

**The Invisible Unattended: Low-wage Chinese Immigrant Workers, Health Care,  
and Social Capital in Southern California's San Gabriel Valley**

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## **Abstract**

This study investigates the availability of health insurance, access to health care, and health care information dissemination among low-wage Chinese immigrants in Southern California. Pierre Bourdieu's capital analysis is used as the major theoretical strategy to examine health care information dissemination and its relations to access to health care. Our findings reveal a severe shortage in health care coverage among low-wage Chinese immigrants. The lack of coverage is partially explained by the lack of employment with employer-provided health insurance within the Chinese ethnoburb. Results also suggest significant capital deficits among low-wage Chinese immigrants. Despite the possession of social capital, network closure caused by the language barrier negatively affected the flow of health care information from mainstream American society into the low-wage Chinese immigrant community.

**Keywords:** Immigrant Community, Ethnoburb, Health Care, Social Capital

## **The Invisible Unattended: Low-wage Chinese Immigrant Workers, Health Care, and Social Capital in Southern California's San Gabriel Valley**

### **Introduction**

This study investigates the availability of health insurance and accessibility to health care among low-wage Chinese immigrants in Southern California. Accessibility is further examined through information dissemination within the community. Health care availability and accessibility have become serious social issues in the United States. Data released by the U.S. Census Bureau suggest the lack of health care insurance and coverage is significantly related to low income, poverty, immigration, and the quality of employment (U.S. Census Bureau 2007). Our research indicates that the unavailability of health insurance and the lack of accessibility to health care are major problems faced by low-wage documented and undocumented Chinese immigrants in Southern California. The extremely limited availability of health insurance and the lack of accessibility to health care among low wage Chinese immigrants are potentially explained by the dearth of full-time and quality employment that provides health insurance benefits and adequate wages, and by gaps in information dissemination within the community. Thus, we argue that it is crucial to firstly examine employment as a key process that provides access to health insurance and health care. However, no known research has been done to understand how the availability of health insurance and the accessibility to health care has been affected by the quality of employment and the employment structure of low-wage Chinese immigrants. Our study thus highlights the relationship of immigrant health care to employment.

In addition, there has been no scholarly effort in understanding the strategies used by low-wage Chinese immigrants to overcome the lack of accessible health care services. The preliminary findings of our study suggest that low-wage Chinese immigrants were frequently forced to substitute mainstream health care services, such as those available through public hospitals and primary care physicians, with alternate health care options or delay care altogether. Critically, their general lack of awareness of public health care programs meant that their options were mostly limited to self-medication and free or low-cost health clinics set up by Chinese charitable organizations. In this regard, we argue that gaps in the dissemination of health care information within the community further reduced the accessibility of health care for low-wage Chinese immigrants.

This study focuses on several empirical issues facing low-wage Chinese immigrants in Southern California. Specifically, this study examines health care and its relationship with the type and quality of employment among low-wage Chinese immigrants. The following questions are to be addressed: 1) the overall health care coverage in the Chinese community; 2) the quality of obtainable employment and its relationship to health care availability and accessibility; 3) the strategies used by respondents to compensate for the lack of health care coverage; and 4) language capacity, social capital, and the dissemination of information regarding health care resources among low-wage Chinese immigrants.

The major theoretical approach used in this study is Bourdieu's capital analysis. Using work and health care as empirical illustrations, this study attempts to address the relationship between the various forms of capital possessed by individuals and collectives, and the effectiveness and limitations of social capital in the accumulation of

further resources and capital. The interaction of language capacity as a form of cultural capital with the acquisition and employment of social capital is argued as the key process in enhancing or prohibiting the access of individuals and collectives to key resources.

### **Pierre Bourdieu's Forms of Capital and Beyond**

Bourdieu theorized capital as the sum of all symbolic or tangible resources known to individual and corporate actors (Bourdieu 1986: 241). Possessing capital motivates and facilitates actors to take further actions to maximize their interests. On the other hand, capital could also become a form of constraint in limiting the outcomes of actions. Furthermore, Bourdieu argues one form of capital is translatable into other forms of capital. Actors are capable of transforming one form of capital into other forms to enhance their actions and positions. However, that also means when actors do not possess key forms of capital, they will experience difficulties in accessing and securing other forms of capital.

In Bourdieu's framework, three forms of capital were specified<sup>i</sup>: economic capital, cultural capital, and social capital (Bourdieu 1980; 1986). Of the three forms of capital, only economic capital is tangible in nature. Economic capital is any material resources available to actors. Physical wealth is a manifestation of economic capital. Cultural capital<sup>ii</sup> refers to skills and knowledge possessed by actors that are recognized by others. Language can be understood as a critical form of cultural capital. Finally, social capital is the actual or potential resources that are gathered from interactions and exchanges in a more or less durable network. Unlike other forms of capital, social capital is not entirely possessed by the individual or corporate actor. Rather, it is embedded in the network of

actors. Therefore, the forms and nature of the networks in which the actor is situated determines the actual amount of social capital available to an actor.

Two specific analytical characteristics of the forms of capital framework and social capital are particularly noteworthy to the present study: the interchangeable nature of different forms of capital and its implications to advantages and structural inequality. As Bourdieu (1980; 1986) theorized, one form of capital can be converted into other forms. This is similar to Coleman's (1988) conceptualization of social capital. In Coleman's (ibid) terms, one form of capital (financial, physical, human or social) can aid in the creation of another. Accordingly, economic or cultural capital can facilitate new interpersonal relationships that would lead to the formation of social capital. By virtue of membership in a specific social group, one could use these interpersonal relationships to engage in further goal-seeking actions. However, it also means that the deprivation of economic or cultural capital also inhibits and places constraints on the accumulation of social capital.

In relation, Lin (2000) commented that while resource acquisition is a significant application of the forms of capital framework and social capital; the framework is also useful in explaining perpetuation of structural inequality and disadvantage. Lin (2000) would thus note that actors would be disadvantaged in the operation of social capital if they experienced deficiencies in economic and cultural capital due to their locations in the social structure. For instance, the inequality in social capital could affect the return of effort invested by actors (Lin 2000). Some groups and individuals are able to generate a higher return of their actions with the same input of effort and other forms of capital because of their possession of social capital that is particularly effective in a specific

market (Bourdieu 1984; Coleman 1988; Lin 2000). On the same token, certain groups and individuals are inevitably less successful in maximizing their efforts in the same market simply because they have less useful social capital. Structural inequalities are thus maintained due to the unequal return of the same efforts (Lin 2000). As Lin highlighted, empirical research had shown that females and minority groups tend to face this problem of inequality in social capital (ibid: 789). In this light, our research examined the operation of social capital in the Chinese immigrant community of the San Gabriel Valley.

