equity (Jost, & Kay, 2010). Social justice is a critical idea, which challenges policy makers to reform their assistance programs and practices for fairness to provide support for immigrants on education and healthcare needs (Jost & Kay, 2010; Sommers, 2013).

Research that focuses on the experiences of immigrant population is viewed as primary ways that educational researchers can engage in social justice-focused action (Pourat, Wallace, Hadler, & Ponce, 2014; Yakushko & Morgan Consoli, 2014).

Immigrants are considered an underrepresented population; therefore, it is important to

focus on their economic and social well-being to provide them the opportunity to participate in national development efforts of the country. However, the remarks of most early thinkers in the way of social justice did not account for the stark divides between social and economic classes, but rather accepted them as seemingly unavoidable. Aristotle stated that individuals ought to be treated in a way that was relative to their worth, basing an understanding of self-worth within the limits of a deeply stratified social system, where slavery and unequal treatment of women was typical (Adam & Bell, 2016; Read, & Reynolds, 2012; Torres, & Waldinger, 2015). Socrates was the first to propose a social contract theory, in which he suggested that individuals ought to follow the rules of the society in which they belong, for it is that same society which protects them and provides for them. Again, this line of thinking does not account for the differences in investment and reward between social strata (Adam & Bell, 2016). Thomas Aquinas and John Stuart Mill later simplified this into the notion that society should treat equally all who deserve it (Adam & Bell, 2016).

One of the key concepts within the social justice framework is that of distributive justice, or the extent to which the allocation of goods within a society is fair or equal based upon group membership (Adam & Bell, 2016). A social system with incidental inequalities in the distribution of wealth is a society that is not demonstrating distributive justice. Other lines of thinking take into account the relative power and responsibility of some groups of individuals over others, arguing that group members who have the most control over political or economic outcomes,

or who have the most authority or status, should receive a greater distribution of the wealth of that society (Adam & Bell, 2016).

While these concepts are consistent with a basic and sensible notion of fairness, they neglect to address the arbitrary nature by which social power is often granted; given the marked social privilege that certain racial and cultural groups possess, particularly in U.S. society. Distributive justice do not account for the statistical likelihood that those individuals who are members of social groups that have great authority or status are frequently there because they were born into their positions of privilege (Adam & Bell, 2016). Distributive justice posits that individuals must be recipients of important societal resources in order to successfully contribute to their community. These notions of distributive justice, equity and need, suggest that social systems ought to be responsible for distributing resources to underprivileged individuals in order to encourage productive assimilation of those individuals into the collective production of wealth (Adam & Bell, 2016; Thomas, Chiarelli-Helminiak, Ferraj, & Barrette, 2016).

As based in relative power, equality, and responsibility, need-based lines of thinking suggest that individuals should receive societal resources based on the extent to which those resources are instrumental to their quality of life. When societal resources are distributed in a way that one is able to contribute back to the social system, need-based conceptions of social justice are directed toward the notion of leveling out societal distributions of wealth in an effort to elevate less privileged, and more disadvantaged groups of people (Adam & Bell, 2016; Hough et al., 2013). In

conjunction with debated issues such as affordable healthcare and the government-sanctioning of welfare programs intended to assist those families who struggle financially, such concepts represent the major differences between equality and equity. These issues relate to social justice and the conflicting viewpoints among major policy makers about prioritizing power over need in social justice discourse (Adam & Bell, 2016; Hough et al., 2013).

Social justice is both an ideological concern and a social movement in itself (Hough, Jackson, & Bradford, 2013). For example, providing social support for immigrant families is seen as encouraging and enabling the high levels of crime and misconduct that are sometimes associated with immigrant communities. The opposing view is that without social support, the immigrant communities would have no resources by which to function more effectively (Adam & Bell, 2016; Hough et al., 2013; Osypuk, 2013). While stratification is able to explain the system by which wealth inequalities are perpetuated, social justice theory is able to describe the moral and ideological discrepancies that drive this pattern (Hough, Jackson & Bradford, 2013). Another theory used for this study is the Social Stratification Theory.

### **Social Stratification Theory**

This theory is one of the oldest sociological theories created to explain social and economic divisions of power and wealth in society (Anthias, 2013; Lenski, 2013). Simply put, the class system used to explain wealth differentials in a society come from issues based on social stratification. However, the theory of social stratification itself is far more broad and complex. Essentially, the concept of social stratification

states that the social sector (stratum) that a person occupies impacts every aspect of life, from the economic state and education level to physical health (Lenski, 2013; Parkin, 2013; Thomas, Chiarelli-Helminiak, Ferraj, & Barrette, 2016). One of the major implications of social stratification is that the social and economic state that an individual is born into is frequently the state the individual will remain in throughout the course of his or her life (Lenski, 2013; Parkin, 2013). The breadth and depth of the factors that predict stratification patterns in society are such that it is relatively unlikely, statistically, for individuals to grow up and live through a stratum other than the one that they were born into (Lenski, 2013). More simply put, the resources an individual is given at birth determine the resources they will attain later – whether those resources are monetary, social, or physical (Parkin, 2013).

Further, stratification involves not just quantitative inequality but the qualitative beliefs that fuel social status (Lenski, 2013; McLeod, 2013). For example, stratification is more than simply stating the flat income difference between two minority groups. Rather, it is about discussing the social circumstances that result in such an income gap, and how those circumstances contribute to other measurable such as healthcare coverage, educational attainment, and quality of life. A stratification approach to examining the various barriers that immigrants in the U.S. face is useful because it allows for the interpretation of the obvious class differences between populations of immigrants and the native-born citizens. Stratification theory also accounts for more than just the statistical inequalities between average income, degree attainment, and other indicators of economic security by providing a framework to

investigate the differences that exist (Lenski, 2013; McLeod, 2013; Muntaner, Vanroelen, Christ, & Eaton, 2013).

The history of America evidences the influxes of immigrant populations. Immigrants from different countries around the world bring their beliefs and traditions, hoping to find freedom and new opportunities to make a better way of life (Hollifield, Martin, & Orrenius, 2014; Millet, 2014; Thornton, 2012; Vesely, 2013; Vesely, Goodman, Ewaida, & Kearney, 2015). The United States has been recognized among countries around the world to have a diverse population. Policies, however, have made access to government services more and more challenging for immigrants (Ayon, 2014; Millet, 2014). For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 made undocumented immigrants unqualified for government support services and made it impossible for legal immigrants to access services until they had established five years of residency (Ayon, 2014; Glick, 2010). Due to the concern over the legal ramifications of their status, many undocumented immigrants do not utilize necessary services for their children even though they are eligible (Javier, Huffman, Mendoza, & Wise, 2010). Immigrants need assistance in the following areas: navigating the systems of healthcare, education, adjusting to discrimination and injustice to strengthen community ties, and advocates for policy change (Avon, 2014).

The immigrant population in the U.S. is estimated to be 42.3 million of the total population of 3161.1 million in 2013 (Zong & Batalova, 2015). In states like California, that number increases to one out of every two immigrants (Zong & Batalova, 2015). The numerical size of the population of immigrants in the United States continued to

increase from 1970 to 2013- i. e., from 9.6 million (4.7%) to 41.3 million (13. 1%) (Zong & Batalova, 2015). This continuous increased in the immigrant population in the United States suggests that policy makers and service providers should develop additional strategies to improve the economic well-being (assistance services) for the immigrants (Sharmeen Shommu et al., 2016; Zong & Batalova, 2015).

Further, most immigrants who entered the United States after 1996 were not eligible for welfare benefits and public health insurance (Upadhyaya, 2008). One of the main challenges service providers face is that immigrants are hard to reach. As a result of the barrier, service providers are challenged to provide necessary assistance. The interaction between an immigrant and service providers, for example on educational, social and healthcare needs, is a cross cultural encounter or interaction which can be used as a good recipe for building cordial relationship or pose as a barrier for receiving of services (Upadhyaya, 2008). In addition, there are ethnic, language and religious differences that impact an individual's daily life when it comes to seeking for assistance (Pereira et al., 2012; Thomas, Chiarelli-Helminiak, Ferraj, & Barrette, 2016; Upadhyaya, 2008).

### **History of Immigration**

From the beginning of this country's establishment to the present day, the United States has been a country of immigrants (Ayón, 2014). The first settlers to build colonies on U. S. soil were immigrants from Europe, and over the following centuries, the United States has garnered its label as, a melting pot, a place where individuals of all creeds, colors, and nationalities can make a life for themselves

(Hollifield, Martin, & Orrenius, 2014). As early as the late 1800s, however, some concern had begun to grow among nativists as a result of the mass migration of Catholic and Jewish immigrants to the country from Italy and Russia (Hollifield et al., 2014; Thornton, 2012).

In particular was the fear that new migrants to the United States would not have the requisite occupational skills needed to fit into American culture (Hollifield, Martin, & Orrenius, 2014). From that point on, the United States began to slowly place restrictions on immigration. At first, regulations were small, but by the time World War I had ended in 1918, Congress had entirely changed the nation's basic policy relating to immigration (Hollifield, Martin, & Orrenius, 2014). In 1921, the National Origins Formula restricted certain number of immigrants from entering the country. In addition, quotas were placed on immigrants from various nationalities in an attempt to create an ethnic and cultural balance within the country (Hollifield et al., 2014). The quotas gave preference to immigrants from Central, Northern, and Western Europe, while barring individuals from Russia and Southern Europe. According to the act, no immigrants from Asia were allowed to enter the United States at this time (Hollifield et al., 2014).

However, the National Origins Formula failed to account for Western Hemisphere countries in the quota system. Thus, the 1920s marked the beginning of the current era in U.S. immigration history, with many immigrants moving from Mexico, the Caribbean, and Central and South America. The United States also admitted a limited number of refugees during this time, particularly during World



War II, with Jewish refugees and non-Jewish Europeans aiming to flee from Communist rule in Central Europe and Russia (Hollifield, Martin, & Orrenius, 2014). The Equal Nationality Act of 1934 was passed which allowed the foreign-born children of American mothers to apply for citizenship, and made it easier for the immigrant husbands of American wives to gain citizenship as well (Hollifield et al., 2014).

In 1945, after the end of World War II, the War Brides Act also allowed for the foreign—born wives of members of the U.S. Armed Forces to travel and live in the United States. This act was also implemented in 1946 to also consider fiancés of American soldiers. Post World War II, the influx of immigrants to the United States increased substantially, with over a million immigrants entering the country between 1941 and 1950 (Hollifield, Martin, & Orrenius, 2014).

Most immigrants were also able to acquire jobs, since the women who had manned the majority of positions while their husbands were fighting overseas had now returned back to the home. In 1948, the Displaced Persons (DP) Act of 1948 allowed individuals who were displaced by World War II to migrate to the United States outside immigration quotas—which brought in 200,000 Europeans and 17,000 orphans (Hollifield, Martin, & Orrenius, 2014). The McCarran Walter Immigration Act of 1952 limited the number of total annual immigrants to one-sixth of one percent of the population of the continental United States in 1920 (Hollifield, Martin, & Orrenius, 2014). Operation Wetback legislations in 1954 compelled illegal immigrants to return to Mexico. In the decade that followed, the number of illegal immigrants who migrated

from Mexico to the U.S. increased by several thousand percent (Hollifield et al., 2014). The Immigration Reform and Control Act (IRCA) passed in 1986, established disciplinary measures for companies and individuals who employed illegal immigrants to work in their companies (Hollifield, Martin, & Orrenius, 2014). As proposed by Congress, the IRCA was projected to give amnesty to approximately one million workers that were residing in the country illegally. At this time, it meant that about 16% of the Mexican population had immigrated to the United States (Hollifield et al., 2014).

### **Current Situation in U.S. Immigration**

Currently, one in five children residing in the United States were born outside of the U.S. or has one parent that was born outside the United States (Javier, Huffman, Mendoza, & Wise, 2010). In states like California, that number increases to one out of every two. The issue of how the United States government will deal with the nearly 12 million undocumented immigrants in the country currently is a major topic in political discourse (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). The Immigration and Nationality Act established in 1952 and amended in 1965, attempts to limit the number of immigrants able to migrate to this country on a work-related visa to a 140,000 per year, in order to protect the wages and job security of native-born American workers from the tolls of excessive immigration (U.S. Immigration & Enforcement, 2012). However, immigrants continue to migrate to the United States at numbers far exceeding the statutes put in place by the federal government (Hollifield, Martin, & Orrenius, 2014; Landsbergis, Grzywacz, & LaMontagne, 2014). They are a part of American communities, social system, and economy, and their health, welfare,

and ability to thrive impacts the entire socio-economic system (Hollifield et al., 2014; Landsbergis, Grzywacz, & LaMontagne, 2014). At present, the Immigration and Nationality Act still requires an alien who is at least 18 years old and have been lawfully admitted to live permanently in the United States to apply for a petition for naturalization.

