Immigrant Children's Health Care Utilization: Inequalities across Metropolitan Destination Contexts

by

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Abstract

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Are Mexican children of immigrants more likely to utilize health care – routine medical and dentist visits – in new or traditional, and in high or low skill immigrant destination contexts in the U.S.? We investigate the effect of immigrant metropolitan destination type on immigrant child health care utilization based on an integrated contextual-ecological theoretical framework that incorporates traditional assimilation model patters of immigrant families. Data on child health and family assimilation indicators from the 1996, 2001, and 2004 nationally representative panels of the Survey of Income and Program Participation (SIPP) are merged with a newly developed typology of metropolitan destinations (Hall, Graefe, and De Jong, forthcoming). The analysis first provides descriptive patterns of U.S. born children of Mexican immigrant parents and Mexican-born immigrant children health care utilization inequalities across immigrant destination metropolitan areas. Second, the analysis provides multi-level multivariate logistic model results which access the effects of metropolitan destination type predictors of health care utilization inequalities, controlling for immigrant family characteristics.

Introduction

One of the most dramatic U.S. demographic changes in the early 21st Century has been the increase in the proportion of population who are children of immigrants. The number of children with immigrant parents has more than tripled over the past 35 years to where the share of children with at least one immigrant parent is now over 20 percent (Capps and Fortuny 2006). Among these children, Mexicans contribute the largest single national origin group, composing 37 percent of the 5.7 million immigrant children age 10 or younger in 2004. (Waldinger and Reichl 2006). Accompanying the rapid increase in Mexican-origin immigrant children has been the redistribution of the Mexican immigrant population from traditional destination states and cities to new and emerging immigrant receiving areas. These immigrant children population re-composition and redistribution trends take on increased significance because Mexican children have been shown to have low rates of health care access and utilization compared to other children (Brown et al. 2008). A consequence of these changing demographic patterns has been the concern for inequalities in preventative health care of immigrant children across immigrant destination areas. In this paper, we address this issue with the following questions which emerge from these new demographic patterns:

1. What is the pattern of preventative health care utilization – routine medical and dentist visits – of U.S. born children of Mexican immigrant parents compared to Mexican-born immigrant children in the U.S.?
2. How does the destination context in which these Mexican immigrant children live affect their health care utilization patterns? Specifically,
    a. Are Mexican immigrant children's preventative health care utilization patterns greater in new or traditional destination contexts?

b. Are Mexican immigrant children's preventative health care utilization patterns greater in destinations which attract adult immigrants with high or low skills?

Why Context Matters for Mexican Immigrant Children's Health Care Utilization

The thesis that immigrant destination area contexts contribute directly to inequalities in health care utilization of Mexican children of immigrants is based on several conceptual arguments. One major consideration is that health insurance coverage and language-sensitive health care vary considerably across states, particularly after welfare reform restricted eligibility for federally funded Medicaid among recent immigrants. Following welfare reform, however, some states chose to cover all immigrants, regardless of their entry date, using state funds. Other states decided to provide Medicaid to immigrants only in cases where federal matching funds were available (Bauer et al. 2002). Currently, 24 states have enacted either universal or expanded health coverage, but Mexican children of immigrants tend not to live in many of these states. For example, one-half of Mexican immigrants live in California, a state that, as of late 2008, had proposed but not passed expanded immigrant coverage measures. State variation in public health services and program eligibility is an important explanation for lack of insurance coverage and health care utilization.

States and metropolitan areas also vary in the availability of community-based health services, which are important service sources of health services of children of immigrant children. Nearly three-fourths of local health departments that serve a county or city-county jurisdiction are located in areas with populations of less than 50,000 (Leep, 2006). Furthermore, the health services offered by local health departments vary largely by the size of the population served and in recent years, by population-based needs. In new destination communities, the

recent growth of Mexican-origin families may not belarge enough to have stimulated services for this population, either in local health departments or the medical infrastructure.

