Immigrant Receptivity, Community Health Contexts and Access to Physician Care: Children of Mexican Immigrants in Emerging versus Established Immigrant Destination Areas

by

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Abstract

A welcoming versus hostile receptivity climate toward immigrants held by local community residents of emerging compared with established destination areas is an untested theoretical explanation for group inequality in access to physician care for immigrant children. We address this proposition for children of Mexican immigrants utilizing data measuring local labor market area immigrant receptivity climate based on content analysis of a random sample of newspaper articles published on immigrants/immigration across U.S. labor market areas from 1995-2010. Receptivity climate and community health context data are integrated with pooled individual-level measures of access to physician care from the nationally representative Survey of Income and Program Participation (SIPP) panels for 1996, 2001, 2004, and 2008. Multi-level modeling tests hypothesized associations between access to health care and the immigrant receptivity climate, versus multiple state and local community health context indicators as alternative explanations, controlling for family and individual-level characteristics.

Introduction

That children of Mexican immigrants have poorer access to health care in the United States compared to native children is now a well established finding (Perez-Escamilla 2010, Perez et al. 2009, Rodriguez et al. 2008, Van Wie et al. 2008, Durden 2007, Flores et al. 2006, Weathers 2004). However, contextual inequality in immigrant children's access to health care across immigrant destination areas is less thoroughly documented and with mixed results (Cunningham et al. 2006, Casey 2004, Blewett et al 2003). In a national sample study, Gresenz et al. (2012) found that U.S.-born Mexican American adults living in new versus traditional immigrant destinations report a greater probability of having an unmet need for or delay in receiving medical care and reduced satisfaction with care, but no difference in health care utilization outcomes. Furthermore they report no new versus traditional destination area health care differences for Mexican immigrants.

Missing from the scholarship which seeks to explain immigrant children's health care access inequality is the role of the local receptivity climate toward immigrants held by residents in newly emerging versus traditional destination contexts across the U.S. Is immigrant children's poorer access to physician care explained by local area variations in hostile versus welcoming receptivity attitudes and behaviors of the local population? Two decades ago Protes (1995) identified receptivity climate as a major potential explanation for inequality in immigrant assimilation, but testing this theory has been impeded by the lack of appropriate longitudinal data on changing immigrant receptivity climate at the local community level. Previous research, focused primarily on the relationship between economic indicators and receptivity, is based primarily on small-sample national-level data or limited area case study research (Espenshade and Hempstead 1996, Scheve and Slaughter 2001, Citrin et al. 1997, De Jong and Steinmetz 2004).

We address this important theoretical explanation for inequality in immigrant children's health care access by utilizing originally collected data to develop immigrant receptivity climate measures for all local labor market areas in the U.S. Measures are based on content analyses of a random sample of all articles on immigrants/immigration published in local print media from 1995 through 2010. We test the impact of the local receptivity climate against four alternative community health context explanations: 1) state immigrant child health insurance eligibility policies, 2) the availability of local community clinics, 3) the availability of language translation services, and 4) traditional community medical system infrastructure characteristics.

While community contextual explanations for improving health and reducing disparities have received increased emphasis in recent population health literature (cf. review by Hillemeier, Lynch, Harper, and Casper 2003; Frohich et al. 2007), a major deficiency of this research literature is the conceptualization and measurement of contextual factors that are uniquely targeted at and applicable to the health care of immigrant children. A justification for this emphasis on contextual analysis in

population health is based on addressing the question: Does the health of immigrant children depend on where they live (Kawachi and Subramanian 2005:793)?

Macintyre (1997) provides a useful distinction between collective and institutional contextual place effects. Collective effects refer to aggregated population group properties (i.e. poverty, race, attitudes, etc.) that exert an influence on health over and above individual characteristics, while institutional contextual effects reflect the broader social, political, and economic structural characteristics of places. In this research we test explanations which tap both of these conceptualizations of the population health context. Key collective contexts we test are the local area receptivity climate and the immigrant population size, growth rates, and co-ethnic population density in newly emerging versus traditional immigrant destination areas. Four institutional context characteristics that are uniquely applicable to immigrant children's health are 1) the impact of state-level policy concerning immigrant children's eligibility for state health insurance programs; 2) the availability of community health care clinics, which have been identified as front-line institutional services for immigrant health needs (Arcury and Quandt 2007, Ku and Matani 2001); 3) community health language translation services; and 4) the traditional community medical system infrastructure.

