Sociogeographic Determinants of Health among Unauthorized Immigrants, Young Adults and other Hard-to-Reach U.S. Populations

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"Human Dynamics Research Cluster" (HDRC) Lightening Talk

SAN DIEGO STATE UNIVERSITY

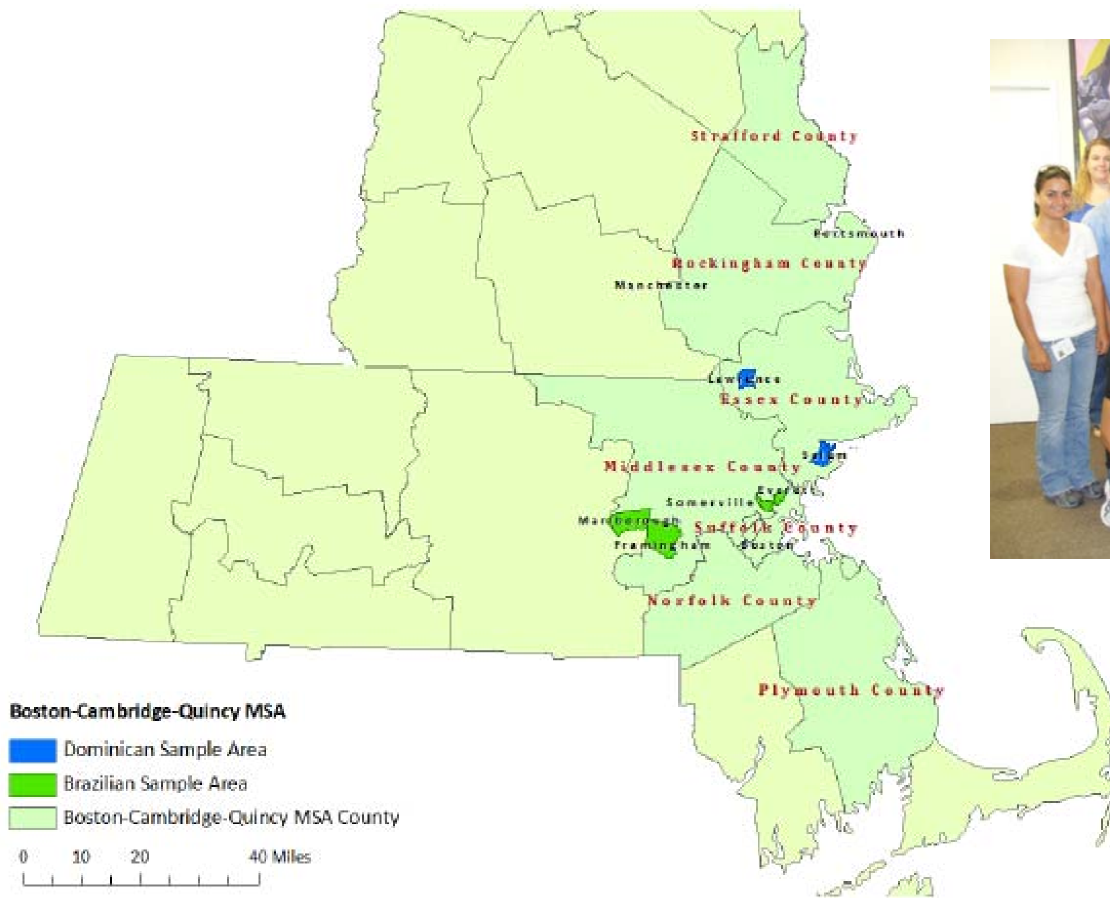
The Community-based Migrant Household Probability Sample Survey

- 1994, 2001 & 2012 Los Angeles County Mexican Immigrant Health & Legal Status Surveys (LAC-MIHLSS)
- 2007 Boston Metropolitan Area Immigrant Health & Legal Status Survey (BM-IHLSS)
- 2014 San Diego County Mexican Immigrant Health & Legal Status Survey (SDC-MIHLSS)

Marcelli, Enrico A. 2014. "Community-based Migrant Household Probability Sampling," in M.B. Schenker et al., Eds., Migration and Health Research Methodologies: A Handbook for the Study of Migrant Populations. Berkeley and Los Angeles, CA: University of California Press, forthcoming.