### **Social Capital and Immigrant Communities**

As Sanders, Nee and Sernau (2002) have pointed out, researchers of immigrant labor markets have been indebted to Granovetter's (1973, 1985) analysis of interpersonal ties and embedded networks in seeking employment and economic actions. In relation, Portes and Sensenbrenner (1993) have argued that the concept of "embeddedness," which is central to Granovetter's (1985) criticism of neo-classical economics' understanding of economic action, can be better specified through the concept of social capital (Portes and Sensenbrenner 1993: 1320-1321). In their view, the use and development of the concept of social capital would better clarify how social structure interacts with individual goal-seeking action (ibid: 1321).

In relation, they noted that immigrant communities present obvious examples of how social context matters in economic action; the circumstances of immigration, i.e. deskilling and the lack of linguistic fluency in host societies, often mean that immigrants are highly dependent on the economic opportunities available in their own communities

(ibid: 1322). They argued that bounded solidarity and enforceable trust were sources of social capital that were particularly salient within immigrant communities. In terms of the former, the shared experiences of immigrants in the processes of adaptation and settlement would encourage altruistic acts of mutual assistance amongst immigrants. On the other hand, enforceable trust emerges through instrumental action within tightly-knit immigrant social networks that have the capacity to penalize or reward individual actions (ibid: 1332). Both sources of social capital entail a degree of social closure. While Bourdieu (1980) would note that social capital is objectively instrumental in orientation, he would agree that both sources of social capital can operate distinctively and in tandem, and be recognized as such by members of a group. Nevertheless, we find that the operation of both altruistic and instrumental modes of social capital lead to similar outcomes, as the form and nature of immigrant networks have determinative effects.

In their discussion of the implications of social closure for ethnic entrepreneurs and workers, Sanders, Nee and Sernau (2002: 283) noted that a degree of social closure is implied in the emergence of trust within interpersonal networks. In particular, social closure can occur through the use of co-ethnic interpersonal relationships or of ethnic newspapers in job searches (ibid: 284). As Lin (2000) would note, a high degree of social closure would affect information diffusion within immigrant communities; information would likely not be varied nor come from diverse sources. Even so, Sanders, Nee and Sernau (2002) argued that immigrants' reliance on social ties can lead to increased job information and opportunities if they obtained direct or indirect ties to contacts outside their immigrant communities. While their findings indicated that the dependence of Asian immigrants on interpersonal networks increased the rate of transitions into jobs of low-

prestige, this was only the case for job transitions where the employer was of a different ethnicity (ibid: 306). In this sense, the social capital of immigrants, while based upon social closure and enforced trust, can produce increased information and opportunities beyond the ethnic economy if it is linked to the larger metropolitan labor market. On the other hand, there is still a need for researchers to consider the issues faced by those who have not been able to obtain access to information, opportunities and resources beyond their closed co-ethnic networks.

While most studies on immigrant communities using the social capital perspective tend to view social capital and intra-ethnic networks as largely positive and favorable in enhancing the economic actions of immigrants and communities, a number of theorists and researchers have also stated that the operation of social capital can produce ambivalent outcomes (Portes and Sensenbrenner 1993; Portes and Landolt 1996; Portes 1998; Lin 2000; Sanders, Nee and Sernau 2002). Portes (1998) stated four negative consequences of social capital that co-exist with its benefits: restricted access to opportunities for outsiders, excessive claims for help by group members on more successful members, restrictions on individual freedoms, and downward leveling norms that discourage efforts by group members to seek individual mobility (Portes 1998: 15-18). Each of them constrains and inhibits individual social mobility, and preserves collective advantage or disadvantage. More importantly, they maintain social closure.

Despite these problems, social capital is a salient form of capital for low-wage immigrants. Nee and Sanders (2001) examined the different patterns in economic assimilation among immigrants into the mainstream society. They argue that the pattern of economic assimilation is largely determined by the possession of social, financial, and

human-cultural capital by immigrant families (ibid: 388). The usage of these forms of capital within and beyond ethnic economic networks and structures are also critical in permitting immigrant families to gain access to resources in mainstream social institutions. They also noted that the social class positions of the immigrant families affected the acquisition of social capital in the host society. In particular, they observed an over-reliance of social capital among immigrants with low human-cultural and financial capital. As they commented,

Unlike financial and human-cultural capital, social capital is available to all classes of immigrants. It is a form of capital that is spontaneously produced and reproduced within the institution of the family and extended family group, and through recurrent social exchanges with in the immigrant community (2001:407).

Immigrants from lower social class positions possess significantly less capital in the financial and human-cultural forms, and therefore they are restricted to using social capital, the most accessible form of capital available to them. This dependency on social capital for economic opportunities is of note. As our findings indicate, the effectiveness of social capital in generating economic or other returns is severely limited when the other forms of capital are absent or inaccessible.

Given that social positions are not always equal, social capital could in fact reinforce existing structural inequalities. Lin (2000) argued:

Inequality of social capital occurs when a certain group clusters at relatively disadvantaged socioeconomic positions, and the general tendency is for individuals to associate with those of similar group or socioeconomic characteristics (Lin 2000:786).

The effectiveness of social capital and socioeconomic mobility must be understood and considered in conjunction with the existing structural context of the specific network.

Constraints imposed by structural conditions could render social capital ineffective in generating upward mobility.

Even with an abundance of information exchanges through network connections, the relative position of the entire network in the existing social hierarchy determines the effectiveness of social capital in facilitating the upward mobility of the individuals within society as a whole. In this regard, the quality of social capital, albeit plentiful, is compromised by macro-structural conditions and factors. For one, the diversity of information that is exchanged within is critical in determining the overall quality and effectiveness of social capital.

Resource-rich networks are characterized by relative richness not only in quantity but also in kind – resource heterogeneity. Members of such networks enjoy access to information from and influence in diverse socioeconomic strata positions. In contrast, members in resource-poor networks share a relatively restricted variety of information and influence (Lin 2000: 787)

Thus, the quality of social capital could still affect the outcome of its usage and the actor's degree of success in maximizing interests. Social capital, therefore, must be assessed in terms of quantity and quality in explaining outcomes (Lin 2000).

While social capital and its implications in economic activities and education in immigrant communities have received much attention, other areas of social life have yet to be adequately examined. Using health care and employment as empirical illustrations, this study shows that an abundance of social capital among low-wage Chinese immigrants in Southern California did not necessarily lead to success in obtaining full time employment with health insurance benefits, and in gaining access to publicly available health care services. Critically, the health care information that was accessible to the individual respondents of this study was significantly inadequate. The quality of

health care information that individual respondents received from interpersonal relationships was compromised by the overall quality of information in the community at large. Specifically, health care information that was publicly available in mainstream society was inaccessible to low-wage Chinese immigrants because of linguistic limitations. The empirical and analytical implications are explored.