### **Barriers to Adequate Access**

Immigrant status: Children in immigrant families experience reduced access to health benefits and decreased utilization of health benefits. A study conducted by Javier, Huffman, Mendoza and Wise (2010) looked closely at the impact of immigrant status on healthcare access. This study used data from the 2001 California Health Interview Survey to attempt to better understand how immigrant status impacted health care access, utilization, and health status. It was found that parents who were ineligible for healthcare were unaware that their children were eligible and undocumented parents often did not pursue healthcare for their children out of the fear of their document status and legal issues. Other factors, such as language, insurance status, ethnicity, and socioeconomic status impacted participant access to services. Immigrant status plays a significant role in the access and utilization of necessary services (Bustamante et al., 2012; Xu & Brabeck, 2012; Yang, 2010).

### **Language and Culture**

Language and culture are another challenge facing immigrants' population that can act as barriers to access. Language barriers can prevent immigrant parents and their children from being able to fully utilize the support services that a community has to offer. Studies that may have been conducted on Korean immigrants revealed that lack of

insurance and unfamiliarity with a healthcare system that was different than that of their home country were the biggest factors in lack of access (Choi, 2013; Bustamante et al., 2012; Liao, 2015; Saechao et al., 2012). This study wish used face-to-face individual in-depth interviews (20 in all) Concluded that Korean immigrants are among the most disadvantaged ethnic groups in regards to health insurance (Choi, 2013). Pandey, Cantor and Lloyd (2014) studied the heterogeneous mix of immigrants in New Jersey. The author used data from the 2009 New Jersey Family Health Survey (NJFHS) and asserted that immigrants often have lower expectations for wellness and healthcare access. Furthermore, their limited proficiency in the English language made seeking out providers and treatment less likely. The importance of understanding how language and culture impact immigrants' ability to utilize services is necessary when designing policy and programs (Akresh, 2009; Glick, 2010; Yang, 2010).

The author also found that utilizing ethnic networks and media would have a significant impact in educating on available resources, disseminating information, which would aid new arrivals navigate the healthcare system (Choi, 2013; Vesely, et al., 2015). Research indicates that culture plays a major role in immigrant help seeking behavior and overall support services utilization (Pereira et al., 2012; Upadhyaya, 2008). It is important to seek an understanding of the various intrapersonal and interpersonal group differences between the various immigrants despite the similarities in values, healthcare and educational needs (Pandey, Cantor, & Lloyd, 2014; Pereira et al., 2012; Upadhyaya, 2008). Transportation was also found to

be an obstacle in pursuing healthcare assistance (Pereira et al., 2012; Upadhyaya, 2008 Vesely et al., 2015).

Vesely et al. (2015) emphasized that while it is true that distance may be an obstacle to accessing assistance, one will also agree that distance from home is not always a barrier for reaching public benefit providers. That is, an immigrant may live in a community with many transportation facilities or owns cars, and does not have a problem accessing assistance. In contrast, an immigrant who lives at shorter distance from the support center but has to walk or cannot afford transportation may seem very far of a distance, which can be identified as an obstacle (Vesely , Goodman, Ewaida, & Kearney, 2013).

### **Community Resources**

Cohesive partnerships between the families and their host communities are important to reduce the loss of identity, which may occur when moving to a new location. The impact of moving from immigrant home country to the United States has a huge impact on their ability to adequately utilize resources and other services available to them (Rodriguez-Valls & Torres, 2014; Yang, 2010). Previous studies confirmed that immigrants are in need of different types of assistance including services such as language, employment, housing, education, health care, legal, and social services when they move to a new country (Camarota, 2011; Guo, 2006; Hildebrandt & Stevens, 2009; Pereira et al., 2012). Furthermore, Guo (2006) found that several publications have identified and confirmed barriers related to language and lack of information about support services.

## **Barriers to Immigrant Healthcare Access**

All individuals, regardless of social position, should have the ability to seek treatment when ill, to take advantage of preventive care, and that the care should be openly available to them and of high quality (Larchanché, 2012; Muntaner et al., 2013). Lack of access to important services is significant when it impacts more than 20% of the U.S. population daily (Baums & Flores, 2011). Lower-income families less likely to seek routine screenings, and are more likely to prolong doctor visits when ill or to not seek treatment for illnesses at all (Pourat, Wallace, Hadler, & Ponce, 2014; Read & Reynolds, 2012). Since first-generation immigrants are likely to work agricultural or other manual labor types of jobs, access to emergency treatment is of particular importance (Read & Reynolds, 2012). However, despite the healthcare needs that many immigrant families face, immigrant minorities do not seek medical care as frequently as American natives. Asanin and Wilson (2008) conducted focus groups from a diverse group of immigrants and discovered that they faced geographic, socio-cultural, and economic barriers in finding healthcare, including lack of existing doctors in their local communities, misalignments between the physician's culture and their culture, and a lack of insurance. Thus, immigrant healthcare is an issue not only of access and availability, but also of quality and cost (Sharmeen Shommu, 2016; Osypuk, 2013; Viruell-Fuentes et al., 2012).

For illegal immigrants specifically, receiving healthcare treatment is difficult to nearly impossible due to the lack of appropriate medical insurance. Bustamante et al. (2012) developed a model to examine differences in healthcare utilization among

immigrants. The author found through the immigrant documentation status that less than 27% of undocumented Mexican immigrants are likely have a doctor visit in the previous year and less than 35% are likely have health care benefits as compared to their documented Mexican immigrant counterparts. Pandey, Cantor, and Lloyd (2014) noted that the Patient Protection and Affordable Care Acts do not address the issue of undocumented immigrants. Illegal immigrants face a particular disadvantage in terms of access to the U.S. healthcare system (Sharmeen Shommu et al., 2016; Viruell-Fuentes et al., 2012). Indeed, immigrant documentation status is a significant deterrent in the likelihood of seeking healthcare (Berk & Schur, 2001; Read & Reynolds, 2012).

In-person surveys conducted of undocumented Latinos in the Houston, Fresno, El Paso and Los Angeles communities revealed that 39% of undocumented adult immigrants expressed fear about their undocumented status which may not qualify them to receive medical services (Berk & Schur, 2001). This also contributed to their reluctance to seek dental care, prescription drugs, and eyeglasses (Berk & Schur, 2001). Similarly, other research found that among abused Latina and Asia immigrant women, there is a distinct fear of coming forward about their abuse to authorities due to a deep-seated fear of deportation (Muntaner et al., 2013; Read & Reynolds, 2012). And, finally, for undocumented migrant Americans, immigrant documentation status is a significant deterrent in likelihood of seeking healthcare (Berk & Schur, 2001; Read & Reynolds, 2012).

Choi (2013) asserted that Korean immigrants are also among the disadvantaged ethnic groups in regards to healthcare coverage. In his study of Korean immigrants in Hawaii, he found that participants delayed seeking primary care. The author theorized that this may in part be due to language barriers and a misunderstanding of services available, and that policymakers should make a better effort to extend knowledge of medical services to immigrant populations. Access to health insurance is but one barrier, however, that immigrants face in acquiring adequate healthcare services. A survey conducted by Carrasquillo, Carrasquillo, & Shea (2000) discovered that about 50% of non-citizen immigrants did, in fact, have healthcare coverage. This healthcare coverage was sponsored by their employers through their full-time job. The authors indicated that immigrants from Guatemala, Mexico, El Salvador, Haiti, Korea, and Vietnam were among the most likely to possess insurance. Social and cultural factors deter immigrants from seeking medical attention even when they are able to do so (Carrasquillo et al., 2000; Viruell-Fuentes et al., 2012).

In the case of immigrant women neglecting to report spousal abuse, for example, collectivistic and individualistic cultural differences come to the surface (Osypuk, 2013; Viruell-Fuentes et al., 2012). Collectivism and individualism refer to the social orientation of a society. Individualistic societies, like the United States, encourage a culture of free speech and expression, and celebrate uniqueness. Collectivistic cultures, like most Hispanic and Asian communities, dictate that the primary prerogative of the individual is to contribute to the social whole, and that the



group (family, culture, and society) is more important than each individual (Osypuk, 2013). Since both Asian and Hispanic cultures place a great deal of emphasis on family unity as the highest priority in a person's life; immigrant women are therefore reluctant to take any legal action that might tear their family apart and also aim to avoid the significant shame associated with abuse.

The likelihood of enduring routine screenings, of visiting the doctor regularly for check-ups, and of seeking treatment and medicine when ill is significantly diminished in immigrant populations, in much the same way these behaviors are less likely to occur in low-income economic groups in general in the United States (Pourat, Wallace, Hadler, & Ponce, 2014; Read & Reynolds, 2012). Immigrants are subject to unique cultural and economic stressors that may spur and exacerbate many physical and mental health issues (Read & Reynolds, 2012; Sharmeen Shommu et al, 2016). Research attempting to glean patterns of immigrant perceptions in their healthcare experiences has indicated that Hispanics, in particular, feel greatly misunderstood by their doctors, with this demographic reporting, more than any other ethnicity, that their doctors do not believe their symptoms and do not take them seriously (Fernando Chang-Muy & Congress, 2015; Ingleby, 2012; Martinez & Slack, 2013; Martinez et al., 2015). Negative perceptions of immigrants can have a tremendous impact on the bedside manner of doctors who frequently treat Hispanic populations, and can influence the level of trust that exists between a Hispanic patient and his or her primary care physician (Ayon, 2013). Other immigrant populations also express fear at visiting an American physician, especially in the case of Muslim Americans, whose concern is

that cultural differences might make treatment and diagnosis difficult (Ku, 2009; Sharmeen Shommu et al, 2016).

### **Mental Healthcare**

Members of immigrant populations in the United States exhibit higher incidences of mental health issues such as anxiety, depression, and substance abuse, than other demographic groups (Galvan, Wohl, Carlos, & Chen, 2015; Hurtado-de-Mendoza, Gonzales, Serrano, & Kaltman, 2014). Chow, Jaffee, and Snowden (2003) asserted that mental healthcare usage is related significantly to the poverty level, and that poverty is a key to understanding why there are disparities in mental healthcare utilization between racial and ethnic groups. Indeed, it is thought that this trend persists for two key reasons. First, the multitudinous stressors associated with living at or near the poverty line have strong associations with higher amounts of anxiety and depression in the general population (Galvan, Wohl, Carlos, & Chen, 2015; Saint Onge, Cepeda, Lee King, & Valdez, 2013). Secondly, the social stressors that many immigrants face in assimilating into American culture may leave many feeling isolated, unsupported, and alone (Hurtado-de-Mendoza, Gonzales, Serrano, & Kaltman, 2014; Nego, 2013). Galvan, Wohl, Carlos, & Chen, (2015) found in their study of Hispanic immigrant workers that chronic stress appears to be a common issue in Latino day laborers. Both work-related and social stressors can dramatically increase the likelihood that Mexican-American adults will turn to substance abuse or suicide as ways to cope (Saint Onge, Cepeda, Lee King, & Valdez, 2013). Asian American immigrants appear to utilize access to healthcare services more frequently

than other minority immigrant populations, yet seek mental healthcare assistance significantly less often (Anthias, 2012). This likely is an illustration of the stigma in many Asian cultures against mental illness, and the idea that those who seek mental healthcare are irreparably sick or insane (Anthias, 2012).

Compared to whites, Latinos do not use mental health services as often and rely more on primary care for services. This trend is related to structural, economic, and cultural barriers. There also seems to be variation in healthcare seeking patterns of immigrants based upon birthplace, generation, and economic status, making it a complex issue impacted by social stratification (Cabassa, Zayas, & Hansen, 2006). Younger individuals (third-generation or later) are more likely in general to seek mental healthcare treatment than first-generation immigrants, though the frequency for this is still less in third-generation individuals from Asian immigrant families (Abe-Kim et al., 2007).

Other researchers point out that most immigrants come to the United States for jobs, not for healthcare access or participation in government programs (Osypuk, 2013; Sharmeen Shommu et al., 2016; Viruell-Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Immigrants, who live in rural communities or low-income, poverty-stricken metro areas, are not likely to be exposed to community initiatives that raise awareness about health-related concerns (Osypuk, 2013; Sharmeen Shommu et al., 2016; Viruell-Fuentes et al., 2012). Language barriers might further contribute to the lack of awareness (Viruell-Fuentes, Miranda, & Abdulrahim, 2012). Immigrants frequently suffer in immigrant communities from a lack of medical care,

which can lead to further consequences, particularly academically (Johnson, 2007). Likewise, for children, school can be an important place to receive medical and mental healthcare assistance, as well as education (Kataoka, & Magnusson, 2003).