Another aspect of destination communities that influences the use of health care by children of Mexican immigrants is the presence of co-ethnics. Ethnic enclaves and the social networks they provide can increase immigrants' knowledge of care. The lack of such information has been cited by Hispanics as a primary reason for not using preventative health care services (Peterson and Grey 2007). However, strong co-ethnic networks may also lead to avoidance of the mainstream medical professions by turning to folk healing or by sharing health-related information and obtaining unused portions of prescriptions from friends and family. Such strategies will tend to lessen contacts with the medical profession except for emergencies.

The parents of Mexican immigrant children tend to be employed in industries and jobs that do not offer health care benefits. And while the presence of labor unions may increase health benefits for low-skill workers, several industrial sections in which Mexican workers are employed have little, if any, union involvement and have notably low rates of health coverage. These include the service, trade, and retail sectors and low-skill agricultural jobs, in which Mexican immigrants tend to concentrate. Such jobs and industries are presumably what draw many immigrant families to new destination communities (Kandel and Parrado 2005). However, Hispanics who move to new immigrant destinations also tend to have more education than those in traditional destinations (Donato et al. 2008; Stamps and Bohan 2006), greater earnings potential (Hall 2008), and live in better neighborhoods (Alba et al. 2008). These conditions suggest a greater likelihood of obtaining health care and utilizing health care services for these children of Mexican immigrants.

Immigrant Destination Context Hypotheses

Based on the above discussion we hypothesize that, controlling for parental statuses, Mexican children of immigrants will have greater utilization of preventative health care in new rather than tradition destinations, and in destinations that are attracting immigrant workers with high vs. low skills. Further we expect this effect will be greater for Mexican-born immigrant children in the U.S. who are theoretically less likely to have access to health care.

Immigrant Destination Typology

. For each metropolitan area, the 2000 Decenniel Census and the 2008 ACS provide data for creating foreign-born skill-ratio measures (the number of high skill relative to low skill working-age foreign born) and for identifying established, new and emerging, and pre-emerging immigrant destination designations according to our recently developed typology of U.S. metropolitan areas (Hall et al., 2009). This typology, shown in Table 1, categorizes metropolitan areas according to their histories of immigrant receptions and the skill level of immigrants who settle there. Our immigrant destination typology builds upon Singer's (2005) frequently-used typology of U.S. immigrant destinations by expanding the sample of metropolitan areas to include medium-sized metropolitan areas (i.e., including areas with populations of at least 250,000 in 2008), by including post-2000 patterns of growth and change in metropolitan immigrant population, and by disaggregating these destination types according to inequalities in immigrant human capital. Our typology is based upon over a century of Census PUMS files plus micro-data from the 1900-2000 decennial censuses and the 2008 American Community Survey (ACS) aggregated to the metropolitan level. These data are used to estimate the size and change in the foreign-born population and the distribution of immigrant skill-levels for each observation

year in each metropolitan area, which are then used to identify 12 primary destination types among U.S. metropolitan areas by cross classifying them according to their history of immigrant reception and the ratio of low- to high-skill immigrants living there. For this paper, we collapse these 12 categories into three – established destinations (with a longer term history of immigrant reception), new and emerging destinations (those which have received a larger influx of immigrants as a percent of the total population than observed for the nation as a whole since World War II), and pre-emerging destinations (those which are home to smaller-sized foreign-born populations and have not experienced growth in their foreign-born populations as great as that experienced nationally).

Analytical Strategy

SIPP has a complex sampling design, which makes it crucial to take geographic clustering into account in the estimations of means and percentages and in the calculation of standard errors. In our descriptive analyses, we do this by using the SUDAAN statistical package with SIPP-supplied stratification weights.

Descriptive analyses evaluate differences in use of routine medical and dental care among the over 1,700 Mexican-origin children of immigrants in the 1996, 2001, and 2004 SIPP panels, by immigrant-destination type. These outcomes are measured at three different points in time in the 1996 and 2001 SIPP panels, and at two different time points in the 2004 panel. This longitudinal measurement permits comparisons across time for the same children, as well as multivariate logistic regression comparisons with control for prior family economic and demographic characteristics, child age, and year. SIPP's data on adult migration history, including year of immigration to the U.S., together with a child's date of birth, are used to

categorize children as immigrant children of immigrant parents or U.S.-born children of immigrant parents so that health care use outcomes are comparable by child nativity as well.