### **The Structural Context of the San Gabriel Valley Chinese Ethnoburb**

The San Gabriel Valley in Southern California is a place that raises many significant empirical questions due to the demographic transformation and socioeconomic change it has experienced. The immigrant Chinese population first established themselves in the city of Monterey Park in the 1970s (Fong 1994; Horton and Calderon 1995; Zhou and Lin 2005; Lin and Robinson 2005). Despite the initial resistance from many white residents (Horton and Calderon 1995; Fong 1994), the Chinese community continued to grow and flourish. As Li (1998; 2005), Zhou and Lin (2005), and Lin and Robinson (2005) have noted, the demographic transformation and socioeconomic change of the San Gabriel Valley has been closely related to the post-1965 influx of immigration and financial capital from Chinese-speaking countries and territories in the Pacific Rim. In relation, Li (1998) has identified the residential concentration of foreign-born Chinese in the San Gabriel Valley as an ethnoburb. Ethnoburbs “can be recognized as suburban ethnic clusters of residential areas and business districts in large metropolitan areas” (ibid: 482). The emergence of this new type of ethnic settlement raises questions about the structural context that it provides for the socioeconomic adaptation of immigrants. Compared to Chinatowns, the ethnoburb seems

to offer a wider range of socio-economic opportunities due to its larger volume of economic, cultural and social capital. Nevertheless, socio-spatial inequalities persist within the ethnoburb (Lin and Robinson 2005).

The ethnoburb of the San Gabriel Valley thus presents a useful site to study the operation and effects of social capital within immigrant communities, particularly in relation to social inequality. To explain the emergence, development, and transformation of ethnic communities, Zhou and Lin (2005: 261) argued that “the interplay of financial capital, human capital, and social capital within an identifiable ethnic community may be broadly conceptualized as ethnic capital.” Their analysis of “ethnic capital” drew on the theory of the ethnic enclave economy that viewed the ethnic enclave as possessing “the potential to develop a distinct structure of economic opportunities as an effective alternative path to social mobility” (ibid: 265). In this regard, they saw the emergence of the ethnoburb in the San Gabriel Valley as being primarily driven by the flows of financial and human capital from Taiwan and the Pacific Rim (ibid: 278). And, unlike in Chinatowns, social capital emerged after the ethnoburb had begun to develop through transnational real estate and commercial development (ibid). Critically, they noted that the flows of human and financial capital have been followed by those of low-skilled<sup>iii</sup> workers, who could secure jobs through family ties or friends (ibid: 279).

Lin and Robinson’s (2005) mapping of socio-economic class within the San Gabriel Valley ethnoburb demonstrated that the Chinese community has indeed become socio-economically diverse. Through analyzing the residential patterns of the ethnoburb, they discovered spatial disparities in socioeconomic class (ibid: 55). The ethnoburb was composed of a lower-to-middle class ethnoburban core, a highly educated and relatively

linguistically assimilated northwest district, and a middle-to-upper class east district (ibid: 55). Since the 1970s, the ethnoburban core expanded from its initial center in the city of Monterey Park, and it now includes the cities of Monterey Park, Alhambra, San Gabriel, Rosemead, El Monte, Temple City and Arcadia (ibid: 57). As Lin and Robinson (2005: 57) state, the Chinese households of these cities exhibit lower median incomes, median home values, and homeownership rates; the households of Temple City and Arcadia are exceptions to this. Notably, the residents and households in the ethnoburban core also have lower levels of educational attainment and higher rates of linguistic isolation than those in the northwest and east districts (ibid).

In light of the socio-spatial structure of the Chinese ethnoburb, the clustering of residents with low levels of economic capital and cultural capital at the ethnoburban core provides a potential site to test and explore Lin's (2000) theoretical proposition on the inequality of social capital. In this regard, the employment of social capital by low-skilled immigrants located in the ethnoburban core would likely be ineffective in accruing important opportunities and resources, like jobs and health care.

Given this concentration of disadvantage, this study thus focused upon Chinese immigrants working or living in the cities in the ethnoburban core. Census data from 2000 showed an exceptionally high concentration of foreign-born Chinese persons within these cities. In the cities of Monterey Park, Alhambra and San Gabriel, the percentages of persons who described themselves as foreign-born Chinese (primarily born in Mainland China, Hong Kong and Taiwan) were 23.64, 19.68, and 17.66, respectively (US Census Bureau 2000). The national average of foreign-born Chinese, meanwhile, was less than .05% at the city level. Geographically, there are several major arteries in this area. Valley

Boulevard, the busiest of all, runs east to west north of the Interstate 10 freeway. Garvey Boulevard is the east to west main road south of the Interstate 10 freeway. Several north to south streets are equally critical to traffic and business: Garfield Boulevard, Atlantic Boulevard, San Gabriel Boulevard, Del Mar Boulevard, and Rosemead Boulevard. Because of the concentration of Chinese businesses and auto and human traffic along these routes, our research efforts were concentrated in these locations. Many interviews were conducted at grocery stores and shopping malls. The researchers also went to the alley ways behind the restaurants along the major streets to find and recruit restaurant workers.

Our observations of this core area suggested the major source of employment has been the restaurant industry. A high concentration of restaurants could be spotted along its main arteries. The researchers also observed the increased presence of foot massage shops along these thoroughfares. Census 2000 data confirmed that restaurants and other food services were the most significant form of employment, followed by the garment manufacturing industry<sup>iv</sup>. In particular, grocery stores and the construction industry were also significant sources of employment. The service, light manufacturing and construction industries thus seemed to be the main source of employment for immigrants without recognized professional skills and certification within the ethnoburban core.

## **Data and Methods**

The dearth of data and research on low-wage Chinese immigrants in ethnoburbs created an unique opportunity for the researchers to collect original data. However, the data collection process proved to be challenging. The researchers decided on a qualitative

strategy due to several methodological and analytical concerns. Due to the time-consuming nature of the interview process, a large sample was beyond the capacity of the researchers. Also, the researchers were interested in nuanced details of the respondent's immigration experience, work history, and their understanding, accounting, and usage of various forms of capital that were at their disposal. A qualitative strategy was therefore suitable in collecting smaller but highly focused data.

The interview process began in the summer of 2007 and concluded in the fall of 2008. This consisted of a street survey and a separate set of in-depth interviews. A total of 89 valid respondents were included in this analysis. 22 respondents were interviewed in depth and 67 respondents were interviewed in shorter street surveys. The 22 in-depth interviews lasted between twenty minutes to four hours. 15 restaurant workers, 11 garment workers, 20 grocery and retail workers, 4 domestic workers, and 17 other workers were included in the survey sample. 3 garment workers, 3 restaurant workers, 5 domestic workers, 5 massage workers, 3 construction workers, 2 supermarket workers and 1 transportation worker participated in the in-depth interviews. Despite the small size of this sample, it reflected the major employment sources in the San Gabriel Valley for immigrants without recognized professional skills and certification. The researchers are thus confident that the data generated through this sample is indicative of the issues faced by low-wage workers in the San Gabriel Valley.