### **Barriers to Immigrant Access to Education**

Most immigrants come to the U.S. for jobs, but arrive in the face of numerous barriers within the job market because of their current education credentials (Galvan, Wohl, Carlos, & Chen, 2015; Harari, Davis, & Heisler, 2008; Hurtado-de-Mendoza, Gonzales, Serrano, & Kaltman, 2014). The education credentials of most immigrants have been found to misalign with the current job market, and as a result some professionals who obtained their degrees in their home countries have found it difficult to gain full employment (Glaraneu & Morissette, 2009; Harari et al., 2008). The lack of education and education credentials, even if acceptable in another country, limit job choices for immigrants (Glaraneu & Morissette, 2009). In 2006, 28% of immigrant men and 40% of immigrant women held jobs with lower education requirements, such as retail sales clerk positions, truck drivers, office clerks, cashiers, and taxi drivers. These jobs also have very little upward mobility, which results in a perpetuation of low-income for many immigrant families who cannot attain higher earning power (Glaraneu & Morissette, 2009).

The lack of education that predicts immigrant placement in the U.S. job market is also generationally responsible for consistent trends of poverty and crime among low-income immigrant communities (Association for the Study of Higher Education, 2013; Coll & Marks, 2012). This translates into educational struggles for

immigrant youth, to the point that some researchers go as far as to assert that being a migrant youth in the United States is a legitimate developmental risk (Coll & Marks, 2012). Latinos graduate from high schools that do not prepare them for higher education, and thus struggle at the college level (Coll & Marks, 2012; Gonzales, Borders, Hines, Villalba, & Henderson, 2013; Stacciarini, Smith, Wiens, Pérez, Locke, & LaFlam, 2015). This ethnic group consistently suffers high university attrition rates (Coll & Marks, 2012; Association for the Study of Higher Education Report, 2013; Gonzales et al., 2013; Stacciarini et al., 2015).

According to the Association for the Study of Higher Education Report (2013), many Latino students face struggles in their educational endeavors, particularly in attaining post-secondary degrees (Association for the Study of Higher Education Report, 2013). Compounding on this, many migrant families are already subject to high amounts of stress (as previously discussed), overwhelmed, and overworked, which means that despite family intentions to support their children's educational endeavors, this intention is not always translated into a home environment conducive to a child's learning (Coll & Marks, 2012). Furthermore, stereotypes about Latino students' academic abilities negatively affect the persistence of students in this minority group (Irizarry & Williams, 2013). The language barriers that immigrant children frequently experience compound the issue of full academic potential. Unsurprisingly, migrant students report feeling the most comfortable with teachers who are like them (Irizarry & Williams, 2013).

However, in many communities, migrant students must learn to exist in academic environments where they are in the racial minority and where they must learn a second language in order to fit in (Coll & Marks, 2012; Irizarry & Williams, 2013). These children are forced to abandon some aspects of their cultural identity in key periods of self-growth, causing further stress and damaging educational outcomes (Coll & Marks, 2012; Irizarry & Williams, 2013). Bastedo and Gumport (2003) argued that stratification in the education system would continue to occur. Community colleges and vocational schools are important transitional tools for immigrants (Szelenyi & Chang, 2002; Teranishi, Suarez-Orozco, & Suarez-Orozco, 2011), and, in the United States, they represent an avenue for educational advancement for immigrants that is comparatively successful in the scope of higher education (Terriquez, 2014).

Immigrant students still face difficulties related to attrition (Terriquez, 2014). Financial hardship and limited employment options associated with precarious legal status, as well as high-stress responsibilities related to caring for undocumented immigrant family members by providing a stable income, contribute to immigrant youth discontinuing their postsecondary education (Terriquez, 2014). Factors that seem to improve immigrant and minority outcomes in education include mentoring to change perceptions and help students navigate the college entrance process (Clark et al., 2013; Grubb, 2013; Jaggars, Hodara, Cho, & Xu, 2015). However, having access does not mean one is equally successful (Tinto, 2014).

Education has the potential to effectively integrate immigrants into the U.S. economic and social systems (Ramirez, 2010; Stout, 2011). Education may also have a significant impact on the development of an individual's personal interests, which contribute overall development of self and the occupations one chooses (Rodríguez-Valls & Torres, 2014; Brickman, Alfaro, Weimer, & Watt, 2013). The two predictors that were identified for attending a 4-year college were one or more parents with a college education and good academic standing GPA (Jun & McKillip, 2014). Yet, for many immigrants and their children, they are the first generation attending school in the United States. This means they are missing some important factors for navigating the postsecondary admission process which some parent has navigated it before them (Nunez, 2009; Szelényi, & Chang, 2002; Teranishi, Suárez-Orozco, & Suárez-Orozco, 2011; Vesely, Goodman, Ewaida, & Kearney, 2015). Other predictors were found to be affordability and high school credits earned (Rodríguez-Valls & Torres, 2014; Sanchez, Usinger, & Thornton, 2015).

Baum and Flores (2011) insist that policy makers and educational leaders should focus on finding ways to increase immigrants' full participation in national services and learning to ensure that the future strength of the U.S. economy is upheld. The benefits of education should not only be seen in monetary value but can also give immigrants broader career choices and prepare them for other better opportunities. Immigrants play meaningful role in the development of U.S. society from the labor market and the educational setting to communities (Adair, 2016; Baum & Flores, 2011; Zong & Batalova, 2015). Educational opportunities should extend to everyone

because the benefits are not only enjoyed by the persons who participate, but also extend to the general society including government through additional tax by those persons who enter the labor market (The Economic and Social Benefits of Education, 2009; Commins, 2013). Courses that help immigrant's students to understand the complexity of immigration problems can promote strong intellectual and practical skills as well as a sense of social responsibility (Commins, 2013).

A major reason that many immigrants are attracted to the United States is that it offers seemingly numerous opportunities for jobs. However, upon their arrival, many immigrants may realize that there is a misalignment between their education credentials and those credentials necessary to secure profitable employment in this country (Galvan, Wohl, Carlos, & Chen, 2015; Harari, Davis & Heisler, 2008; Hurtado-de-Mendoza et al., 2014). The education credentials of most Latino immigrants were found to misalign with the current job market (Glaraneu & Morissette, 2009; Harari et al., 2008). This is due to both a lack of education and a lack of the education credentials that immigrants possess being recognized as high quality in this country (Glaraneu & Morissette, 2009).

Furthermore, the author found that stereotypes about Latino students' academic abilities negatively affect the persistence of students in this minority group (Irizarry & Williams, 2013). Unsurprisingly, migrant students report feeling the most comfortable with teachers who are like them (Irizarry & Williams, 2013). Often, immigrant students must learn to exist in academic environments where they are in the racial minority and where they must learn a second language in order to fit in and truly master academic



content (Coll & Marks, 2012; Irizarry & Williams, 2013). Compared to other higher education option accessible to immigrant populations, the community college setting seems fairly conducive to encouraging the academic success of immigrant students in higher education. This demographic often withdraws with intentions to return, but then never actually continues their education due to life constraints. While the children of immigrants exhibit higher rates of enrollment within community colleges than other higher education institutions, those who remain undocumented stop at disproportionately high rates (Terriquez, 2014).

### **Barriers to Social/Government Services**

Due to the difficult environment that many non-native children face, migrant families may move frequently in attempt to seek a better educational fit for children (Rodriguez-Valls & Torres, 2014). These families also may relocate in an attempt to secure higher-paying or more secure jobs and community resources. Immigrant families a quite often already struggling amidst significant financial burdens, and long-distance or frequent moves take an additional toll on their finances (Ayon, 2013; Zayas, 2015). The struggle that these families face to fit in with a long-term community is exacerbated when they constantly feel forced to uproot, leading to a sense of isolation and disconnectedness, particularly for children (Ayon, 2013; Hayden, Mevawalla, Britt, & Palkhiwala, 2013; Pisnanont et al., 2015). A concurrent study conducted by Chang (1993) found that Asian Americans were among the most likely group of U.S. immigrants to have greater access to legal services, likely due to the educational advantage that Asian Americans might have. Even still, cultural

differences between service providers and migrant clients may result in feelings of misunderstanding or mistrust on the part of immigrants (Dong & Dong, 2013). Often, churches and other community centers are important stepping-stones for migrant families to become aware of community services available to them. Access to services in the host community, such as daycare, can significantly contribute to the success of migrant families and their children (Small, 2006). Immigrant families may relocate often in an attempt to secure higher-paying or more secure jobs and community resources. Consequences of frequent relocation among immigrant populations maybe a result of financial burdens or a sense of isolation (Ayon, 2013; Hayden, Mevawalla, Britt, & Palkhiwala, 2013; Pisnanont et al., 2015; Zayas, 2015). A majority of the studies cited in this chapter focused on samples of immigrants in the Midwestern region areas of the country. For example, Illinois hosts a significant number of immigrants in the United States, with the foreign-born contributing 14% of its population (Fennelly, 2012; Signs of the times: Midwestern demographic trends and their implications for public policy, 2016).

Further research on immigrant growth in the Midwestern states of Missouri, Indiana, and Minnesota from 2000- 2010 was ranked one of the highest in the nation (Fennelly, 2012). Some of the research gaps relate to the methodological difficulties in investigating immigrant populations. Participants, representative of the demographic being studied, are difficult to obtain based on the time and commitment required by immigrant populations for the study (Creswell, 2013; Fennelly, 2012; Ford, 2013; Immigration in the global Midwest, 2016; Llorente, 2013; 15

Methodological Issues in Research on Educational Interventions, 2001). The Midwest U.S. is an especially important site to study immigration because increases in migration have transformed the region with Latinos accounting for a major and significant growth in Minnesota. For instance, the Twin Cities of Minneapolis and St. Paul host the largest populations of Hmong and Somali immigrants as well as American Indians living in an urban area (University of Minnesota, Immigration in the Global Midwest, 2016).

For this dissertation study, a quantitative study design was chosen over qualitative. This was because a quantitative design is better suited for describing the correlation between several variables. The goal of this study is to explore what strategies are in place to improve the extent to which immigrants' access support opportunities on healthcare, education, and other necessary assistance in the Midwestern U.S. Counties and the factors that affect their help seeking behavior.

### **Stigma and Discrimination**

Social reactions toward immigrants, serve to reinforce the fears and insecurities that non-natives may already have about seeking health aid in the United States. Social sensitivity toward racial minorities is a variable in immigrant health-seeking behaviors (Chiricos, Stupi, Stults, & Gertz, 2014; Gonzales, Suarez-Orozco, & Dedios-Sanguinetti, 2013; Torres & Waldinger, 2015; Viruell-Fuentes, et al., 2012). Immigrants are subject to associations relating to ethnic group stereotyping (Chiricos, Stupi, Stults, & Gertz, 2014; Gonzales, Suarez-Orozco, & Dedios-Sanguinetti, 2013; Torres & Waldinger, 2015; Viruell-Fuentes, et al., 2012). Immigrants are recognized as different, while simultaneously being expected to conform systematically to the same expectations as

native-born American citizens (Chiricos, Stupi, Stults, & Gertz, 2014; Torres & Waldinger, 2015). Fiske, Cuddy, Glick, & Xu (2002) discuss patterns of intergroup perceptions within the context of the Stereotype Content Model (SCM). Low competence rankings of immigrants relates to their perceived low status in American society. Mexican immigrants in particular are associated with perceptions so negative that they bordered on contempt and disgust and stereotypes (Lee & Fiske, 2006).

Stereotypes of immigrants are a result of the notion that migrant populations are not deserving of societal resources or are taking advantage of the social system (Gonzales et al., 2013; Sommers, 2013; Torres & Waldinger, 2015). This leads to stereotyping of Hispanic immigrants and perceptions of low competence (Chiricos, Stupi, Stults, & Gertz, 2014; Fiske, Cuddy et al., 2002; Pisnanont et al., 2015; Torres & Waldinger, 2015). In the field of healthcare, these perceptions can have a tremendous impact on the bedside manner of doctors who frequently treat Hispanic populations, and can influence the level of trust that exists between a Hispanic patient and primary care physicians (Ayon, 2013). Qualitative research attempting to glean patterns of immigrant perceptions in their healthcare experiences has indicated that Hispanics, in particular, feel greatly misunderstood by their doctors, more than any other ethnicity, that their doctors do not believe their symptoms (Fernando Chang-Muy & Congress, 2015; Ingleby, 2012; Martinez & Slack, 2013; Martinez et al., 2015).

## **Social Networking**

Fawcett, Fisher, Bishop, and Magassa (2013) noted that homogenous online networks are both advantageous and disadvantageous in a few respects: On one hand, they provide users with the ability to connect with others who are like them, and to express their current identities in a social circle where they feel respected and safe enough to do so. On the other hand, limited diversity in online interactions, to some extent, dictates who children are likely to spend their time with face-to-face. For immigrant youth, this means that an overly homogenous online social circle perpetuates the cultural and social gap between immigrants and the host communities in which they live (Fawcett, Fisher, Bishop, & Magassa, 2013).

This research indicates that there appears to be distinct sectors of online youth socialization patterns, with some groups eager to speak to individuals outside of their cultural group; this out-group socialization behavior encourages the diversification of connections and integration within communities of individuals that vary by cultural identity. Forming online connections as a segue into face-to-face communication could encourage integration of youth into communities of peers who are different than they are. This may lead them to be comfortable with beliefs, ideologies, and languages that differ from the ones they are exposed to within their family (Fawcett, Fisher, Bishop & Magassa, 2013).

