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Unfriendly shores: How immigrants children fare in the U.S. health system

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Abstract (Article Summary)

The proliferation of poor immigrant children in the US raises concern about their high uninsurance rates and access to care. The joint effects of health insurance status and place of birth on use of health services by children of the working poor were examined. Of foreign-born children, 52% were uninsured and 66% had a regular care source, compared with 20% and 92%, respectively, of native-born children. Foreign-born uninsured children were less likely than their native-born peers were to have a regular care source or to have sought care. Health insurance and immigration policies must act in concert to increase health care access for foreign-born children.

Full Text (3244 words)

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[Headnote]
Even children with legal citizenship, in working poor immigrant families, find it difficult to obtain basic access to care, and the problem is only getting worse.

[Headnote]
ABSTRACT: The proliferation of poor immigrant children in the United States raises concern about their high uninsurance rates and access to care. We examined the joint effects of health insurance status and place of birth on use of health services by children of the working poor. Of foreign-born children, 52 percent were uninsured and 66 percent had a regular care source, compared with 20 percent and 92 percent, respectively, of native-born children. Foreignborn uninsured children were less likely than their native-born peers were to

have a regular care source or to have sought care. Health insurance and immigration policies must act in concert to increase health care access for foreign-born children.

MORE THAN ONE MILLION CHILDREN came to the United States from other countries between 1987 and 1990.1 Since 1990 the number of children in immigrant families has expanded almost seven times faster than the number in U.S.-born families has. However, few studies have focused on access to health care for foreign-born children.2 A recent study shows that such children are at much higher risk of being uninsured than are native-born children of either immigrant or native parents.3 Furthermore, there are wide racial variations in insurance coverage among the foreignborn. While Southeast Asian children have low rates of uninsurance because of their refugee status, Latino immigrant children, who constitute 55 percent of all children in immigrant families, have high rates of uninsurance. Health insurance is a major determinant of access to health care for immigrants.4 It promotes financial access to care, connects children to a regular source of care, and enables use of services.5 The extent to which foreign-born uninsured children experience more access barriers than U.S.-born uninsured children has not been examined.

In this paper we examine the joint effects of health insurance status and place of birth on access to care and use of health services by children of the working poor. We assess if crude differences in access and use along these two dimensions persist after socioeconomic status, demographic characteristics, and health status are controlled for. We use a random probability sample of children from the 1997 National Health Interview Survey (NHIS).

Study Methods

* Sample and data source. The NHIS is a continuing survey of the civilian, noninstitutionalized U.S. population, sponsored by the National Center for Health Statistics (NCHS). Different households are sampled each year for this cross-sectional survey. It is administered face-to face by trained Census Bureau staff, using computerassisted technology.6

In 1997 one child per family was randomly selected for a more in-depth interview on access to and use of health care. Of the 15,350 families with eligible children under age eighteen, 14,290 had interview data on a selected child. Adult family members provided information about their children. Compared with children whose parents responded to the survey, children of nonrespondents were more likely to be African American and in good rather than excellent health. They did not differ with respect to disability status, place of birth, receipt of public assistance, or insurance coverage.

Sampled children's records were linked to their parents' records to determine parental work status. Children who did not live with a parent (n = 487) were excluded. Parents were considered working poor if they were either currently working or had been employed for at least six months in the past year, and if their combined family income was at or below 200 percent of the federal poverty level ($31,822 for a family of four using 1996 poverty thresholds). Welfare recipients were assumed to have incomes below 200 percent of poverty. We imputed poverty level for 1,640 children who had missing information on income and could not be otherwise classified as working poor. Imputation used a hot-decking approach, randomly assigning a poverty level category (in 25 percent increments) characterizing individuals with similar geographic location, parental education, race/ethnicity, and broad income levels, if available. The final sample included 5,342 children in working poor families.

* Measures of access and use of care. Access to care was measured by the presence of a particular person or place to which a child usually goes for treatment when sick, for health advice, or for routine or preventive medical care; we also ascertained if the usual place of care was a doctor's office or a health maintenance organization (HMO) rather than a clinic, hospital, or some other place.

Respondents also were asked if they delayed or missed getting medical care because they could not afford it, and the interval since they last spoke to or saw a health professional about their child's health.

These variables were stratified by children's perceived health status (excellent versus less than excellent). Health care utilization variables included the number of visits to a doctor or other health care professional, the use of two or more emergency room (ER) visits, and the mean number of hospital episodes, all in the past year and stratified by perceived health status. Small sample size precluded stratification on disability status.

* Independent variables. Children were classified into foreignand U.S.-born status. We used several questions from the health insurance supplemental questionnaire to classify children into insured (any private or public coverage) and uninsured status (if not covered by any insurance and used public or free clinics exclusively).