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Table 1. Top 100 Metro Areas in Established, New/Emerging, and Pre-Emerging Gateways

Established		
Bakersfield, CA	Honolulu, HI	Providence-New Bedford, RI-MA*
Boston-Cambridge-Quincy, MA-NH	Houston-Sugar Land-Baytown, TX	Riverside-San Bernardino-Ontario, CA
Bridgeport-Stamford-Norwalk, CT	Los Angeles-Long Beach, CA*	Rochester, NY
Buffalo-Niagara Falls, NY	McAllen-Edinburg-Mission, TX	San Antonio, TX
Chicago-Naperville-Joliet, IL-IN-WI	Miami-Fort Lauderdale, FL*	San Diego-Carlsbad-San Marcos, CA
Cleveland-Elyria-Mentor, OH	Milwaukee-Waukesha-West Allis, WI	San Francisco-Oakland-Fremont, CA
Dallas-Fort Worth-Arlington, TX	Modesto, CA	St. Louis, MO-IL
Detroit-Warren-Livonia, MI	New Haven-Milford, CT	Stockton, CA
El Paso, TX	New York, NY-NJ-PA*	Tucson, AZ
Fresno, CA	Oxnard-Thousand Oaks-Ventura, CA	Washington, DC-VA-MD-WV*
Hartford-West Hartford, CT*	Pittsburgh, PA	Worcester, MA

New/Emerging		
Atlanta-Sandy Springs-Marietta, GA	Lakeland-Winter Haven, FL	Portland-Vancouver, OR-WA*
Austin-Round Rock, TX	Las Vegas-Paradise, NV	Raleigh-Cary, NC
Baltimore-Towson, MD	Minneapolis-St. Paul, MN-WI*	Sacramento--Arden-Arcade, CA*
Cape Coral-Fort Myers, FL	Nashville-Davidson, TN*	Salt Lake City, UT
Charlotte-Gastonia-Concord, NC-SC	Orlando-Kissimmee, FL	San Jose-Sunnyvale-Santa Clara, CA
Columbus, OH	Philadelphia-Camden, PA-NJ-DE-MD*	Seattle-Tacoma-Bellevue, WA
Denver-Aurora, CO	Phoenix-Mesa-Scottsdale, AZ	Tampa-St. Petersburg-Clearwater, FL
Greensboro-High Point, NC		

Pre-Emerging		
Akron, OH	Des Moines-West Des Moines, IA	Oklahoma City, OK
Albany-Schenectady-Troy, NY	Grand Rapids-Wyoming, MI	Omaha-Council Bluffs, NE-IA
Albuquerque, NM	Greenville-Mauldin-Easley, SC	Palm Bay-Melbourne-Titusville, FL
Allentown-Bethlehem-Easton, PA-NJ	Harrisburg-Carlisle, PA	Portland-South Portland-Biddeford, ME
Augusta-Richmond County, GA-SC	Indianapolis-Carmel, IN	Poughkeepsie-Newburgh, NY*
Baton Rouge, LA	Jackson, MS	Provo-Orem, UT
Birmingham-Hoover, AL	Jacksonville, FL	Richmond, VA
Boise City-Nampa, ID	Kansas City, MO-KS	Scranton--Wilkes-Barre, PA
Bradenton-Sarasota-Venice, FL	Knoxville, TN	Springfield, MA
Charleston-North Charleston, SC*	Little Rock-North Little Rock, AR*	Syracuse, NY
Chattanooga, TN-GA	Louisville-Jefferson County, KY-IN	Toledo, OH
Cincinnati-Middletown, OH-KY-IN	Madison, WI	Tulsa, OK
Colorado Springs, CO	Memphis, TN-MS-AR	Virginia Beach-Norfolk, VA-NC*
Columbia, SC	New Orleans-Metairie-Kenner, LA	Wichita, KS
Dayton, OH	Ogden-Clearfield, UT	Youngstown-Warren, OH-PA*

Note: *Metropolitan name shortened for presentation. Source: Hall, Graefe, and De Jong (2010)