## **Intervention/Ways Access can be Promoted**

However, there have been interventions that have been effective in aiding immigrants in accessing services, particularly healthcare services. Navigator programs

are intended to help guide vulnerable populations in overcoming barriers when attempting to access healthcare (Sharmeen Shommu et al., 2016). A literature review by Sharmeen Shommu et al. (2016) showed that there was substantial improvement in health outcomes for groups where the navigators were present in their community. Excluding undocumented immigrants from receiving government assistance would mean unfair treatment between documented and undocumented immigrants which may undermine full healthcare access and utilization (Bustamante et al., 2012). Furthermore, Thomas, Chiarelli-Helminiak, Ferraj, & Barrette (2016) conducted a study of one immigrant community's social navigator program, hoping to shed light on the structural, economic, and political struggle of many immigrants to integrate into existing U.S. community circles. They found that existing social networks were an important component to the successful integration of immigrants into pre-existing community social circles.

The successful intervention of programs like this point to positive factors that increase access and outcomes for immigrant populations in regards to healthcare and potentially other services. Not being able to overcome these barriers can increase the risk of developing acute and chronic conditions. Sharmeen Shommu et al. (2016) confirmed that there was substantial improvement in health outcomes for groups where the navigators were present in their community and help to increase access and outcomes for immigrant populations in regards to healthcare and other important services.

Community-based organizations represent an important force in ensuring that immigrants are able to receive all the benefits that they are able to from their

community and from the local and federal government. There are advantages to interventions originating from a community library. The library is seen as a neutral, shared, safe space where all members of the public can feel at home (Chiarelli-Helminiak et al., 2016). Policy makers and transportation experts can collaborate to develop plans to resolve transportation barriers to immigrants accessing public assistance (Broomes, 2013). Research is needed on transportation policy and what impact it has on immigrant success regarding accessing public benefit programs (Syed, Gerber, & Sharp, 2013). Interventions are needed to provide access to educational opportunities and transportation facilities to improve access to employment or jobs and other services (Syed, Gerber, & Sharp, 2013).

### **Review of Research Literature**

Welfare programs are the core of the U.S. welfare system that caters to the needs of immigrants and their families (Camarota, 2011; Hildebrandt & Stevens, 2009; Pereira et al., 2012). Hildebrandt and Stevens (2009) proposed TANF interventions methods with job skills training and interpersonal skills building to assist the immigrants learn basic concepts about living in the United States. In studies conducted by Vesely et al. (2015) and Pereira et al. (2012), the authors revealed that there is information provided under the federal policy for low-income immigrants' access to support programs for healthcare, transportation, and employment benefits.

Some states take total control of how they administer their benefit programs with different levels of flexible administrative strategies designed to establish eligibility criteria, including language services and application forms, for receiving

assistance (Pereira et al., 2012). For example, the state of North Carolina operates on a county-administered and state-supervised basis (Pereira et al., 2012). Moreover, regardless of the differing flexibility and administrative strategies put in place, local county governments should consider amending their policy on education and health care to meet the socioeconomic needs of the immigrants (Pereira et al., 2012; Vesely et al., 2013).

Regardless of the immigrants benefiting from government assistance, there is still discrepancy in receiving benefits due to some immigrant cultural orientation, education, eligibility criteria and language barrier (Vesely et al., 2015). There is limited literature on how immigrants and their families use government support opportunities to create viable socioeconomic status (Vesely et al., 2015). As a result, there is a need to investigate this problem to ascertain the cause of the apparent assistance gap that exists in the immigrants' community in several Midwestern U.S. Counties (Hildebrandt & Stevens; 2009; Vesely et al., 2015).

### **Methodological Literature**

Researchers conduct investigations and categorize their literatures according to particular methodological issues such as research methods and analysis techniques in order to provide meaningful inputs about methodological perspectives (Woo, Pettit, Kwak, & Beresford, 2011). Pereira et al. (2012) conducted both in-person and phone interview with selected government agencies responsible for administering assistance programs (Medicaid/CHIP, SNAP, and TANF programs). In similar fashion, other researchers examined the effect assistance programs had on immigrants'



socioeconomic wellbeing. The authors found that the problems immigrants encounter are related to transportation, healthcare assistance, and driving credentials (Adams, 2010; Borders, 2006; Guo, 2006; Syed, Gerber, Sharp, 2013).

In order to gain more information, they spoke with community-based service providers and faith-based organizations that provide assistance for immigrants (Pereira et al., 2012). Khanlou, Haque, Sheehan & Jones (2015) employed a similar method in a qualitative study conducted in the Greater Toronto Area. The researchers used interview consultations and telephone interview to explore the experience of service providers on the challenges immigrant parents encountered in accessing public services (Khanlou et al., 2015). Telephone surveys or interview method was the most effective way to collect the necessary information because it is relatively cost-effective and provided extended access to participants (Opdenakker, 2006; Suttle, 2017).

One of the limitations of telephone survey is the reduction of social cues, where the researcher does not see the interviewee; as a result body language may not be used as a source of extra information. Another limitation is that the interviewer has no view on the situation in which the participant is situated which creates lesser possibilities to create a good interview ambience (Opdenakker, 2006). In other words, they are not able to view the people they are interviewing and their reactions to help determine whether the answers are truthful (Suttle, 2017).

## **Review of Methodological Issues**

A review of methodological analyses was conducted, which revealed quantitative research method as a more commonly used technique actually practiced by applied researchers (Ferron et al., 2006). Quantitative research methods were used for this study to examine immigrant access to government services. Previous studies have established that a quantitative method is the best choice when attempting to understand relationships among variables (Orcher, 2005; Pollara & Broussard, 2011). Comparing both Aretakis (2011) and Khanlou, Haque, Sheehan, & Jones (2015) methods, Khanlou recruited volunteered service providers for interview consultations and telephone interview, while Aretakis used students for sample population to gather more information from service providers on the difficulties immigrant face in accessing public services. Researchers must be able to collect sufficient data to gather detailed information about the study population (Creswell, 2013).

Consistent with Aretakis (2011) and Khanlou et al. (2015) methods, Pereira et al. (2012) employed similar method and spoke with community-based service providers and faith-based organizations in order to collect more data. The researchers noticed that the interview consultations and telephone interview methods were the most effective ways to collect information because they were found to be relatively cost-effective and provided extended access to participants (Khanlou et al. 2015; Opdenakker, 2006; Suttle, 2017). However, the limitation of telephone survey was the reduction of social cues. Researchers do not see the interviewee to allow them use body language as a source of extra information. Another major methodological issue associated with their studies was

related to the fact that the interviewer does not view the situation in which the participant is situated and their reactions to help determine whether the answers they provide are truthful.

### **Synthesis of Research Findings**

Transportation is one of the obstacles immigrants face in accessing healthcare (Vesely , Goodman, Ewaida, & Kearne, 2013). The California Health Interview Survey conducted in 2007 showed that there were about 2,600 documented and 1,038 undocumented Mexican immigrants (Bustamante et al., 2012). Immigrant families far exceed set quotas and are continued to filter into the U.S. shaping the country's economy and culture with their presence (Kesler, & Schwartzman, 2015; Sutton, & Stewart, 2013; Xi, Takyi, & Lamptey, 2015). Access to healthcare and utilization disparities among immigrants from Mexico exists for Mexican immigrants (Bustamante et al., 2012). In contrast, no significant relationship existed between socioeconomic status (SES) and student achievement (Ford, 2013).

Some of the major factors that contribute to assistance gap among immigrants are lack of English language, low family socio-economic status and shortage of bilingual service providers; and lack of role models at learning institutions (Ford, 2013; Guo, 2009; Pereira et al., 2012). Lack of English language learning and cultural orientation are some of the important factors that cause assistance gap among immigrant (Lemu, 2015). Time of stay in the U.S., English proficiency and deportation fears are important conditions that can determine healthcare access and utilization (Bustamante et al., 2012). Language difficulties and cultural are major barriers that can exist between the service providers

and the immigrant community (Guo, 2006; Pereira et al., 2012). Other factors such as the complexity of the application process and eligibility rules; and administrative issues also contributed to obstacles in receiving assistance. English proficiency among immigrants may not always determine healthcare utilization, equally. Lack of English proficiency is not necessarily a determinant for undocumented status (Bustamante et al., 2012).

Studies conducted and focusing on samples of immigrants in the Midwestern region areas of the country indicate that Illinois hosts a significant number of immigrants in the United States, with the foreign-born contributing 14% of its population (Fennelly, 2012; Immigration in the global Midwest, 2016; Llorente, 2013; Signs of the times: Midwestern demographic trends, 2016). Further research on immigrant growth in the Midwestern states of Missouri, Indiana, and Minnesota from 2000- 2010 was ranked one of the highest in the nation (Fennelly, 2012). Some of the research gaps relate to the methodological difficulties in investigating immigrant populations. Participants representative of the demographic being studied, are difficult to obtain based on the time and commitment required by immigrant populations for the study (Creswell, 2013; Fennelly, 2012; Immigration in the Global Midwest, 2016; Llorente, 2013; 15 Methodological Issues in Research on Educational Interventions, 2001).

The Midwestern U.S. is an especially important site to study about immigration because increases in migration have transformed the region with Latinos accounting for a major and significant growth in Minnesota. For instance, the Twin Cities of Minneapolis and St. Paul host the largest populations of Hmong and Somali immigrants as well as

American Indians living in an urban area (University of Minnesota, Immigration in the Global Midwest, 2016).

Rawls' theory of justice (1971) serves as a theoretical framework for the study and use Qualtrics Survey for data collection. Another theoretical perspective that guided this study is the social stratification theory. The quantitative study design was chosen over qualitative because it is better suited for describing the correlation between several variables. This study will also explore what strategies are in place to improve the extent to which immigrants' access support opportunities on healthcare, education, and other necessary assistance in the Midwestern U.S. Counties and the factors that affect their help seeking behavior.

### **Critique of the Literature**

Immigrant families, far exceeding set quotas have continued to filter into the U.S. over the decades, continuously shaping the country's economy and culture with their presence (Kesler, & Schwartzman, 2015; Sutton, & Stewart, 2013; Xi, Takyi, & Lamptey, 2015). The literature review has revealed that there is a significant portion of the U.S. population who is underserved in regards to services such as healthcare and education (Clark, Ponjuan, Orrock, Wilson, & Flores, 2013; Woods, Dooley, Luke, & Exley, 2014; Sensoy, & DiAngelo, 2015). However, more research is needed to better understand what factors impact immigrant perception of access to government services and how policy and programs can assist in overcoming these barriers (Anthias, 2013; Bustamante et al., 2012; Camarota, 2012; Ku, 2009).

The barriers that immigrant populations in the U.S. face in healthcare, education, and accessing social and governmental resources are numerous. Language and literacy barriers hinder the academic progress of migrant students and contribute to the prevention of meaningful social and cultural connections between migrant families and their host communities (Barak, Leighton, & Cotton, 2014; Gregson, 2013; Kesler, & Schwartzman, 2015; Landsbergis, Grzywacz, & LaMontagne, 2014). Trends and gaps in the existing literature suggested a need for a more holistic and overarching approach to understanding barriers to immigrant access (Pereira, et al., 2012;). There is a significant portion of the U.S. population who is underserved in regards to services such as healthcare and education (Bustamante, et al., 2012; Camarota, 2012; Clark, et al., 2013; Woods, Dooley, Luke, & Exley, 2014; Sensoy, & DiAngelo, 2015). More research is needed to better understand what factors impact immigrant access to government services and how policy and programs can assist in overcoming these barriers (Anthias, 2013; Bustamante et al., 2012; Camarota, 2012; Ku, 2009).

## **Summary**

Research on the social justice theory and social stratification theory were discussed in this chapter. The theories provide a basis for understanding how social and cultural factors impact immigrant patterns of social and governmental engagement. Examined, as well, in this chapter was the body of research relating to the various barriers that the U.S. immigrant population faces related to accessing healthcare, education, and social services. Presented in the next chapter is the

methodology for the current study and details about the methods including data collection and data analysis procedures.

### **Chapter 3: Methodology**

For this study, the relationships between the immigrants residing in Midwestern United States (U.S.) counties and perceptions of access to government services on healthcare were measured. The mean scores of several subgroups such as male and female, age group, and new immigrant and U.S. citizen immigrant participants were compared to determine the effect on access to healthcare services.

#### **Purpose of the Study**

The purpose of the quantitative descriptive survey research study was to understand the perception of access to healthcare and government services in Midwestern US counties for immigrants. Data was collected from the California Health Interview Survey (CHIS) to gain an understanding of participants' perception of access to health care services. The CHIS survey was used to examine immigrant experience of seeking government assistance program. This survey uses a five points Likert Scale (5 = Strongly Agree, 4 = Agree, 3 = Neither agree nor disagree, 2 = Disagree, and 1 = Strongly Disagree. Examined for the study was the immigrant's perception of access to health care based on age, gender and for foreign born US citizens.