Three major areas were included in the design of the interviews: immigration experience, work experience, and health care. The respondents were first asked to relate their overall immigration process. Questions included immigration status, motivation to leave their home countries, sponsorship, initial arrival in the United States, who offered

assistance to them upon arrival, overall perception towards the American society, finding work, establishing new friendships, getting access to basic critical social services, and so forth. The focus then turned to work-related issues. The respondents were asked about the number of jobs and industries that they have worked, wages, working conditions, basic labor rights issues, how they found new jobs, switching to a different industry, benefits and entitlements, and so forth. To assess health care coverage, the interviews were structured around several major issues: 1) whether the respondent had any form of health insurance coverage, 2) whether the respondent received health benefits from his/her employer, 3) the dissemination of information regarding public health care services among low-wage Chinese immigrants, and, 4) the strategies used by respondents to circumvent the lack of health care coverage.

Recruitment of respondents proved to be the most challenging aspect of the study. Many of the interview questions could have been considered as rude and inappropriate in Chinese culture; asking directly about one's finances, immigration status, and employment can be construed as invasions of privacy. Because we and the other researchers were raised and socialized in Chinese societies outside of the United States, we were sensitive to the social norms recognized by Chinese immigrants. As such, the researchers made efforts to bring up sensitive issues in ways that would put the respondents at ease. For instance, during interviews, the researchers asked about help received during immigration rather than asking for the interviewees' immigration status. Also, we made efforts to communicate with our respondents in their preferred dialect. Interviews were conducted in either Cantonese or Mandarin, depending on the place of

origin of our interviewees. This helped to establish a sense of familiarity and mutual understanding with our respondents.

The data collection strategies went through several phases to increase the effectiveness of recruiting suitable respondents. In the first phase, the researchers used convenient sampling as the main strategy. The researchers attempted to conduct surveys at locations with a high level of human traffic. Several sites, including parking lots and main entrances of shopping centers and supermarkets were selected. Volunteers from local high schools and organizations were recruited to assist the data collection process. All volunteers spoke Chinese in various degrees, and they went through a training session before the survey sessions. Convenient sampling turned out to be problematic because of the invasive nature of the questions and the different levels of experience of the surveyors. For example, many of the respondents surveyed by the high school students reported that they faced no problems at work, while this was not the case for respondents who spoke to surveyors who were more experienced. Also, the different dialects spoken by the surveyors and respondents created additional problems.

In the second phase, snowball sampling and purposive sampling were adopted simultaneously to increase the effectiveness of the recruitment strategy for in-depth interviews. Several interviewees were recruited through local community organizations. Several additional respondents were recruited by the original interviewees based on friendships and other interpersonal relationships. Furthermore, the researchers employed purposive sampling to target several key industries in the San Gabriel Valley. For instance, the restaurant industry was one of the most significant sources of employment in the San Gabriel Valley. To interview restaurant workers, the researchers visited the

back alley ways of restaurants during non-peak hours when restaurant workers were resting. The researchers used the same method to target grocery store workers. Several interviews were conducted when respondents were resting in the back alley ways of the supermarkets or in the adjacent food court. The researchers worked in pairs when approaching workers; this allowed us to communicate in either Cantonese or Mandarin.

Reliability and validity presented some challenges to the researchers. Given that several of our interviewees were recruited through personal relations and with the assurance of confidentiality, we were convinced that they had no reason to provide false information during the interviews. Also, the social status and the associated credibility of the researchers provided an additional advantage for eliciting candor from our respondents. When approaching our respondents, we identified themselves as a university professor and a graduate student; university professors and academics still command respect in Chinese culture. The cultural familiarity of the researchers was also indispensable. Small gestures, such as verbal and nonverbal gestures of respect to the respondents were acknowledged by the respondents in many cases. For example, we sat or squatted down when we approached restaurant workers resting behind their restaurants. This often bought us a few minutes, during which we could properly introduce ourselves and make the workers feel at ease with our presence. Building rapport was ultimately possible due to the researchers' language capacity and cultural familiarity. Many respondents became extremely candid after rapport was established. Finally, we explained our intentions to our respondents in great length to ensure that our respondents understood the research's purpose was not to cause the respondents any embarrassment or harm.

Still, to scientifically overcome these problems, interviews and transcripts were crossed checked to ensure the validity and reliability of our respondents' claims. A high level of corroboration was found in the data. In particular, the job-seeking, working and health care experiences disclosed by individual respondents who did not know one another were found to possess significant commonalities. They often referred to the same organizations and practices within the ethnourban core. This facilitated the comparison of their claims, and allowed the researchers to identify and understand the specific opportunities and resources within the ethnourban core that Chinese immigrants could access in seeking employment and health care. Also, we were able to corroborate the data on the employment practices of key industries for low-skilled Chinese immigrants by recruiting respondents through various sampling strategies. As such, we are confident that our protocols and strategies were adequate to provide us with valid and reliable data.

## **Findings**

In general, health care was identified as a major issue among low-wage Chinese immigrant workers in San Gabriel Valley.<sup>v</sup> Over 60% of our respondents did not have employer-provided health insurance. The lack of coverage was chronic. The vast majority of our respondents had never received any form of coverage.<sup>vi</sup> The problem could be partly attributed to the lack of full-time employment with benefits. Full-time employment was extremely rare among grocery and retail workers. Specifically, employees of larger supermarket chains in the area were often given approximately 37 hours of work each week.<sup>vii</sup> They were therefore not qualified for employer-provided health insurance and other benefits. One respondent purchased health insurance plans through his employer for

his family because he was only employed at 37.5 hours a week. These large businesses, according to our respondents, were frequently inspected by various state agencies, and therefore they were more likely to follow proper codes and procedures. On the other hand, employees of smaller businesses were found to often work for more than 40 hours without any employer-provided health insurance benefits. The situation was particularly severe among smaller employers with an oversupply of labor. All respondents who worked in the restaurant, garment, and home care industries worked more than 40 hours a week on average, but none of these respondents received any form of health insurance from their employers. Table 1 includes other characteristics of the survey respondents.

Insert Table I Here

Several of our respondents complained about health care in the United States. These respondents were fully aware that there was no free or subsidized health care for the general public and they told the researchers that they were shocked and disappointed when they learned about not having access to affordable health care services in America. As one respondent said, “I don’t ask for a lot, but health insurance is most important.” Another respondent noted that the existing government (federal and state) healthcare plans had many requirements like age and income that she did not fulfill. It is of note that the ages of our interviewees ranged from the late 20s to the 50s. This meant that they would likely not have qualified for federal and state health care programs like Medicare or Medi-Cal (California’s Medicaid program). In this regard, most of our respondents

also worked and earned enough to render them ineligible under these programs' income requirements; the median monthly income of our survey respondents was \$1000-\$1500.

Given the significant lack of health insurance and health care coverage in general, our respondents resorted to several basic strategies to compensate for not having access to mainstream health care services. Avoiding injuries and sickness at work and in daily life was the most frequently reported strategy by our respondents. One respondent, a supermarket worker, viewed being more careful at work and taking better care of one's health as the most important strategy to compensate for not having insurance and no access to the health care system. Other respondents delayed care as a strategy. Some of our respondents suffered from chronic work-related injuries or ailments that had not been treated early due to time or cost constraints. In particular, chefs and masseuses often experienced joint problems in the hand, arm and shoulder areas, such as carpal tunnel syndrome, due to the nature of their work. These injuries often severely affected their ability to continue work. One of our survey respondents, a cook, related that he had been forced to stop working for a few months because of his arm injury; previously, he worked about 60 hours per week. He then sought care during this period of unemployment. Notably, in light of the time and cost constraints they faced in obtaining health care in America, several of our respondents noted that they would return to China to purchase medicine and treatment.