Other independent variables included sex, age, ethnicity, health status (excellent, very good/good, and fair/poor), and disability status, defined as a reduction in daily living activities. Household characteristics consisted of family structure and size, poverty level, receipt of public assistance, highest parental education attainment, and parental employment. Geographical characteristics included region and a metropolitan statistical area (MSA) location.

* Data analysis. We first compare foreign- and U.S.-born children on sociodemographic characteristics and insurance status. We then present unadjusted percentages and means for access and utilization measures by place of birth and by the four combinations of birth/insurance status. We adjust for covariates by using logistic and linear regression. The covariates include the child's age, sex, ethnicity, family structure, family size, disability status, parental education, region, MSA, and perceived health status, where appropriate. These variables have been shown to affect access to health care and utilization.7 In the main effects models for place of birth and for insurance status, the other factor is also included as a covariate. Adjusted rates are discussed in the text only.

Because the design of the NHIS is a complex, multistage sample, the standard errors and significance tests are weighted and corrected for stratification and sampling clustering. The analyses were conducted using SAS version 6.12 and SUDAAN version 7.5.3.

There are several limitations to our approach. The NHIS is a government survey that primarily interviews the legal population. Undocumented persons who came to the United States illegally or overstayed their visas are likely to be underrepresented. Results, therefore, may underestimate the true problems of access and use for immigrants. However, the foreign-born may travel abroad and receive care in the health care system of their country of origin, and these encounters may not be reported in the NHIS. Because our analysis is based on cross-sectional data, we cannot determine temporal relationships between health insurance status and access to and use of care. Furthermore, although our analysis of access and utilization differentials includes statistical adjustment for available covariates, some confounding inevitably remains. Finally, the recall of health events and visits is known to be difficult, especially for children who are frequent health care users.

Study Results

* Characteristics of foreign-born children of the working poor. Foreign-born children of working poor families in the United States in 1997 were more likely than their U.S.-born counterparts to be older and of Latino or Asian origin, and to live in two-parent households, in families with six or more members, and in households where the head of the family has a low education (Exhibit 1). These children also were more likely to live in households with incomes below the federal poverty level yet not to depend on public assistance.

EXHIBIT 1

Although foreign-born children are perceived to have health status that is similar to that of native-born children, the prevalence of disabilities was lower among foreign-born children. In addition, foreign-born

children were two and one-half times more likely than native-born children were to be uninsured in 1997.

* Access to care and use of services. Only 66 percent of the foreign-born children of the working poor had a regular source of care, compared with 92 percent of their U.S.-born counterparts, and among these children, the foreign-born were less likely to seek care in a doctor's office or HMO (Exhibit 2). The interval since foreignborn children last visited a doctor was also longer than was the case for native-born children. Among children in less-than-excellent health, 15 percent of the foreign-born versus 2 percent of the U.S.born had never visited a physician or had not had a physician visit in more than three years before the survey.

Similarly, among children in less-than-excellent health who visited a doctor in the previous year, foreign-born children had fewer doctor visits. ER visits and hospital episodes were also lower among foreign-born children than among U.S.-born children.

EXHIBIT 2

* Access and use differentials. Disparities in health care access and use of service by health insurance status were found as expected among both U.S.- and foreign-born children of the working poor (Exhibit 3). Yet among insured children, the foreign-born were less likely than the U.S.-born were to have a regular care source or to have visited a doctor in the previous year. Among those who visited a doctor in the past year, foreign-born children in both excellent and less-than-excellent health were less likely to have had four or more doctor visits than were U.S.-born children of the same health status. Furthermore, insured foreign-born children in lessthan-excellent health were less likely to have had two or more ER visits than were their insured native-born counterparts. Differences in birth status, particularly for regular source of care, were not apparently attributable to differences in type of health insurance. Among U.S.-born children, 61 percent had private coverage, compared with 55 percent of foreign-born children.

Among the uninsured, foreign-born children were less likely than U.S.-born children were to have a regular source of health care and to seek care in a doctor's office or HMO. A delay of more than one year since seeing a physician was also more likely for foreign-born than for native-born uninsured children, regardless of health status. Among uninsured children seeking care in the previous year, foreign-born children in less-than-excellent health were less likely to have four or more visits. The rates remained similar after adjusting for confounders, with two exceptions: (1) the number of doctor visits, which no longer showed birth-location disparities among the uninsured in less-than-excellent health; and (2) the interval since the last doctor visit, which was similar for foreign- and U.S.-born uninsured children in excellent health. After adjusting for confounders, foreign-born uninsured children stood the highest risk of not having a regular care source, for that care source not to have been provided in a doctor's office or HMO, and for not having seen or visited a doctor on a timely basis, if in less-than-excellent health.