#### **Research Questions and Hypotheses**

The following research questions guided the study:

RQ 1. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and gender of the immigrant?

RQ 2. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and age of the immigrant?



RQ 3. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status of the immigrant?

### **Hypotheses**

H<sub>01</sub>: There is no difference in the perception of access to government services, with respect to immigrant status and gender of the immigrant.

H<sub>a1</sub>: There is a difference in the perception of access to government services, with respect to immigrant status and gender of the immigrant.

H<sub>02</sub>: There is no difference in the perception of access to government services, with respect to immigrant status and age of the immigrant.

H<sub>a2</sub>: There is a difference in the perception of access to government services, with respect to immigrant status and age of the immigrant.

H<sub>03</sub>: There is no difference in the perceptions of access to government services, with respect to immigration status of the immigrant.

H<sub>a3</sub>: There is a difference in the perceptions of access to government services, with respect to immigration status of the immigrant.

### **Research Design**

A descriptive research method was used for this study since it helps to describe and provide better understanding of the research settings and utilizes a detailed examination of data for quality measures and analysis of the data (Lemu, 2015).

Descriptive research design as an approach is based in a paradigm of personal interest and emphasizes the significance of how knowledge is interpreted which allows the researcher to understand and gain insights into people's experience and actions (Creswell, 2013; Fincham, & Draugalis, 2013; Lemu, 2015). Previous study has established that

quantitative method is a better choice when attempting to measure between variables (Ford, 2013).

Furthermore, the descriptive survey research design is appropriate for this study since descriptive method provides quantitative responses based on information gathered from the respondents (Smiley, 2011). The data gathered for this current study were restricted to quantitative data obtained from a set of questions adopted from the 2001 California Health Interview Survey (CHIS) Adult Questionnaire (Respondents Age 18 and Older), and was administered through the Qualtrics Survey in an online survey. In particular, a number of survey questions were administered to supply data for the study in order to determine the extent to which a relationship exists between immigrant status and access to necessary social supports. The responses to the five points Likert Scale survey questions were used to identify and analyze the effects of the factors related to perceptions of access to government services. The quantitative data informed the study with statistical information that supported the existence of assistance gap among immigrants.

The use of the descriptive survey research design provided information that addresses the research questions and objectives of the study. The descriptive survey research study design is a valid method to use to examine perceptions of access to government services, because it provided an understanding in order to draw inferences from the strength of quantitative approach (Creswell, 2013; Ford, 2013; Stern, Bilgen, & Dillman, 2014). In contrast, employing other research approach or method would be less effective because of the limitation of existing research on immigrant perception of access

to government assistance including healthcare and education (Smiley, 2011). Qualitative research would not be viewed as appropriate for this study method choice because of the numerical data involved.

The California Health Interview Survey Adult Questionnaire (Respondents Age 18 and Older), was used with little modification. Sixteen questions using Likert-type scales (5 = strongly agree; 1 = strongly disagree) was administered to respondents. Consistent with Dennick and Tavakol 2011, a sample frame provided by Qualtrics Audience Service was employed for this study. Qualtrics Company was contracted to provide a source of participants for the study.

Companies who offer a source of participants for surveys often have procedures they use to collect data, names and contact information and processes to minimize duplicate representation (Callegaro & DiSogra, 2008; Hays, Liu & Kapteyn, 2015). For this current study, Qualtrics Survey was contacted to obtain data because they have access to the study population. Included in the survey were basic demographic questions required for the study.

### **Target Population and Sampling Method (Power)**

According to Migration Policy Institute, report/data from the (Grieco et al., 2012; U.S. Census Bureau, 2014; Zong & Batalova, 2015), showed that there are over 41 million immigrants in the United States. A subset of this population, consisting of 3.7 million who reside in the Midwest U.S. who actively seek government assistance were the population for this study (Larsen, 2004). A total sample size of 85 was determined as required at the significance level ( $\alpha = 5\%$ ).

The Qualtrics Survey (the recruiting organization) provided a sample frame reflective of the U.S. population required for this study. Qualtrics is widely used by over 1,400 major higher institutions of learning and business organizations in the United States for data collection and analysis (NDSU, 2014; Snow, 2006). The researcher sought permission from Qualtrics Company to allow the use of their Survey, to gather data for the research. Individual participation in the survey was voluntary and participants were free to withdraw at any time. Inclusion criteria included only immigrants and foreign born U.S. citizens age 18 and over, who resided in the geographic location of U.S. Midwest Counties. A participant who did not meet the inclusion criteria was not selected for participation in the survey. Descriptive statistics was used mainly to calculate the standard deviation and Mean scores to indicate the spread of data within the variables. In order to answer the research questions, a two-way MANOVA and an independent sample t-test were used to examine the effects of two forms of immigrant status and gender on perceptions of access to government services in the Midwestern U. S. counties.

### **Instrumentation**

The instrument used in this current study was the 2001 the CHIS survey. The survey is a population based health survey which was used to assess health concerns for more than 55,000 California households. Few of the questions on the survey were modified to suit the study. The researcher obtained permission to use the instrument. A five point Likert Scale was used for the survey. The points on the scale contained the following: (5 = Strongly Agree, 4 = Agree, 3 = Neither agree nor disagree, 2 = Disagree,

and 1 = Strongly Disagree. Demographic items included gender, age, and immigrant status.

California Health Interview Survey instruments have been widely used by public health experts, policymakers and researchers to improve immigrants access to healthcare services and to develop prevention programs for health-related problems (Alba et al., 2005; Brown, Holtby, Zahnd & Abbott, 2005). Previous studies have used these instruments to investigate various issues of concern, including healthcare, educational assistance, and other important government services among immigrants. For example, Alba et al. (2005) examined data from the 2001 CHIS and the result identified key content areas including health-related behaviors and health insurance coverage, and access to health related services. This study on the survey instrument was conducted in six languages including English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, Korean, and Khmer (Cambodian) with participants aged 18 and older. Breen, Rao and Meissner (2010) study also used the 2001 California Health Interview Survey (CHIS) instrument and result shows that immigrants' lower rates of health-related condition may exist because of the lack of fluency in English and knowledge about navigating U.S. health care system. The result also shows the largest Mexican-American sample in a U.S. survey.

In another study conducted by Reza et al. (2016) found that new arrivals face language, cultural and financial difficulties which limit their access to and use of health services. The author recommended that intervention programs, such as educational courses and counseling, for new arrivals and their families will be helpful in improving

their health status (Reza et al., 2016). They found that disparity in healthcare and educational services between immigrants who newly arrived and their counterparts can be reduced by improving their skills in English and educating parents regarding good health practices (Reza et al., 2016).

The 2001 California Health Interview Survey (CHIS) was culturally adapted and translated into several languages: Spanish, Chinese, Vietnamese, Korean, and Khmer, where the multiethnic and multilingual approach illustrated how important it is to adapt culture and linguistic in developing diverse population-based surveys (Ponce et al., 2004). This study yields similar results using similar population and cases as indicated in the study conducted by Alba et al. (2005).

The CHIS sample provided statistically reliable estimates of important health conditions and health-related behaviors. In addition to providing statistically reliable information on the health conditions of adults, CHIS is the nation's largest state health survey and data resources able to provide diverse population-based health-related information about people (California Department of Public Health, CHIS, 2016; Ponce, et al., 2004). The article further confirms the reliability and validity of the 2001 CHIS survey instrument by producing similar results and measurement that covers the entire issues of health, education, and language difficulty of immigrant individuals. The survey adopted from the California Health Interview Survey (CHIS) was not piloted and so it is a threat to the internal validity of the study

The survey also covers cross section of people including Latinos, Asians, American Indians and Pacific Islanders (California Department of Public Health, CHIS,

2016; Ponce, et al., 2004; Prochaska, Sung, Max, Shi, & Ong, 2012). Policymakers, researchers, and experts in the field depend on CHIS for credible data on the health and education issues (Prochaska et al., 2012). Demographic variables used in the study included age, gender, and immigrant status, which are similar and align with the quantitative methodology, research questions, and the independent variables that are used in this study.

Previous researchers used descriptive statistics method to analyze their data and results showed reliability of their instruments and concluded that the survey data reflected the most accurate sample (Freese & Fultz, 2012; Rogers, 2012). They administered the same survey developed by Chandler and Swartzentruber (2011), although they modified few questions to suit their study, as was done in this current study. A program should not only be effective in a particular setting, but also be effective in other settings and with other populations (Steckler & McLeroy, 2008).

### **Data Collection**

The sample recruitment was done through Qualtrics. The company has access to the study population and provided the respondents for the online survey. Those participants who met the criteria to participate in the survey proceeded to the next screen which welcome them and expressed appreciation for taking their time to take part in the survey. They were also presented with an explanation of what the study is about, information describing how long the survey will take, the researcher's name and information about how the researcher could be contacted, just in case a participant had a question, and a consent form to ensure that participants were voluntarily agreeing to be

included in the study. Once consent forms are electronically signed (i.e., “I agree”), participants were prompted to begin the survey items to be answered in seven minutes or less.

Responses were obtained from 85 participants residing in the geographic location of the Midwestern U.S. Counties. The survey is closed-ended and used an ordinal 5-point Likert-type scale. Participants were free to discontinue the survey at any point without any negative consequences and were also free to skip any questions which they were not comfortable to answer. Their participation in the survey was entirely voluntary and is free to withdraw at any time.

Data from the CHIS survey included demographics, immigrant status, gender, age and perception of access. Upon signing in to take the survey, participants were requested to complete a pre-screening questionnaire to ensure that they meet the inclusion criteria. Inclusion criteria included sample solely restricted to immigrant and foreign born U.S. citizen participants, age 18 and above, currently residing in the Midwestern U.S. region. Participants who met the inclusion criteria were allowed to take part in the survey.

### **Operationalization of Variables**

A researcher must be able to establish and understand the key variables involved in her or his study before discussing quantitative or qualitative approach (Creswell, 2013). The key variables involved in this current study are immigrant status, gender, age and perception of access to government services. For this study, immigrant status is defined as either immigrants or U.S. citizens who are foreign born.



## **Data Analysis Procedures**

Upon successful completion of the desired survey participants, the data was loaded into SPSS for analysis. Questions that fall under a particular variable in the survey: immigrant status, gender, age and perception of access were grouped in order to keep the survey logical and focused (Smiley, 2011). This includes survey data information on access, and demographic characteristics such as immigrant status, age, gender, and education. The statistical analysis for this study was calculated using SPSS for the analysis of the data. Descriptive statistics was used to calculate the mean and standard deviation to indicate the spread of data within the variables. A two-way MANOVA and an independent t-test were used to determine if there is any significant difference between immigrant status, gender, and age in the study data. Statistical analysis for a sample *t*-test and MANOVA were conducted to analyze the study data using an alpha of 0.05 (i.e., significance level ( $\alpha$ ) = 5%).

## **Limitations and Delimitations of the Study**

There were several limitations and delimitations in this study. The limitations of the study were related to the anonymity and accuracy of participant responses which may not be validated. Factors unconsidered by the government agencies were not surveyed and therefore were not considered in this study. This study was also limited because all the counties or states in the Midwestern region of the United States were not covered in the survey. Another limitation is that only participants whose addresses were provided by Qualtrics Company from the area under investigation were represented in the sample size.

To ensure the generalizability of the result, the study sample was matched to the study population at large to ensure comparability of the demographic characteristics. Metzler (2009) emphasizes that the aim is to make logical generalization that ensures the same research can be conducted several times and in different contexts and locations, and the analysis treated by different researchers before claiming its generalizability (Heale & Twycross, 2015; Metzler, 2009). Generalizability of this current study referred to the extent to which the findings from the study can be applied to the wider population (Kadir & Qureshi, 1994; Metzler, 2009; Roberts, Priest, & Traynor, 2006). The sampling allowed generalizability through the contexts that the study sample is a statistically representative of the larger immigrant population (Metzler, 2009). Sample size is considered the more important factor in generalizability, where the smaller the sample size, the smaller it falls below the point where the researcher cannot make any kind of useful generalization (Chapter 3-research methodology, 2014; Heale & Twycross, 2015; Metzler, 2009; Roberts, Priest, & Traynor, 2006).

The delimitation for this current study is that measurements such as survey questionnaire that was confined to eighty-five participants from counties in the Midwestern region of the United States. This study data was also delimited to data gathered from a chosen set of participants from the Midwest Counties. Due to the limited resources and time for the study, data were gathered from a larger recommended population of the study. Yet, due to the comprehensive nature of the surveys gathered, it was adequate for gaining an understanding into the nature of immigrant access to government services.

### **Internal and External Validity**

The reliability of this descriptive survey study considered two components, including internal validity and external validity. The internal validity considered how reasonable the data collected were, as well as the consistency in the information obtained from each participant (Smiley, 2011). In order to enhance validity of this current study, the researcher restricted the study population to individuals who are comparable for the outcome and from whom accurate information can be obtained. A study is invalid if it cannot provide accurate information that can enable the researcher to draw inferences from the total population studied (Kadir & Qureshi, 1994).