A few of our respondents who experienced health problems also told the researchers that they would rest and use over-the-counter pharmaceutical medicines or Chinese medicinal products to manage their pain. In several cases, the respondents relied upon Chinese medicinal resources as they were cheaper than seeking Western medical

care in America. One such case through a discussion with a respondent about possible remedies for a cough that one of the researchers had:

We [the respondent and researcher] began chatting about my health, after I told him that I was sick and had been coughing for several weeks now. He said that I should try a few herbs. He also suggested that I try eating pears (Asian pears) because they would reduce the phlegm that I had. He gave me a recipe for a soup that he thought I should try. We carried on discussing how to make the soup, given my conditions. As we talked about the different ingredients, he mentioned how each of them had different medicinal qualities. For instance, he mentioned that I should try using the pears because they nourished the lungs and would be able to reduce inflammation. When I asked him about how he knew of all these herbs, he said that he always had them whenever he had a cough. If he fell sick with a cough, he would brew these soups, or eat pears to get well.

He did ask if I had seen a doctor, and I told him that I had not. And I also began to ask him where he sought medical advice when he had been sick. He told me that he would go to medicinal shops and ask them for advice about herbs to use or see the Chinese medicinal doctor who was there. He also recommended a shop to me. It is located at Garvey He stressed that it was relatively cheap to see a doctor there, and it costs about \$20 for both a consultation and for medicine.

[...] I returned to talking about treating the cough that I had, and I returned to asking about how he would treat himself when he fell sick. He then told me that he would try both Chinese and Western medicines, and when Chinese medicines did not work, he would see a Western doctor. I asked him where he did this, and he said it was back in China. I asked if he had seen a Western doctor since coming to the States and he noted that he had not.

When the injuries or illness become serious, several respondents did go to private physicians and hospital clinics. Even so, they did not immediately seek medical treatment from these sources because of the cost;<sup>viii</sup> they would only consider these health care services during emergencies. One respondent saw the issue of cost as a key consideration in seeking health care.

R: I don't have health insurance. I don't have health insurance. So, as I am still young, I don't have many problems. [...] Yes, that's how it is. Really, if you don't have insurance, it's very expensive to go to the doctor. For a small matter, you will need \$50 or \$60, and you haven't purchased the medicine yet. That's how it is.

In an extreme case, one respondent who suffered from a career-threatening occupational injury still expressed hesitation in seeking care due to cost issues. When we met with her, she had stopped working for several months, and was struggling to make ends meet. As we discussed her hand injury, which occurred during her work as a masseuse, she noted that she was still seeking care. An acupuncturist had offered her treatments at the rate of \$25 per session for a few sessions, but she did not know if she should undergo treatment as she felt it was too expensive. She also stated that she could not seek private physicians as she had no money<sup>ix</sup>. Finally, a minority of respondents used low-cost or free clinics run by Chinese charitable organizations in the area.

In addition to the extremely limited health insurance coverage, health care information dissemination created further obstacles for our respondents in accessing health care services. The researchers asked questions regarding health care rights and how they received information on public or private health care services. Most respondents had nearly no knowledge on the basic health care rights of immigrants. While the majority of the respondents understood that they were entitled to receive treatment under emergency and life threatening situations, they knew very little otherwise. Also, many respondents believed they could not afford any treatment at private physicians or public hospitals due to the high costs. For one, they were not aware of the County health care programs available to low-income earners that could help subsidize costs. We confirmed their lack of knowledge of these programs during a health care

forum that was organized at the end of the field research. During this forum, a few representatives of nongovernment organizations specializing in the health care rights of immigrants presented information about Los Angeles County health care programs that were available to low-income persons. All the attendees of this forum had not heard of these programs beforehand. Furthermore, during our research, none of our respondents had experiences of using these health care options. Their lack of awareness of these County programs was compounded by the fact that many of our respondents would not have qualified for federal and state programs that were more selective.

To assess their knowledge and health care information dissemination, the researchers asked respondents questions on public and private health care services. In the San Gabriel Valley area, there were three low-cost or free private clinics that offered basic health care services to qualified individuals. These clinics were unique because they were the only facilities in the area established to specifically serve the Chinese community. Basic health care services were also available from several county clinics and other facilities in the San Gabriel Valley and Downtown Los Angeles. With no health insurance of any form and low income, these facilities became the only available and accessible form of health care services for our respondents. However, our respondents in general had limited knowledge about the existence, location, services provided, eligibility, cost, or other information regarding these health care facilities. A respondent told the researchers about an injury sustained in an auto accident.

Q: What about arthritis? When your hands hurt and other problems and can't work?

R: Nothing you can do. I got into a car accident and I was hurting after. I still had to go to work. We have no insurance or benefits. I work for a non-Chinese

company that pays better, but I still get no insurance. I get paid better when business is good. That's all.

Q: So if you are ill you will have to take care of yourself or rest?

R: Yes. Nothing at all.

Q: What if you really need treatment? Where would you go?

R: I have never sought help. Hypothetically I would get information for the cheapest organizations like Christian hospitals or something like that. I know something like that around Carnation Avenue.

As indicated above, the comprehensive knowledge and usage of these critical resources was not widespread or routine amongst our respondents. Instead, health care strategies like self-medication were more common. Nevertheless, some of our respondents actively used these limited but available services. As we will demonstrate later, their awareness and regular usage of these resources was related to the composition of their networks.

Common with many of the respondents in the sample, one respondent told the researchers that he did not know where to seek medical care at all. He did not even know the location of the nearest hospital to his residence even having lived in the area for at least five years. When the researchers asked whether he ever needed medical care at all, he replied that he has not been seriously ill since he came to the United States, and the only problems were work related. He had a joint problem in his shoulder and he used over-the-counter medication and plaster to manage the pain. He also believed that such problems were age-related and that they are inevitable. He also had a slight allergy problem, but he said it was not bad enough to seek care. So he believed that he must rely on rest and other remedies to take care of himself. Being careful and self-medication was the most important health care strategy. Another respondent shared that she had two friends from her hometown – one injured his/her shoulders, hips and elbows while doing

home-care work, and the other broke his/her thumb while working at a restaurant. She then told the researcher that “[their] purpose for coming to the US” was to earn money, and they would work even if they were injured. She also noted that “massage workers, or just those seeking work” had no idea where to seek care even though they had money. As her description indicates, time, money and the access to information affected the health care of immigrant workers most directly.

In general, the most significant source of information on health care was interpersonal relationships. Respondents relied primarily on acquaintances from the same region, friends, extended family members, coworkers, and other personal connections to seek information on where to seek treatment.