San Diego State University

2007 Boston Immigrant Health & Legal Status Survey (BM-IHLSS)



San Diego State University

Examples of Publications …

(In)Visible (Im)Migrants:
The Health and Socioeconomic Integration of Brazilians in Metropolitan Boston

Enrico Marcelli, San Diego St
Louisa Holmes, University of So
David Estella, Brazilian Immigrant Center & Massachusetts
Fausto da Rocha, Brazilian Imi
Phillip Granberry, University of Mas
Orfeu Buxton, Harvard Med
Foreword by:
Maxine L. Margolis, Universi

Unauthorized Mexican Workers in the 1990 Los Angeles County Labour Force[1]

Enrico A. Marcelli* and David M. Heer**

ABSTRACT

By analysing how unauthorized Mexicans compare with seven other ethno-racial groups in Los Angeles County, separately and collectively, by educational attainment and time spent in the US, we find that unauthorized Mexicans had relatively fewer years of formal education (either in the US or in Mexico) and had been in the US a relatively fewer number of years than in-migrants of other ethno-racial backgrounds in 1990. These findings are then used as proxies to compare the human capital endowments of different ethno-racial groups. We next estimate the number of unauthorized Mexicans by occupation, industry and class of worker, and compare these distributions with the total labour force and with the other ethno-racial groups in Los Angeles County. To the extent that unauthorized Mexicans are found to be substitutes (complements) in the labour market, they can be expected to be a valid (invalid) empirical source of social tension and hence contemporary restrictionist immigration policy sentiment. Results show that amounts of human capital are positively related to the kinds of occupations filled. Analysis of the percentage of discordant pairs shows that unauthorized Mexicans are found to be most dissimilar (potential complements) to non-Latino (1) Anglos; (2) Blacks; (3) American Indians, Aleuts, and Eskimos; and (4) Asians and Pacific Islanders. Results also show that those ethno-racial groups most similar to (potential substitutes for) unauthorized Mexicans are (1) legal Mexican in-migrants and (2) other Latino foreign-born persons (both authorized and unauthorized). The ethno-racial group which falls into the intermediate realm of (dis)similarity is US-born Mexican. Consequently, for most persons residing in Los Angeles County the rise of restrictionist immigration sentiment is not consistent with their labour market experiences, and restrictionist immigration policy, to the extent it is based on a labour market competition assumption, may not be justified.

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The Unauthorized Residency Status Myth: Health Insurance Coverage and Medical Care Use among Mexican Immigrants in California

Enrico A. Marcelli
Harvard University

ABSTRACT
Informed by recent developments in the behavioral model of medical care use and social epidemiology, this article employs
rized residency status among non-elderly M
in California influenced the probability o
received medical care. Unauthorized resid
the probability of having been insured, a
relied on public health insurance. Howe
characteristics, neighborhood context, an
dency status appears to have influenced w
care. Rather, neighborhood context, diffi
civic engagement appear to be more imp
services.
Keywords: 1. International migration, 2.
4. Mexico, 5. United States.

RESUMEN
Tomando en cuenta los avances recientes e
cia médica y la epidemiología social, est
estimar si el estatus de residencia no auto
llegan a la vejez y otros inmigrantes latinos
que tuvieran seguro de salud y recibieran a
residencia no autorizada ha disminuido la
y, a su vez, ha aumentado la de que re
embargo, después de controlar otras caract
dad y el capital social, ni el seguro ni el esta
que una persona obtuviera la asistencia m
vecindad, la dificultad para encontrar un
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Palabras clave: 1. migración internac
indocumentados, 4. México, 5. Estados U

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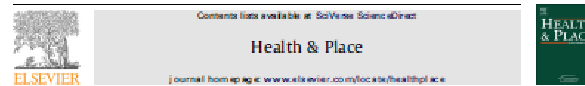

Neighborhoods and systemic inflammation: High CRP among legal and unauthorized Brazilian migrants

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ABSTRACT

We estimate cross-sectional associations of neighborhood-level disorder, socioeconomic characteristics and social capital with individual-level systemic inflammation, measured as high C-reactive protein (CRP), using Boston Metropolitan Immigrant Health & Legal Status Survey (BM-IHLSS) data—a sample of relatively young, healthy foreign-born Brazilian adults. Logistic regression analyses suggest high CRP is positively associated with neighborhood disorder and negatively related to neighborhood social capital. Although we find no significant associations between other neighborhood socioeconomic variables and high CRP; males, those who were born in an urban area and those who had been graduated from high school were less likely to have had high CRP. Unauthorized Brazilian adults, those who smoked cigarettes daily and those who had a higher body mass index were more likely to have had high CRP. Our findings suggest that investigating sociogeographic stressors and social support may be important for understanding physiological dysregulation even among relatively healthy U.S. sub-populations.
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1. Introduction