### **External Validity**

The results of this current study may be internally valid within the sampled respondents who resided in the geographic location of U.S. Midwest Counties, but since there could be better access in the area surveyed than in other regions; as such the results cannot be generalized to the entirety of the immigrant population. The results may not be valid for immigrants in any other time and location than in the U.S. Midwest Counties. The external validity of the data for this study was verified by comparing the information gathered with the information collected from other previous studies (Smiley, 2011). The external validity determined whether the information that collected for the current study confirms to other studies in the field or not. This shows that it is important to recognize that a program should not only be effective in a particular setting, but can also be effective in other settings and with other populations (Steckler and McLeroy, 2008).

**Internal Validity**

There were efforts made to eliminate researcher bias from within the known population from which the sample was taken. However, because the population size accessible for this study was limited, the sampling was stratified and was not entirely random. Also, immigrants routinely experience several challenges in accessing support services which may impact the mean level of perceptions of access to public benefits which are related to their economic well-being. Such challenges are language difficulty, complexity of application processes and eligibility rules, lack of knowledge about public assistance programs and cultural orientation.

**Reliability**

The reliability of this survey included internal validity and external validity which considered how reasonable the data collected were, and the consistency in the information obtained from the participants. The findings led to correct inferences about the issue, where these inferences drawn were generalized to the larger population (Creswell, 2013; Kadir & Qureshi, 1994; Smiley, 2011). The external validity of the data was verified to compare the data gathered with the information collected from other sources or studies (Smiley, 2011). The validity was also based on how well the study instrument will perform at measuring the research variables and ensure that the information collected and results obtained actually represent the respondents (Smiley, 2011; Steckler and McLeroy, 2008).

## **Expected Findings**

The results are expected to highlight particular difficulties immigrants' families encounter, which include language and cultural barriers, eligibility criteria, and communication when accessing social support in light of their immigration status. It is also expected that the findings of this research are relevant to policy and research literature and indicate that language and communication are viewed as significant access barriers for immigrant (Khanlou, Haque, Sheehan, & Jones, 2015). Another expected finding is that transportation barriers impact access to medication while distance from a patient to a service provider would seem to be a barrier to healthcare and education access (Syed, Gerber, & Sharp, 2013). When a patient does not get to the health care provider on time, she or he misses the opportunity for evaluation and treatment of health problem that may escalate care which as a result can also delay interventions that may reduce disease complications (Syed, Gerber, & Sharp, 2013).

## **Ethical Issues in the Study**

There are always ethical concerns to a greater extent, which the researcher is obligated to address in order to build trust and protection with the participants (Mcguire, 2006). The researcher must address or discuss ethical considerations such as what are required of the participants and their rights, the risks the participants might encounter, and the benefits they might accrue (Creswell, 2013; Mcguire, 2006; Rogers, 2012).

The participants of this current study were selected from the demographic location of the Midwestern U.S. counties. This region is selected since majority of immigrants are concentrated there and based on the researcher personal interest. Data

collection was done with the consent of individual participants. No names or identifying data were collected. All data were kept and protected for three years after the study, and then subsequently destroyed appropriately. In other words, the study data and documentation were secured in a locked filing cabinet and the confidentiality of each participant was maintained with no personal information accessible (Smiley, 2011). Survey respondents were not identified by the name.

This study fully followed the ethical procedures established by the Institutional Review Board (IRB) before collecting data from the participants. In addition, the researcher attempted to provide necessary information to all participants before starting data collection. This included information about the description and purpose of the study; potential risks and benefits to the participants; and the statement indicating that participation in the process is voluntary and individual participant may decide to withdraw from the process at any time without penalty (Rogers, 2012). Researchers must watch against misconduct and impropriety that may exist in their research, which might reflect negatively on their institutions; and cope with new and challenging problems (Creswell, 2009; McGuire, 2006; Rogers, 2012).

### **Chapter 3 Summary**

The purpose of this study and the appropriateness of utilizing a quantitative descriptive study design were presented in this chapter. Within chapter there is an in-depth discussion on the research design, data collection, analysis, and ethical considerations that were used during the course of this study. Furthermore, presented in this chapter is information on the population sample as well as the technique used in the

sampling. Additionally, the data collection process, instruments, statistical approach used, and the validity and reliability of the instruments used in this study were discussed.

Covered in Chapter 4 is the data analysis and results of the study.

## **Chapter 4: Data Analysis and Results**

For this study, eighty-five participants completed the survey adopted from the 2001 California Health Interview Survey (CHIS). The survey adopted from the California Health Interview Survey (CHIS) was not piloted and so it is a threat to the internal validity of the study. There were twelve questions addressing participants' perception of access to government services in the Midwestern United States counties. Because there were twelve dependent variables three tables were used to represent the results, with each table representing four of the twelve perception variables. The results of the tests of the three-null hypotheses are presented in this section. Tables that highlight relevant information are also included. The findings are summarized and evidence is presented leading to the rejection or acceptance of the hypotheses. This section of the study presents the summaries of the descriptive data and data analysis using independent sample t-test and a two-way MANOVA. IBM® SPSS® Statistics Version 25.0 was utilized to conduct the data analysis.

### **Description of the Sample**

Survey participants self-reported responses for the demographic data. The sample consisted of 85 participants age 18 and older, who resided in the geographic location of U.S. Midwest counties and who actively sought government assistance. Participants answered questions intended to produce specific demographic data about their age, gender, status, and education levels. The frequency table with a summary of the demographic data is presented below.



Table 1

*Frequency and Percentage Summaries of Demographic Information*

		U.S. citizen (Foreign born)	Percent	Immigrant	Percent
Gender	Male	12	14	7	8
	Female	47	55	19	22
Age	18 – 27	14	16	9	11
	28 – 37	14	16	12	14
	38 -77	31	37	5	6
ImmigrantStatus					
	Immigrants			26	31
	U.S. citizens	59	69		

*Note.*  $N = 85$

Totals may not equal 100% due to rounding.

The summaries showed that, of the 85 participants who participated in the survey, 66 (78%) were females and 19 (22%) were males. Of the 66 (78%) females who participated in the survey, 22% were immigrants and 55% were foreign born U.S. citizens. Of the 22% males who participated in the survey, 8% were immigrants and 14% were U.S. citizens. For the criteria of age, 23(27%) immigrants were aged 18 to 27 years old. Of the 23 participants age 18 to 27, 11% were immigrants and 16% foreign born-U.S. citizens. Of the 28 to 37 years old, 14% were immigrants and 16% foreign born-U.S. citizens. Within the 38 to 77 years old, 42% were immigrants and 37% foreign born-U.S. citizens. Immigrant status for this study is defined as either immigrants or U.S. citizens who are foreign born. For immigrant status, more than half of the 85 participants were foreign born-U.S. citizens 69% and 31% were immigrants.

## Detailed Analysis

Results RQ 1: What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and gender of the immigrant?

H<sub>01</sub>: There is no difference in the perception of access to government services, with respect to immigrant status and gender of the immigrant.

Table 2

*Mean Scores and Standard Deviations for perceptions of Place and Cost of Government Immigrant Healthcare*

Group	Place for care		No place for care		high cost of insurance		high cost of medical care	
	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>
Male								
New Immigrant	3.88	.99	2.13	1.38	2.00	1.41	2.25	1.58
U.S. Immigrant	4.00	1.18	1.91	1.16	2.18	1.40	2.00	1.34
Female								
New Immigrant	3.50	1.29	2.06	1.21	2.56	1.58	2.72	1.67
U.S. Immigrant	3.92	1.35	1.67	1.06	1.85	1.20	1.96	1.11

A MANOVA was conducted to evaluate the effects of gender and immigrant status on immigrant perceptions of their access to government health services. The means and standard deviations for immigrant perceptions as a function of the two factors are presented in Table 2. The MANOVA indicated no significant interaction between gender and immigration status,  $F(12, 70) = .43$ ,  $p = .95$ , partial  $\eta^2 = .07$ ; and no significant main effects for gender  $F(12, 70) = 1.01$ ,  $p = .45$ , partial  $\eta^2 = .15$ , and immigration status  $F$

$(12, 70) = .72, p = .73$ , partial  $\eta^2 = .11$ . There are no differences in the perceptions of new immigrants and U.S. citizen immigrants. Women and men did not differ either. There was also no difference in perceptions among men who were new immigrants, women who were new immigrants, men who were U.S. citizen immigrants and women who were U.S. Citizen immigrants. Because of this, the null hypothesis that there would be no difference in the perception of access to government services, with respect to immigrant status and gender of the immigrant was accepted.

Results RQ 2: What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and age of the immigrant?

H<sub>0</sub>2: There is no difference in the perception of access to government services, with respect to immigrant status and age of the immigrant.

Table 3

*Mean Scores and Standard Deviations for perceptions of age group of Government*

*Immigrant Healthcare*

Group	Speaks my language		No insurance or lost insurance		Not approve, cover, or pay for my care		Transportation problems	
	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>
Age								
New Immigrant								
18-27	2.22	1.21	2.67	1.50	2.67	1.66	2.78	
		1.56						
28-37	1.50	.67	2.42	1.68	2.33	1.44	1.75	
		.14						
38-Abo	1.40	.89	1.40	.89	1.80	1.10	1.20	
		.45						
U.S. Immigrant								
18-27	1.86	1.29	1.93	1.07	2.36	1.15	2.07	
		1.07						
28-37	1.50	.94	1.57	.94	2.14	1.29	1.43	
		.76						
38 Abo	1.39	.84	1.55	.85	1.61	.96	1.45	
		.77						

A MANOVA was conducted to evaluate the effects of age and immigrant status on immigrant perceptions of their access to government health services. The means and standard deviations for immigrant perceptions as a function of the two factors are presented in Table 3. The MANOVA indicated no significant interaction between Age-regrouped and immigration status,  $F(24, 138) = 1.01$ ,  $p = .46$ , partial  $\eta^2 = .15$ ; and no significant main effects for Age-regrouped,  $F(24, 138) = 1.18$ ,  $p = .28$ , partial  $\eta^2 = .17$ , and immigration status,  $F(12, 68) = .92$ ,  $p = .53$ , partial  $\eta^2 = .14$ . There are no differences in the perceptions of new immigrants and U.S. citizen immigrants. Age group did not

differ either. There was also no difference in perceptions among age group between ages 18-27, 28- 37 and 38-77 who were new immigrants and those who were U.S. Citizen Immigrants. Because of this, the null hypothesis that there would be no difference in the perception of access to government services, with respect to immigrant status and age of the immigrant was accepted.

Result RQ 3: What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status of the immigrant?

H<sub>03</sub>: There is no difference in the perceptions of access to government services, with respect to immigrant status of the immigrant.

Table 4

*Mean Scores and Standard Deviations for Perceptions of New Immigrant and U.S. Immigrant of Government Immigrant Healthcare*

Group	Discriminated against because of my language or my accent.		Discriminated against because of gender		Discriminated against because of my age.		Discriminated against because of country of origin	
	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>	<i>M</i>	<i>S</i>
Status								
New Immigrant	1.92	1.13	2.04	1.37	2.00	1.36	2.23	1.53
U.S Immigrant	1.75	1.06	1.71	1.12	1.83	1.18	1.68	1.04

An independent sample t-test was conducted to evaluate the effects of the difference on immigrant perception of their access to government services between new

immigrant and U.S. citizen immigrant. The means and standard deviations for immigrant perceptions as a function of the two factors are presented in Table 4. The independent sample t-test indicated no significant difference between new immigrant and status of the immigrant, The results of the two independent sample t-test for research question 3 ( $t(83) = -0.53, p = 0.59$  (i. e.  $p$  greater than significant level of .05),  $n^2 = 0.003$ ) indicated that there is no statistically significant difference in the mean score between new immigrant and U.S. Citizen immigrant in the population from which the samples came. There was no difference in perceptions among those who were new immigrants and those who were U.S. citizen immigrants. There are no differences in the perceptions of new immigrants and U.S. citizen immigrants. Therefore, the null hypothesis that there would be no difference in the perception of access to government services, with respect to immigration status of the immigrant was accepted.

### **Summary of Results**

Results showed that there are no statistically differences in the perceptions of access to government services among the survey participants in the population in Midwestern U.S. counties. As result, there was no statistically difference in the perception of access to government services with respect to immigrant status and gender among the survey participants from Midwestern U.S. counties. Therefore, the first null hypothesis that there would be no difference in the perception of access to government services with respect to immigrant status and gender of the immigrant was supported.