Q: How did you learn about the hospital on Harris?

D: Through the church, through my friends at church... Then, I had a fever, and my friends at church told me that this place was free for low-income people. So I went to register. Up till now, that's how it is.

Respondents also received information through their personal contacts on where to seek more information on health care. The few respondents who received treatment by one of the low-cost or county clinics told the researchers that they learned about the clinic from their friends. One respondent fell ill and over-the-counter remedies were ineffective. He was ultimately told by his friend to find help at the clinic. Another respondent learned about the locations and eligibility of the clinics from his relatives. One respondent actually referred another respondent to a low-cost clinic after she injured her hand at work and did not know where to go. In fact, the respondents viewed their personal contacts as the most immediate, convenient, and important source of information on health care.

Respondents also mentioned a variety of additional information sources. Several respondents used advertisements in the Yellow Pages or the Chinese newspapers to find private physicians, clinics and pharmacies. Other respondents mentioned a local radio station and churches as information sources. Finally, a small number of respondents mentioned they sought referrals from local social service organizations. However, these other sources were less important than interpersonal relationships. Interpersonal relationships likely provided a context of mutual trust that these other sources lacked in comparison. One respondent lamented the incompleteness and inaccuracy of these information sources as they seemed to contradict each other. Another respondent, after exhausting his personal contacts, experienced difficulties in receiving health care information and treatment from a local social service organization. He then commented that, “the lack of information in San Gabriel Valley has reached a critical level.” A few other respondents also shared their frustrations with social service organizations. In one extreme case, 2 of our respondents had purchased a health care discount plan through a social service organization. They subsequently discovered that this plan was not recognized by the clinics that the plan claimed to cover. Given this perceived lack of trustworthy public information, it is perhaps not surprising that interpersonal relationships were salient in the dissemination of health care information.

When the researchers asked our respondents why they still depended on their friends and other personal contacts for information even though they acknowledged the limitations and problems associated with the information that they received from these networks, they brought up language as the reason. We then asked the respondents to describe their friends, extended family, and other contacts, the respondents’ networks

were almost exclusively Chinese immigrants who had very limited English language skills. Very few respondents had contacts who knew English or were established outside of the Chinese community. However, the 6 interview respondents who were involved with social service organizations and religious organizations provided exceptions to this form of closure. They were able to gain some access to key resources through their contacts at these organizations when in need. Unlike those respondents who had experienced negative experiences at social service organizations, they were able to successfully obtain some level of assistance either as participants in the activities and services of these organizations, or they had had durable and lasting exchanges with others who were participants.

Even when individuals gained access to some degree of health care services, the language barrier persisted to limit the range of options presented to individuals who had little or no English language capacity. This was pointed out by one of our respondents.

R: [A friend of mine] goes to a small clinic. These small clinics are listed in the Chinese papers. So, if you go to them, it won't be any problem. But if you have a serious condition and need to be hospitalized, there'll be a problem. Because I think that in large hospitals, there aren't many Chinese. Neither are there many Chinese in the courts, you know? Because many people don't know how to speak English, it's a problem.

Some of our respondents chose to seek care within the Chinese immigrant community after frustrating experiences with mainstream health care outlets. One respondent sat and waited in a county hospital for nine hours after the initial intake process. Not knowing English, she did not know whether her name was ever called. Ultimately she left and never used the county facility again. This respondent's account was hardly unique. Many respondents reported similar difficulties in finding printed material and pamphlets in

Chinese. They also noted the absence of Chinese-speaking doctors, nurses, or staff at county clinics and hospitals. The lack of documents, forms and material in Chinese and Chinese-speaking staff at most mainstream health care facilities discouraged many of our respondents from seeking treatment from these facilities and likely further restricted the flow of critical health care information into the community.

A similar pattern of a heavy reliance on personal relationships is also found with regard to work and employment. The following experience was very common among respondents.

R: [My friend] called me and told me that she was still working at the garment factory. She asked me whether we needed people and then I asked my boss if we needed anyone. He said, “We need a vegetable washer!” I asked her, “Do you want the job as a vegetable washer?” She said yes. I thought she could also make dumplings and so I recommended her to my boss for that. It turns out she couldn’t. (laughs) I bought some flour and we practiced at home. Who knew she could not do that? However, I already told the boss and so I bought a whole lot of flour and taught her how to do the wrapping.

Q: So friends are very important...

R: For information. That’s because we don’t know English. So we depend on friends to communicate. We rely on friends to get jobs.

Also, many of our respondents switched from one industry to another frequently. The previous quote describes a typical scenario: when one friend gets a better paying job in another industry, he or she helps his or her friends to get employed in the same workplace regardless of experience. Given most of the employment opportunities available in the San Gabriel Valley were either low-skilled or semi-skilled, transitions to another industry did not require extended or comprehensive training. The respondent

above started working as a garment worker when she arrived in the United States. She had no previous formal experience before she emigrated. Because of the poor treatment and pay at the garment factories, she started working in a restaurant kitchen after being recruited by an extended family member. The respondent later learned that there were further openings at the restaurant kitchen. She called her friend about the position. Her friend started working at the kitchen almost immediately. Later, her friend left the kitchen and received training to become a professional masseuse. Her friend informed the respondent about the better pay. She left the kitchen soon after and became a masseuse as well. It was extremely common among many of our respondents to be switching industries frequently. Almost all the switches occurred through information exchange between friends, extended family members, or other informal interpersonal contacts. As soon as one individual learns about an opportunity, the individual would typically inform his or her friends or family members.

A different pattern emerged when professions that required a relatively higher level of skills were examined. A chef told the researchers about this entire professional experience. He had been living in the United States for about five years, when he was asked how he received information about his previous and current jobs, he made the following comment:

R: The circle is quite tight in this profession. You depend on your friends for everything. We get word from our friends about better paying jobs and that is how we go from job to job.

The same respondent further told us that employment in his profession was almost exclusively sought through friends referring and introducing one another. He mentioned several times during the interview the significance of relying on friends to find work.

This was also the case for the construction industry. One construction worker told us that he relied on his friends for job referrals increasingly as he became more established in the industry. In contrast, when he had just arrived in the United States, he obtained his jobs through employment agencies.

When asked about problems and issues in general, one respondent said that his biggest problem was the scale and nature of his social circle. His social circle composed of individuals who shared similar socioeconomic status and education background, including family members, relatives, friends and acquaintances. They were mostly recent immigrants from China who were not familiar with the American mainstream society. They were also typically from relatively low socioeconomic backgrounds with minimum education and skills. He understood the various obstacles that he faced in securing resources, such as jobs, housing, applying for ordinary and critical social services, and legal information, were significantly due to the limited knowledge that exists within his immediate social circle. To him, the problem was twofold: overall social isolation from the mainstream American society and language barrier. Specifically, he complained about the lack of knowledge in various processes and ways to apply for basic social services. People within his social network simply had no idea what types of social services were available and where and how to apply for these social services and other opportunities. As such, there was very little useful knowledge that existed among people in similar conditions. He also understood the language barrier as another issue related to the restricting social circle. He said the language barrier was not just a problem that affected him as an individual, but it was also a collective problem. As very little English skills existed within the entire social network of recent immigrants, the language barrier

compounded the unfamiliarity of various social services and application processes to contribute to the inaccessibility of critical social services and opportunities in mainstream society.