The observation that newcomers to a socioeconomically disadvantaged urban area may be at greater risk of various diseases and all-cause mortality was first recorded by John Graunt in the 17th century, and since then many physical and social risk factors have been implicated in this process (Macintyre and Ellaway, 2003). Indeed, the origins of American public health began by acknowledging the need to protect the working class, many of whom were immigrants residing in impoverished neighborhoods, from both environmental and social toxins associated with early and rapid industrialization and urbanization—that is at home and work (Duffy, 1992; Melosi, 2000). Residents of lower income areas have been shown to be more susceptible to conditions such as psychological distress and depression (Hill et al., 2005; Ross, 2000), obesity (Mujahid et al., 2008) and chronic disease (Cubbin et al., 2001; Murray et al., 2010). The mechanisms linking disadvantage to disease are varied and not always well-understood; however, lower income groups that are also disproportionately composed of ethno-racial minorities, including immigrants, are more likely to live in residentially segregated neighborhoods (Acevedo-Garcia and Lochner, 2003; Massey and Denton, 1998), areas of higher crime and with greater alcohol and fast food outlet density (Block et al., 2004; Cohen et al., 2008; Kwate et al., 2009), as well as areas with less access to municipal services like recreational facilities or walkable sidewalks that may promote health (Cubbin et al., 2001; Holmes and Marcelli, 2011; Lovasi et al., 2009a). Most studies demonstrating these links rely on measures of individual income, often aggregated to a "neighborhood" or local area boundary, to define associations between illness and disadvantage; however, those that have instead constructed measures of neighborhood-level SES have similarly found material deprivation to be associated with poor health outcomes (Bird et al., 2010; Merkin et al., 2009).

More recently and increasingly, neighborhood socioeconomic disadvantage has been linked to cardiometabolic disease (Augustin et al., 2008; Cubbin et al., 2001, 2006; Diez Roux et al., 2001; Murray et al., 2010) and cumulative biological risk for disease (Bird et al., 2010; Finch et al., 2010; Merkin et al., 2009). However, much less research exists on more specific links between neighborhood sociogeographic factors and physiological mechanisms that may be important for predicting disease onset (Buxton and Marcelli, 2010). Chronic systemic (as opposed to acute) inflammation has emerged as a potentially decisive risk factor for the development of cardiometabolic disease, and validation of high-sensitivity assays for inflammatory markers like C-reactive protein (CRP) have made it possible to measure inflammation in population-based studies (McDade et al., 2004). CRP—an acute phase protein produced in the liver in response to

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The 2014 Multi-mode San Francisco Bay Area Young Adult Health Survey (BAYAHS)

Marin County
Contra Costa County
Albany
Berkeley
Emeryville
Piedmont
Oakland
Alameda
Seacliff
Downtown
Mission
San Francisco County
Lakeshore
Bayview
San Leandro
Castro Valley
Ashland
Fairview
San Lorenzo
Hayward
Dublin
Pleasanton
Livermore
Alameda County
Union City
Sunol
Newark
Fremont
San Mateo County
Santa Clara County

SAN DIEGO STATE UNIVERSITY

The 2014 Multi-mode San Francisco Bay Area Young Adult Health Survey (BAYAHS)

Completed Questionnaires by Ethnoracial Group

600
500
400
300
200
100
0

Target
NH Asian/PI
NH White
Latino
NH Black

San Diego State University

Estimated Number of Unauthorized Migrants by County, Percent, CA

Del Norte
South Sacramento
East Oakland
Richmond
Southwest Merced / East Merced County
Central / Southeast / Southwest Fresno
East Salinas
South Kern County
Boyle Heights
South Figueroa Corridor / Vermont-Manchester
Central Santa Ana
East Coachella Valley
Central Long Beach
City Heights

Percentage Uninsured
Total non-Cuban Foreign-born
1.7% - 3%
3.1% - 6%
6.1% - 9%
9.1% - 18.1%

0 30 60 120 180 240 Miles

Data: 2012 LAC-MIHLSS & 2008-2012 ACS PUMS

A Sociogeographic Model of Health

SOCIOGEOGRAPHIC FACTORS

Individual-Sociogeographic Interaction

OUTCOME

Distress

INDIVIDUAL-LEVEL FACTORS

Thank You.

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