Also, there was no statistically difference in the perception of access to government services with respect to immigrant status and age group among the survey

participants from Midwestern U.S. counties. Therefore, the second null hypothesis that there would be no difference in the perception of access to government services with respect to immigrant status and age of the immigrant was not rejected. Furthermore, there was no statistically difference in the perception of access to government services with respect to immigration status of the immigrant among the survey participants from Midwestern U.S. counties. Therefore, the third null hypothesis that there would be no difference in the perception of access to government services, with respect to immigrant status of the immigrant was also accepted. Results indicated that the perception of immigrant and foreign—born U.S. citizens to government and health care services were similar according to gender, age and status.

Chapter 5 includes further analysis of the results presented in this chapter. Each of the results of the different statistical analysis was reviewed and the potential implications for each of the results of the analysis discussed in the succeeding chapter.

## **Chapter 5: Discussion and Conclusion**

Immigrants have long been the foundation of the United States. Indeed, the country was established by those who, often persecuted in their nation of origin, sought a better life for themselves in what was to them foreign lands (Ayon, 2014; Millet, 2014). Even in the establishment of this country's government, immigrants played a significant role; seven out of the thirty-nine men who were signers of the Declaration of Independence were born outside of the United States. Despite immigrants' early and continuous contribution to the economic and social growth, previous studies of the U.S. indicated that access to public services was severely limited in immigration communities (Ayon, 2014; Liao, 2015; Sharmeen Shommu et al., 2016). This limited access to services leads to more detrimental effects including poor health, low education and socioeconomic levels, as well as a lack of autonomy (Javier, Huffman, Mendoza, & Wise, 2010; Sharmeen Shommu et al., 2016). The assistance gap – a lack of access to various economic, social, and health resources and services is an impediment to the well-being and success of immigrants (Luemu, 2015; Pereira et al., 2012). Understanding the perceptions of access to government services within immigrant communities is paramount to creating positive reform in services as well as access to resources (Aretakis, 2011; Bustamante et al., 2012; Gelatt & Koball, 2014).

The purpose of this quantitative descriptive survey was to assess the perception of access to public services among immigrant communities, specifically looking at immigrants within the Midwestern United States. The knowledge gained from this study could help government service providers be more aware and better equipped to address the



challenges faced by immigrants in the U.S. by providing feedback on the perception of the availability and ease of access to public services. The literature suggests that many factors may play a role in the lack of access including language barriers, lack of knowledge about the services, difficulties in completing applications, and fear of stigmatization or even more severe immigration consequences (Aretakis, 2011; Bustamante et al., 2012). This study examined the factors of gender, age, and immigration status on the perceived accessibility of social services in the Midwestern United States.

A summary and discussion of the results, is included in this chapter. Also, how the results relate to the literature, the implications of the results on policy, practice, and theory, limitations of the current study, and suggestions for future research. The intent of this chapter is to succinctly discuss the results and implications of the current research.

### **Summary Results**

The purpose of this study was to analyze the perception of access to healthcare and government services in Midwestern U.S. counties for immigrants and the effect based on status, gender, and age. The problem is that the lack of access to vital services results in poor health outcomes, low education levels, and difficulty in improving economic outcomes (Javier et al., 2010; Sharmeen Shommu et al., 2016).

The results of the research questions were as follow:

- RQ 1. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and gender of the immigrant?

To address research question one, a two-way MANOVA was conducted to evaluate the effects on the perceptions of access to government services with respect to immigrant status and gender of the immigrant. The MANOVA indicated no significant difference between the gender and immigrant status on the perceptions of their access to government services,  $F(12, 70) = .43$ ,  $p = .95$ , partial  $\eta^2 = .07$ ; and no significant main effects for gender  $F(12, 70) = 1.01$ ,  $p = .45$ , partial  $\eta^2 = .15$ , and immigration status  $F(12, 70) = .72$ ,  $p = .73$ , partial  $\eta^2 = .11$ . Results from the analysis, p-value was greater than the level of significance value of 0.05, which showed that the participants' responses about their perceptions of access to government services were not significantly different according to gender and immigrant status. Because of this, the null hypothesis was not rejected. There was no difference in the means for new immigrants and U.S. citizens immigrants in the perception of their access to government services between gender and immigrant status from Midwestern counties.

RQ 2. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status and age of the immigrant?

To address research question two, a two-way MANOVA was also conducted to evaluate the effects on the perceptions of access to government services with respect to the age of immigrants and immigrant status. The MANOVA indicated no significant interaction between Age-regrouped and immigration status on the perceptions of their access to government services,  $F(24, 138) = 1.01$ ,  $p = .46$ , partial  $\eta^2 = .15$ ; and no significant main effects for Age-regrouped,  $F(24, 138) = 1.18$ ,  $p = .28$ , partial  $\eta^2 = .17$ , and immigration

status,  $F(12, 68) = .92, p = .53$ , partial  $\eta^2 = .14$ . There are no differences in the perceptions of new immigrants and U.S. citizen immigrants. This was p-value greater than the level of significance value of 0.05, which showed that the participants' responses about their perception of access to government services were not significantly different according to age and status of the immigrant. Because of this, the null hypothesis was not rejected. There was no difference in the means for new immigrants and U.S. citizens immigrant in the perception of their access to government services between ages 18-27, 28- 37 and 38-Above from Midwestern counties.

RQ 3. What differences exist in immigrant perceptions of their access to government health services, with respect to immigrant status of the immigrant?

To address research question three, a two independent sample t-test was conducted to evaluate the effects on the perceptions of access to government services with respect to the status of the immigrants. The results of the two independent sample t-test indicated no difference in the means in the perception of access to government services according to the status of the immigrant. The results of the two independent sample t-test,  $(t(83) = -0.53, p = 0.59)$ . This was p-value greater than the level of significance value of 0.05, which showed that the participants' responses about the perception of their access to government services were not significantly different according to status. Because of this, the null hypothesis was not rejected.

The theoretical framework for this study was based on, Rawls' theory of justice developed by John Rawls (1971) and social stratification theory, one of the oldest sociological theories explaining divisions of power and wealth in society (Adam & Bell, 2016; Anthias, 2013; Lenski, 2013). Rawls's theory of justice describes how ensuring

that fairness and equality for all members of society is paramount to the health of the society as a whole. Society does not function optimally when members are not treated with equal justice (Garrett, 2005; Rawls, 1971). The latter theory suggests that resources, and thus social status, of an individual at birth will determine the resources and status they will acquire later in life (Parkin, 2013). As such, it is of the utmost importance to help individuals at an economic, social, or physical disadvantage which includes vulnerable populations such as immigrants in the U.S. (Ayon, 2014).

Previous literature indicated that access to vital resources within immigrant communities was severely lacking (Ayon, 2014; Liao, 2015; Pandey, Cantor, & Lloyd, 2014; Sharmeen Shommu et al., 2016). Several factors including social, cultural, and political climates, contribute to the challenges faced by immigrants in the United States (Pereira et al., 2012; Upadhyaya, 2008). Immigrants especially need assistance with healthcare and education, but face unique challenges such as language differences and lack of information to receive the support they need (Ford, 2013; Garrett, 2005; Lemu, 2015; Vesely, 2013; Yang, 2010). Furthermore, research suggests that cultural differences influence how an individual perceives social justice and that immigrant needs are often underrepresented or ignored (Adam & Bell, 2016; Jost & Kay, 2010; Rodriguez-Valls and Torres, 2014; Sommers, 2013).

The 2001 California Health Interview Survey Adult Questionnaire CHIS) was used with little modification to provide data for this study. The CHIS survey consists of sixteen questions using Likert-type scales (5 = strongly agree; 1 = strongly disagree) as well as a few open-ended questions to confirm or expand upon information obtained from

respondents. The sample size was 85 participant adults over the age of 18. Results showed that a majority of the 85 participants surveyed have strong access to government services and that there was not a significant difference between the responses according to gender, age or immigrant status.

### **Discussion of Results**

The purpose of this study was to assess the perception of access to healthcare and government services in Midwestern U.S. counties for immigrants. However, the majority of immigrants in this study were found to have a strong access to support services. While the research questions proposed in this study were based on the previous literature that suggested very limited access, this study found that services were perceived as both available and accessible in the community. For example, the first item, “there is a place that I usually go to when I am sick or need advice about my health,” majority of the participants either agreed or strongly agreed. This study specifically looked at gender, age, and immigration status as possible factors in determining whether an individual felt a reduction in access to support services. The three factors were not significant contributing factors which affect perception.

There are a few possible explanations why the population survey had both knowledge of strong access to support services. One, there could be better access in the area surveyed than in other regions; as such the results cannot be generalized to the entirety of the immigrant population. Two, the demographics indicated that the majority of respondents held an advanced degree. Education levels are known to increase the awareness of and likeliness to seek out support services (Adam & Bell, 2016). Higher

education levels also suggest higher paying jobs and, concurrently, the possibility of receiving health insurance benefits through employment, thus making healthcare services more affordable and more accessible (Adam & Bell, 2016). Such an interpretation would be in line with Social Stratification Theory because it outlines how the social stratum that a person occupies impacts every aspect of life, from the economic state and education level to physical health (Adam & Bell, 2016; Anthias, 2013; Lenski, 2013; Parkin, 2013). Thus a person's educational level would impact a person's access to social support. This population also surveyed only immigrants who have obtained legal permission to be in the country. Undocumented immigrants would clearly face additional challenges and barriers (Javier, Huffman, Mendoza, & Wise, 2010).

Due to the fact that the results showed the majority of those surveyed had strong access to support services, it is reasonable that there would be fewer deterrent factors such as gender or immigration status because there are fewer deterrents in general or those deterrents are easier for this sample to overcome. On the other hand age factor could perceive more access to services because they have been in the country longer and thus have more experience with navigating support systems than those who have more recently immigrated (Sharmeen Shommu et al., 2016; Zong & Batalova, 2015). Further research would be needed to evaluate if time spent in the country has an impact on an immigrant's likelihood to seek out support services and could influence how services attempt to reach those newer to the country.

The majority of those surveyed was also legalized U.S. citizens and thus may have more familiarity with the available support services and how to access them

(Upadhyaya, 2008). It is possible that those who have been in the country longer or have gone through the process of becoming a legal citizen feel more cultural integration into the U.S. and thus feel less stigmatized, making them more likely to seek out support services (Upadhyaya, 2008). Again, further research would need to be conducted specifically looking at this variable to determine if length of time spent living in the U.S. influences the knowledge and accessibility of support services available to immigrants.

### **Discussion of Results in Relation to the Literature**

The purpose of this study was to assess the perception of access to healthcare and government services in Midwestern U.S. counties for immigrants. Previous literature has shown that immigrants have severely limited access to support services in the United States (Ayon, 2014; Liao, 2015; Luemu, 2015; Pereira, Crosnoe et al., 2012; Sharmeen Shommu et al., 2016). The problem is that limited access to services creates negative consequences such as impoverished conditions including lack of education and poor health, as well as directly influencing chances of improving these conditions (Javier et al., 2010; Sharmeen Shommu et al., 2016). The majority of immigrants residing in the Midwestern United States who were surveyed reported strong access to support services. This does not suggest that the previous literature and the current study are in direct opposition, but rather that the current study provides additional information to the academic community and provides more factors to investigate in future research. Specifically, future research would benefit the community if it looked at the contributing

factors to the increased access to support services within the immigrant population sampled.

Despite the projected image of the United States as a country with a diverse population, its governmental policies have become increasingly more restrictive to immigrant populations (Ayon, 2014; Millet, 2014). Specifically, developing and passing policy such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, has made it so that undocumented immigrants are no longer qualified for government support services as well as creating a 5-year minimum residency requirement for legal immigrants to begin accessing these services (Ayon, 2014; Glick, 2010). Furthermore, the literature has also shown that restricted access to these services is detrimental to the well-being of immigrants in this country and thus to the health of the society as a whole (Sharmeen Shommu et al., 2016; Upadhyaya, 2008; Zong & Batalova, 2015). While previous literature has shown that political and social culture restricts access to immigrants, the current study showed that at least some of the immigrant population is utilizing support services available to them, which according to literature should help their well-being and future success (Ayon, 2014; Liao, 2015; Luemu, 2015; Pereira et al., 2012). The current study then can be seen as not a contrast to previous literature, but as additional information to be considered in future research

The age of an immigrant may influence the perceived access to support services. This could be an important issue to investigate because the age of immigrants has not been adequately researched in the previous literature. While research has shown that immigrants often do not realize their children are eligible for support services, it has



not shown whether the age of the immigrant affects their own perceived access to support services (Javier, Huffman, Mendoza, & Wise, 2010). Age may also influence access as it relates to less life experience or to less time spent in a new country and thus less familiarity with navigating the process to obtain support services.

An important consideration is the fact that undocumented immigrants face additional barriers including fear of severe consequences should they seek government support services (Javier, Huffman, Mendoza, & Wise, 2010). This fear prevents them from accessing the services that are available to their children. Undocumented immigrants are difficult to reach and much less willing to risk exposure and face the ramification of such exposure. (Ayon, 2014; Millet, 2014; Upadhyaya, 2008; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). While the results of the current study suggested that the immigrant population surveyed reported uncharacteristically high access to support services, they do not represent the entire immigrant population nor do they represent the fraction of the immigrant population most in need. This is one of several limitations to be discussed in the following section.