The same problem was shared by many of our respondents. They relied heavily on their friends and extended family members for information on employment opportunities, health care, social services and so forth. Even so, several respondents were highly aware of the constraints that they faced as Chinese immigrants due to their language barrier.

Q: So you mentioned the first job after you came to the US is at a garment factory. The work hours were long and they owe you your pay, so the question is: you came here as a legal immigrant, and so why did you work at the garment factory?

W: It is very simple. You don't know how to speak English. It is a huge problem. If you can't even speak English, where do you go find work?

## **Discussion**

Our findings reveal the following. 1) Low-wage Chinese immigrants experienced a severe shortage in health care coverage. Health care was one of the scarcest resources for low-income persons in the Chinese community. Only a small minority of our respondents received health care coverage in any form. 2) Employment options were also typically limited to low-skilled industries that rarely provided any form of health care insurance. Employer-provided full insurance coverage was extremely uncommon. 3) Low-wage Chinese immigrants were forced to resort to several strategies in order to compensate for not having health insurance and access to health care facilities, including delaying medical care, using over-the-counter medicine, other remedies, and even returning to China for treatment. The exchange of information on health care among co-

ethnic individuals constituted an important health care resource. 4) The significance of social capital was demonstrated through our respondents' dependence on informal networks for exchanges of information on health care, employment, and other areas of community life. However, the limitations of solely relying on social capital were also observed in the process. Despite the successful exchange of information, the effectiveness of social capital in allowing individuals in obtaining resources was noticeable. Network closure caused by the language barrier significantly limited the flow of information from sources outside of the low-wage Chinese immigrant community.

Viewing from both Bourdieu's (1980; 1986) and Coleman's (1988; 1990) conceptualizations of social capital, the respondents of this study possessed substantial social capital on both the individual and collective levels. Our respondents were relatively well connected as individuals in the San Gabriel Chinese immigrant community. All of our respondents were able to establish, secure, and expand their social networks after they arrived in the Southern California area. They reported strong and useful connections with acquaintances, friends, extended family members, coworkers, and other individuals. Frequent information exchange took place between individuals, and these exchanges typically led to some success in securing health care information, jobs, and other essential resources. In Bourdieu's conceptualization (1980; 1986), these individuals would be characterized as possessing rich social capital.

Our respondents would also display a high degree of social capital according to Coleman (1988; 1990). They were able to obtain information through their social relations with other Chinese immigrants by virtue of group membership. One striking instance of social capital and its effects was how some respondents were able to receive

information about job openings simply because they came from the same hometown as their informants. As demonstrated, the overall rate of information exchange within the networks in the Chinese immigrant community was quite high. All respondents had exchanged health care, employment, and other information with their acquaintances, friends, extended family members, and other individuals with whom they had personal relationships. Also, as reported by respondents who worked as chefs and those who worked in the construction industry, information sharing within social networks was of utmost importance in their professions. Our respondents were able to establish interpersonal ties with other Chinese immigrants due to their co-ethnic identity and shared Chinese dialects. These closed networks, as Coleman (1988; 1990) would argue, did appear to benefit the formation of social capital.<sup>x</sup>

Our research thus supports the broad thesis that social capital is a salient form of capital within immigrant communities, especially for immigrants with limited economic or cultural capital (Portes and Sensenbrenner: 1993; Portes: 2000; Nee and Sanders: 2001; Sanders, Nee and Sernau: 2002; Zhou and Lin: 2005). Other researchers have demonstrated the reliance of immigrants on their ethnic networks to find jobs, raise capital and procure labor (ibid). While their work has focused primarily on the economic actions of immigrants, we argue that this focus on the operation of social capital within immigrant communities can be extended to understand immigrants' access to health care. Our data demonstrates that the same ethnic social networks that are used to find jobs can also yield information about health care resources. However, we also find that the lack of cultural capital, i.e. language skills, amongst low-wage Chinese immigrants inhibited and constrained their employment and health care strategies. In relation, these deficiencies in

the operation of social capital can be attributed to the lack of good jobs and the employment structure of the ethnoburban core, and the linguistically-limited networks and information channels that were available and accessible to low-wage Chinese immigrants.

We find an important linkage between the structure of employment in the ethnoburban core and health care coverage. For one, the low-wage jobs within the ethnoburban core's service, light manufacturing and construction industries did not provide any form of health insurance to workers. Also, the low wages of workers and, in some industries, their long hours of work often meant that they could not afford to see private physicians even when they were sick or injured. The employment structure of the ethnoburban core thus directly restricted the availability of health insurance to low-wage Chinese immigrants and their access to health care. Despite the dependence of low-wage Chinese immigrants on social capital, their job-seeking networks suffered from resource deficiencies that were closely related to the local employment structure.

Even so, it would be insufficient to explain the lack of access to health care amongst low-wage Chinese immigrants as the result of resource deficiencies within the ethnoburban core. For one, this explanation is not satisfactory as this problem seems to have a solution. Given the lack of good jobs in the ethnoburban core, why did our respondents not seek employment beyond the ethnoburban core? As Sanders, Nee and Sernau (2002) have demonstrated, within the context of a metropolitan labor market, Asian immigrants' reliance on social ties to find jobs were positively related to their transitions to low-prestige jobs with employers outside of their respective communities. A small number of our survey and interview respondents did make such transitions. Even

so, not all of them obtained health insurance; those who did found employment with the County as home-care workers. As such, the quality of the jobs mattered more than the location and ethnicity of their employers in determining health insurance coverage. And, as Sanders, Nee and Sernau (*ibid*) would note, the social networks of low-wage Chinese immigrants would likely not facilitate job transitions into prestigious jobs beyond the ethnoburban core. Instead, they noted that competency in English was a strong predictor of such job changes (*ibid*: 301). Our research corroborates their findings. And, we argue that our respondents' lack of cultural capital, i.e. language skills, resulted in a form of closure that reinforced the resource deficiencies of the local employment structure. In relation, their lack of cultural capital also limited their access to information.