We further examined differentials in access to care and utilization within ethnic groups along birth status lines. Sample sizes restricted this analysis to white and Latino children. Among white uninsured children of the working poor, foreign-born children were less likely than U.S.-born children were to delay or miss care because of lack of affordability but more likely not to have seen a doctor in the past year, if they were in less-than-excellent health.

Larger birth-location differentials were observed among Latinos than among white uninsured children of the working poor. Foreignborn Latinos were more likely than U.S.-born Latinos were to lack a regular source of care and were less likely to have sought care in a doctor's office or to have visited a doctor in the previous year. Latino foreign-born children in less-than-excellent health also had fewer than four doctor visits than did their Latino native-born counterparts, and those in excellent health tended to have fewer ER visits than their native-born counterparts had (data not shown).

EXHIBIT 3

Birth status had similar associations with access to care among the uninsured in the three age groups examined (younger than age six, ages six to twelve, and ages thirteen to eighteen). In most cases, foreign-born uninsured children were less likely to access care than native-born uninsured children were. However, foreign-born children over age six were more likely than their native-born counterparts were to delay care because care was unaffordable, and foreign-- born children ages thirteen to eighteen were the most likely to experience intervals of three or more years without visiting a doctor. Among the older children who had visited a doctor in the past year, foreign-born children in less-than-excellent health were more likely to have fewer doctor visits than were their native-born peers in similar health (data not shown).

Discussion And Policy Implications

Our findings suggest a clear hierarchy in access to health care for the children of America's working poor. On nearly every indicator we examined, foreign-born children in working poor families had lower access and health care use than did their U.S.-born counterparts, uninsured children were worse off than insured children, and uninsured foreign-born children faced the worst access to health care. What is even more troubling is that among foreign-born uninsured children, those who had less-than-excellent health status faced more barriers to timely access to care than did those whose health status was excellent. Furthermore, consistent with other studies on minority health, Latino foreign-born children-who constitute 58 percent of the foreign-born children of the working poor-faced more barriers if uninsured than their white counterparts did, perhaps because of cultural and legal barriers.8 These findings suggest that health care, immigration, and welfare policies may be hampering access to health care for immigrants.9

In fact, the disparities in coverage for immigrant children may be growing as a result of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, immigration policies, and ballot initiatives.10 PRWORA gave states the option of terminating nonemergency Medicaid coverage for legal immigrants who arrived after 22 August 1996. After a five-year stay, the income of an immigrant's sponsor, along with the immigrant's personal income, are to be counted when determining the immigrant's eligibility for public assistance and Medicaid. This is a marked change from the prior social contract, which treated legal immigrants and U.S. citizens alike in determining income and eligibility.11 Under PRWORA, children of undocumented immigrants are no longer able to receive Medicaid if designated as "permanently residing under color of law." Furthermore, insurance expansions created under the State Children's Health Insurance Program (SCHIP) exclude undocumented children.12 Many immigrant families have avoided enrolling in Medicaid or SCHIP for fear of being labeled a "public charge."

Our findings suggest that simply extending health insurance coverage to uninsured foreign-born children of the working poor is likely to have a major impact on their access to and use of health care. Perhaps the most expedient policy solutions would be for Congress to amend PRWORA by removing states' option to terminate nonemergency Medicaid coverage and to prohibit states from excluding foreign-born children from SCHIP. However, increasing eligibility for public insurance programs may not be enough. Despite recent assurances by the government, immigrant families are reluctant to enroll their children in public programs for fear of becoming a public charge, which could jeopardize their green cards, future citizenship, and income.13 Nonfinancial barriers to care for foreignborn children also need to be addressed, by ensuring that children are connected to a continuous care source.

Changes in immigration policy at the federal level may also enable access to health care for foreign-born children. Short of regularizing the legal status of undocumented families, developing an agreement with the government of Mexico to provide health insurance to guest workers in the United States, strengthening the enforcement of labor laws under the North American Free Trade Agreement

(NAFTA), and subsidizing employers of working poor immigrants so that they can afford to provide health insurance to their employees are policies that merit further consideration.

If Congress does not revise the policies that enable foreign-born children to enroll in public health insurance programs, another option for states is to seek Section 1115 waivers from the Health Care Financing Administration (HCFA) to require less documentation on immigration status for foreign-born children. Another option for states, recognizing the political difficulty of changing these policies, is to strengthen the safety net of public clinics and hospitals that provide care for the uninsured.

GIVEN THE RAPID INFLUX of immigrants into the United States, and their contributions to the U.S. labor market, it is short-sighted to ignore the health care needs of foreign-born children. Where a child is born and the income of his or her parents should not be the major determinants of access to immunizations against communicable diseases, regular check-ups to assess normal growth and development, and access to medical treatment when ill or injured. If the United States fails to extend health insurance coverage to the foreign-born children of the working poor, the wide disparities we have observed in their access to and use of health care services will continue.

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[Footnote]
NOTES

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