### **Limitations**

There are several limitations to the study contributing to these results. The first and primary limitation has to do with the sample. Both the size and demographics of the sample could have influenced results. This study was limited by a small sample of 85 participants, which limits the generalizability of the results. The majority of the population surveyed held advanced degrees, which is not representative of the entire population. (Lemu, 2015; Pereira et al., 2012). Education level influences levels of

income and both education and economic status influence the likelihood to seek out and have access to support services as described by Social Stratification Theory (Lanski, 2013; McLeod, 2013; Muntaner, Vanroelen, Christ, & Eaton, 2013). While the demographics collected were informative, additional information such as salary and financial stability would also be beneficial to understanding why this population had such strong access to support services. The study data also lacked demographic information about the length of time an individual had been in the country, which may have influenced an individual's access to and knowledge of support services. The factors of age and immigrant status should be seen as significant discussion in the perceived access to support services in this study; it would be valuable to know whether older immigrants have been in the United States longer and if that contributes to their knowledge and access of support services. Also, immigrant status can contribute to accessing support services.

Another limitation of the sample was the lack of undocumented immigrants surveyed, as they are the most vulnerable population within the immigrant community and thus most in need of support services (Javier, Huffman, Mendoza, & Wise, 2010). However, as previous literature has shown, this population is harder to reach and more reluctant to participate in studies for fear of unwanted consequences (Bustamante et al., 2012; Xu & Brabeck, 2012; Yang, 2010).

### **Implications of the Results for Practice, Policy, and Theory**

This study attempted to assess the perception of access to support services within the immigrant population with some unexpected results. The majority of this particular

sample demonstrated strong access to support services, which contrasts with previous research that has shown that immigrants have limited access to these vital support services (Ayon, 2014; Liao, 2015; Lemu, 2015; Pereira et al., 2012; Sharmeen Shommu et al., 2016). This suggests that some immigrants do have strong access to support services and as such has important implication for practice, policy and theory. For example, understanding why this sample has strong access to support services could help inform the practice of support services in environments or among individuals that do not have strong access. It could be that the framework of social justice is more practiced in this area by giving equal opportunity and programs to all of its members, especially the disadvantaged members of society and that would account for the strong access to support services among a population that historically does not have such access (Garrett, 2005; Rawls, 1971). In addition to practice, a closer examination of the policies in place in this region in contrast to other regions where support services are reduced in access could help to shape theoretical foundations for future policy makers (Pereira et al., 2012; Vass, 2010).

Examining the results in light of the two theories driving the current study reveals insightful interplay and useful considerations. The two primary theories used within the current study were Rawls's theory of justice and social stratification theory. It is essential to understand the implications of the results by placing them within the context of these two theories and how the theories and results inform one another. Rawls has stated the necessity of establishing equality in terms of opportunities and accessibility to resources as the foundation for modern society (Garrett, 2005; Rawls, 1971).

Another central concept within this theory by Rawls is the fair distribution and allocation of goods and services to all members of society paying careful attention to society's most vulnerable or disadvantaged populations (Adam & Bell, 2016; Garrett, 2005; Sommers, 2013). The results, specifically that the majority of the sample used reported strong perceived access to support services, suggests that at least within this sample in this specific region, the theory of social justice is more widely practiced and recognized as essential to societal health (Jost & Kay, 2010). Further evaluation of why this sample had stronger perceived access is necessary for examining the overall implementation of the theory of social justice. This critical concept ensures policy makers create and implement assistance programs and fair practices in regards to supporting immigrant populations with emphasis on educational and healthcare needs (Jost & Kay, 2010; Sommers, 2013).

Social stratification theory is one of the oldest attempts at explaining social and economic divisions of power and wealth in society (Anthias, 2013; Lenski, 2013). The theory suggests that the strata a person resides in will have direct consequences on virtually all aspects of life including education, financial security, and both physical and mental health (Lenski, 2013; Parkin, 2013; Thomas, Chiarelli-Helminiak, Ferraj, & Barrette, 2016). This theory is particularly useful for thinking about the demographic information gathered on the sample for the current study.

These results also show that within this sample, some individuals could be reaping the benefits of belonging to a higher educational stratum (Lenski, 2013; McLeod, 2013). Further evaluation of what is helping this sample have such strong

access to support services is needed to further understand the implication of the social stratification theory at play in these results. In addition to looking at the quantitative data found in the current study, the theory of stratification in conjunction with this data could help to inform the qualitative aspects of the challenges facing immigrant population (Lenski, 2013; McLeod, 2013). Meaning, rather than just viewing the data strictly as numbers and percentages, this theory in conjunction with the data can help to evaluate how things like education influence access to support services and income disparities across different groups.

### **Recommendations for Further Research**

In addition to adding insight and information, the most significant contribution this study made may be the implications it has for future research. This study looked at the factors of gender, age, and immigration status and revealed that many other important factors need to be examined in future research. The factors identified for future research during this study include: financial background, annual salary, type of employment, length of time spent in the United States. The research could also be strengthened by including information for undocumented immigrants as they are the most vulnerable fraction of the immigration population (Bustamante et al., 2012).

The scope of this study was delimited by sample environment, which was restricted to the Midwestern United States. More research is needed to look at other regions and environments in order to obtain a larger picture and more generalizable results. The current study did not show significant differences in gender, age or immigrant status; however, these factors need more consideration in the future.

Further investigation based on the results of the study could help benefit policy and frameworks by highlighting what policy makers can do to encourage the utilization of support services within the immigration community. Thus, further research on why and how the sample used in the current study had access to support services is key to understanding the factors needed to make available the resources and services necessary for a fair, just, and equal society.

## **Conclusion**

The purpose of this study was to contribute to the body of research. Despite, or perhaps because of, unexpected results, the study succeeded in adding new knowledge to the literature. While much of the previous research has shown the lack of access immigrants have to social services, the current study revealed that there are some immigrants that have a strong access to social services. This is valuable information and can help to direct future research to not only examine the negative factors, those reducing access, but also the positive factors, those that might increase access to vital social services and resources.

The results showed that all three factors (gender, age, or immigrant status) did not significant influence access to services. However, repeating this study with other samples in other regions would be beneficial. While some results were unexpected, the current study has contributed new knowledge and possible directions for future research. The problem of limited access to social services within the immigrant community is an ongoing issue that affects not only the immigrant community, but all of society. For justice does not exist in a society where even one individual does not have fairness and

equality when it comes to basic human rights. This includes access to the vital services and resources that can contribute to a person's ability to not only survive, but to give them an opportunity to thrive.

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## **Appendix A: Consent Form**

**Research Study Title:** A Study of Access to Support Services by Immigrant Populations in Midwestern Counties in the United States

**Principal Investigator:** S Pee Vululleh

**Research Institution:** Concordia University-Portland

**Faculty Advisor:** Dr. Sally A. Evans

### **Purpose and what you will be doing:**

The purpose of this survey is to explore a better understanding of the factors that reduce immigrant access to government assistance and also seek to identify the major factors that contribute to assistance gap among immigrant families as compared to native-born families and how these factors influence immigrant help seeking behavior. The researcher expects 85 respondents/volunteers to take this survey. Enrollment is expected to begin on January 5, 2017 and end on January 14, 2017.

**Procedures:** If you agree to participate in the study, you will be requested to sign a consent form, confirming you agree. Following your consent, you will be asked to respond to or participate in a survey questionnaire that will last for about 5 minutes or less. You are free to discontinue the survey at any point, as you wish, without any negative consequences. You are selected and invited to participate in this research because as an educator and parent, you have significant experience to share and provide relevant information to the study. The information gathered in this study will help researchers and service providers to understand links between immigrant status and

access relating to help seeking behavior. Please read this consent form and ask any questions you may have before participating in this survey.

**Risks:** There are no risks when you participate in this study. The researcher will protect your information. No data in this study will have your identifying information. You will not be identified in any publication or report. Your information will be kept private at all times. There is no chance that the questions that you will be asked will make you feel uncomfortable. You are free to skip any item and can stop filling out the survey without penalty or hard feelings.

**Benefits:** The study would inform public policy and education, creating more awareness, to engage in action that will improve immigrant access to needed government services. The findings of this study will allow researchers and expert practitioners in the field to learn more about the relationships between immigrant status and access to government social support. There will be no compensation for the participants.

**Confidentiality:** This research records and information will be kept private and confidential and will not be exposed to any agency. No one, besides the researcher, will know that the information you give comes from you. That is, findings from the study will report only general information, for example, gender, age, country difference, and immigrant status, will be used. In any report published, the researcher will have no information included that will identify you in any way. The signed consent forms will be kept in a locked file cabinet where only the researcher will have access to and will be kept for three years following the completion of the study per Federal regulations after which all study documents will be destroyed.



**Right to Withdraw:** Your participation in this survey is whole heartedly appreciated. You are free at any time to choose not to engage with the survey. You may skip any questions you do not feel comfortable to answer.

Your participation in this research is your choice and is completely voluntary. This means that you may change your mind and withdraw your participation at any time. Your decision whether to participate or not, will not affect your relationship, in any way, with the researcher or Concordia University, Portland.

**Contact Information:** If you have questions you can talk to or write the principal investigator, [Name, email, phone redacted]. If you want to talk with a participant advocate other than the investigator, you can write or call the director of CU-P institutional review board, [Director's name, email, phone redacted].

**Your Statement of Consent:** I have read the above information. I asked questions if I had them, and my questions were answered. I volunteer my consent for this study.

_____ Participant Name	_____ Date
_____ Participant Signature	_____ Date
<u>S Pee N. Vululleh</u> Investigator Name	<u>10/20/2016</u> Date
_____ Investigator Signature	_____ Date

Investigator: S Pee N. Vululleh email: gantatti2006@yahoo.com  
C/o: Professor: Dr. Sally A. Evans,  
Concordia University–Portland  
2811 NE Holman Street  
Portland, Oregon 97221



## **Appendix B: Questionnaire/Survey Instrument**

### **Demographic Questionnaire**

DQ1. Gender: ---Female ---Male

DQ2. Were you born in the United States? --Yes -- No

DQ3. Which region of the country do you live in?

Midwest- IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI

Northeast- CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT

Southeast- AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV

Southwest- AZ, NM, OK, TX

West- AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY

DQ4. Age:

Below 18

18 –27

28 -37

38 -47

48 – 57

58 – 67

68 -77

78- Above

DQ5. Education Level

Less than high school

High school graduate

Some college

2-year degree

4-year degree

Professional degree

Doctorate

DQ6. Immigrant Status

Permanent Resident

Non-Permanent Resident

U.S. Citizen

DQ7. Employment Status

Employed

Unemployed

Self-Employed

Retired

Military

Student

## Questionnaire

Instructions: Rating scale: Please select the number/option below that best represents how you feel about your experience as an immigrant. 5 = Strongly Agree, 4 = Agree, 3 = Neither agree nor disagree, 2 = Disagree, and 1 = Strongly Disagree.

Questions	Strongly Agree 5	Agree 4	Neither agree nor disagree 3	Disagree 2	Strongly Disagree 1
There is a place that I usually go to when I am sick or need advice about my health.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The main reason I do not have healthcare is because I do not know where to go or how to sign up for care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not have a source of healthcare insurance because it is too costly.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not have a source of healthcare because of the cost of medical care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I do not have a usual source of healthcare because I am not able to find a provider who speaks my language.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I do not have a usual source of healthcare because I have no insurance or lost insurance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I delay or do not get my prescriptions filled because the insurance company will not approve, cover, or pay for my care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I delay or not get my prescriptions filled because of transportation problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thinking of my experiences with receiving healthcare in the past, I felt I was discriminated against because of my language or my accent.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thinking of my experiences with receiving healthcare in	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

the past, I felt discriminated against because of my gender (because I am a male or because I am a female).					
Thinking of my experiences with receiving healthcare in the past, I felt I was discriminated against because of my age.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thinking of my experiences with receiving healthcare in the past, I felt I was discriminated against because of my country of origin.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The main reason I do not go to school to continue my education is because of the high cost.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

To provide more confirmation or verifications for the findings of some of the concerns noted, the following questions will also be used:

1. Describe your experience with receiving healthcare services.

2. How has your family benefited or not benefited from healthcare services?
3. What would you like to see improved for better access to public services?

## Appendix C: Statement of Original Work

I attest that:

1. I have read, understood, and complied with all aspects of the Concordia University- Portland Academic Integrity Policy during the development and writing of this dissertation.
2. Where information and/or materials from outside sources has been used in the production of this dissertation, all information and/or materials from outside sources has been properly referenced and all permissions required for use of the information and/or materials have been obtained, in accordance with research standards outlined in the *Publication Manual of The American Psychological Association*



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Digital Signature

S Pee N. Vululleh

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Name (Typed)

01/23/2018

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Date