A close examination of the interpersonal ties that our respondents relied on for job referrals and health care information reveals serious gaps in information diffusion that further inhibited immigrants' access to health care. Even though public health facilities and low-cost or free clinics run by Chinese charitable organizations were present within the ethnoburban core, we observe a low rate of usage of these resources amongst our respondents. For one, our findings indicate that the language barrier discouraged direct access to public health facilities and limited our respondents' knowledge of public health care programs for low-income persons. The language barrier thus meant that interpersonal ties were crucial for information on health care resources. As for the low-cost or free clinics run by Chinese charitable organizations, comprehensive knowledge and usage of these resources was neither routine nor widespread. Many were simply unaware of these clinics like others in their networks. But, for those who had received treatment at these clinics, they had been referred by their friends at Chinese social service

or religious organizations. In this regard, the limitations of social closure could be overcome through relationships with social service or religious organizations, or with other immigrants who had well-developed social networks. This is similar to the findings of Sanders, Nee and Sernau (2002: 306) who noted the importance of “bridge ties” to immigrant job searches in a metropolitan labor market. Nevertheless, the dissemination of information about available health care resources was constrained by the lack of linguistically-accessible information channels and by the closed social networks of low-wage Chinese immigrants.

Resource deficiencies linked to the local employment structure and the closed information channels and networks of Chinese immigrants thus affected the operation of social capital among low-wage Chinese immigrants in the ethnoburban core. This resulted in the lack of health care coverage within the community, and the use of alternate coping strategies. Hence, we argue that our research provides evidence for Lin’s (2000) thesis that the simultaneous operation of structural disadvantage and homophily leads to the inequality of social capital. In addition, using immigrant health care as an empirical illustration, we specify how this process is undergirded by the lack of cultural capital.

As Lin (2000) commented, the possession of social capital does not necessarily promise success in yielding economic or other rewards. In fact, inequality in society is potentially reproduced in social capital due to the fundamental inequalities in the socioeconomic positions of social groups. While language and ethnic identity as form of cultural capital favored the formation of networks and information exchange among low-wage Chinese immigrants who already lacked economic capital, they constituted a deficit of cultural capital in mainstream society. This led to a form of network closure among

Chinese immigrant workers that severely limited the diversity of information and resources within their networks. In other words, their lack of economic capital and cultural capital in American society was reproduced as a social capital deficit. Having extremely limited abilities in reading or speaking English, our respondents' personal ties were typically limited to other Chinese-speaking individuals who shared similar socioeconomic backgrounds and circumstances.<sup>xi</sup> While they had abundant social capital, the quality of their social capital, in terms of gaining access to jobs with health insurance benefits and to health care, was homogeneous and poor.

As many respondents attested, they recognized the limitations of their personal contacts and networks as the primary source of information on jobs, health care, social services, the law, government agencies, and so forth. They were fully aware that the information that they received from their acquaintances, friends, extended family members, and other individuals from their personal networks were either incomplete or inaccurate. However, they had no other alternatives but to rely on these unreliable sources due to the language barrier. The dimensions that determine the quality of social capital (Lin 2000), resource quantity and heterogeneity, significantly affected low-wage Chinese immigrants' access to health care. The language barrier as a cultural capital deficit among low-wage Chinese immigrants not only restricted their employment to the service, light manufacturing and construction industries within the ethnoburban core where they could not obtain health insurance benefits and adequate wages; it also exacerbated their pre-existing disadvantage as immigrants in directly receiving information about health care rights and services from the mainstream American society. The resulting closed networks and homophily further blocked information about available health care resources. Despite

the amount of information exchange, the diffusion of information within their networks remained inadequate due to their networks' lack of diversity from other socioeconomic strata. The disadvantage of low-wage Chinese immigrants in gaining access to health care was therefore perpetuated by inequalities in social capital.

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## Footnotes

i On symbolic capital, Bourdieu (1986: 243) commented, “*Symbolic capital*, that is to say, capital -- in whatever form -- insofar as it is represented, i.e., apprehended symbolically, in a relationship of knowledge or, more precisely, of misrecognition and recognition, presupposes the intervention of the habitus, as a socially constituted cognitive capacity . ” In relation to social capital, symbolic capital is possessed by virtue of the prestige of one’s social position.

ii While Bourdieu criticizes the concept of human capital, we agree with Nee and Sanders (2001:392) that the concepts of human capital and cultural capital overlap significantly. Hence, in our review of the literature, we follow the various cited authors in their respective uses of human capital, cultural capital, or human-cultural capital. In the case of our empirical research, we follow Bourdieu’s use of cultural capital.

iii It is important to note that the reference to job skills in this study refers to skills that are *recognized* in the host American society. During our fieldwork, we encountered physicians who worked as garment workers after immigrating to America as they did not speak English and their professional training and/or certification in China could not be recognized.

iv We used Census 2000 Public Use Microdata Sample (PUMS) 5% data to determine the key industries that Chinese immigrants living in the West San Gabriel Valley worked in. This area includes the following cities: Alhambra, Arcadia, Monterey Park, El Monte, Rosemead, San Gabriel, San Marino, South Pasadena and Temple City. Only foreign-born immigrants born in Mainland China, Hong Kong and Taiwan were included in this sample.

v It is important to avoid attributing our respondents’ lack of access to health care services in the United States to blind belief in Chinese medicine and resistance towards Western medicine. While a small minority of our respondents viewed traditional Chinese medicine as superior, the vast majority of our respondents relied on Western medicine as the main source of medical treatment. When they used Chinese medicine, they used it either because they could not afford Western medical services or they used it as a supplement. For instance, one respondent’s coworker visited a Chinese chiropractor after he suffered a work-related injury. When asked why his coworker chose a Chinese chiropractor instead of a Western chiropractor, he said his coworker could not afford the western chiropractor. All of our respondents received some form of Western medical care in their home countries before they migrated into the United States. Ironically, many of our respondents commented that they wait until they visit their home countries to receive Western medical treatment. Our respondents clearly do not reject Western medicine in any way.

vi Also, the lack of coverage and access cannot be simply explained by immigration status. The researchers enquired on the respondents’ immigration status whenever possible. The majority of our respondents were either legal resident aliens or citizens of the United States. While we acknowledge that undocumented immigrants would likely be further disadvantaged due to their lack of status, our findings indicate that legal resident aliens and citizens were also unable to obtain health care and health insurance.

vii According to California State Law, full-time employment is at least 40 hours per week.

viii Most private physicians and clinics charge a minimum fee of US\$40 for a visit. Prescription charges are additional. The monthly household income of the vast majority of our respondents is less than US\$2,000.

ix In her case, she did not file for workers’ compensation as her employer did not carry workers’ compensation insurance. Also, she had thought that filing for compensation would affect her relationship with this employer, who might employ her again.

x However, contrary to Coleman’s claims, there is also a high degree of distrust within the closed networks of Chinese immigrants in general. While individual respondents do display a high degree of trust towards individuals whom they are

familiar with, many respondents characterized the Chinese community as dishonest, suspicious, and untrustworthy. Our respondents only exchanged information with a handful of individuals that they share close relationships. Closed network did not appear to generate enforceable trust within the community in general. The relationship between social capital, closed networks, and trust will be discussed in another study.

xi The researchers asked the respondents why they did not learn English by taking free or low-cost ESL (English as a Second Language) classes that are offered throughout the area. With many respondents working long hours and a six-day work week, time and energy depletion becomes to main obstacle in learning English. Therefore, the lack of English language skills is not due to a lack of motivation. It is a simple matter of lacking time and energy.