Addressing these contextual effects have important public health policy implications as they provide evidence on alternative approaches for enhancing preventative health care utilization. Example alternative strategies related to our research questions include 1) implementing programs designed to change the local community immigrant receptivity climate, 2) expanding state health insurance program eligibility criteria regarding immigrant children, and 3) increasing the services directed toward immigrant children provided by community health clinics and by the traditional medical system.

We integrate originally collected data on the immigrant receptivity climate in local labor markets and originally collected data on state Child Health Insurance Program immigrant child eligibility policy, along with county-level data on health clinic availability, translation services, and traditional medical system indicators with pooled individual-level longitudinal data from the nationally-representative Survey of Income and Program Participation (SIPP) panels for 1996, 2001, 2004, and 2008 to address the following research questions:

1. Is the positive-to-negative receptivity climate of residents toward immigrants in local communities related to access to a physician care among children of Mexican immigrants?

2. How does the shock of rapid local community immigrant population growth and the co-ethnic population density in emerging versus established immigrant destination areas impact the relationship between receptivity climate toward immigrants and access to physician care for children of Mexican immigrants?

3. Can we explain the relationship between the immigrant receptivity climate of residents in local communities and physician care access for children of

Mexican immigrants by the availability of local community clinics, translation services, and traditional health system indicators, as well as by state immigrant child health insurance eligibility policies?

4. Do these local community and state contextual impacts on physician care access for children of Mexican immigrants continue to matter when individual and family attributes are introduced as control variables in the analysis?

<u>Receptivity Climate and Child Health Care Access</u>

We use segmented assimilation theory to frame the relationship between health care access of children of Mexican immigrants. Segmented assimilation theory posits that the path to assimilation is not uniform across all immigrant groups but is rather segmented into several paths, some leading to upward and others downward outcomes. Alternative assimilation outcomes reflect barriers encountered by first and second-generation children and their families and the social and economic resources that families possess to confront these barriers (Portes and Zhow 1992). Segmented assimilation theory has usually been applied to research on uneven education, labor force participation, and occupation attainment of immigrant youth (Rumbaut 2005, Perlmann 2005, Lopez and Stanton-Salazar 2001), rather than a framework for understanding access to health care outcomes. Following Portes et al. (2009), we argue that a welcoming or hostile receptivity climate toward immigrants by the resident populations in immigrant destination communities is a major exogenous factor in successful or unsuccessful (segmented) health care access of children of Mexican immigrants.

To date the sparse population-based research literature provides little empirical evidence on the relationship between resident population receptivity climate and immigrant child health access. Two possible strategies can be used to conceptualize and measure immigrant receptivity climate for health care access research: 1) immigrants' perception of the local community receptivity of immigrants, and 2) direct indicators of resident population's attitudes and behaviors toward immigrants. Employing the former strategy, Beiser et al. (2011) used data from the new Canadian Children and Youth Survey, collected in major cities in Canada, to examine how immigrant perceptions of welcome account for the relationship between immigrant children's (ages 4-6 and 11-13) mental health and place of resettlement. While not specifically focused on health care access, this study documented that immigrant-perceived marginalization conveyed by the resident population differed across Canadian cites, and that the perception of not being welcome was a statistically significant determinant of immigrant child mental health, net the effect of family human and social characteristics. These results support the hypothesis that the local receptivity context impacts the wellbeing and adaptation of children in immigrant families.

We have not identified any previous population-based studies of immigrant access to physician care that have conceptualized and measured the impact of direct indicators of local community residents' attitudes and behaviors toward immigrants. Previous receptivity climate research employing direct indicators, usually from opinion

surveys of resident population attitudes toward immigrants, largely focuses on economic outcomes of immigrants (Espenshade and Hempstead 1996, Scheve and Slaughter 2001, De Jong and Steinmetz 2004). However, the broader research literature on immigrant access to physician care identifies several possible explanatory processes that are indirectly related to local area immigrant receptivity context. Foremost for undocumented immigrant parents is the fear of deportation and distrust of the health care system and workers associated with eligibility rules and the application process for health insurance, as well as the search for medical care for their children (Grove and Zwi 2005, Hagan et al. 2003, LeClere et al. 1994). Fear of deportation and distrust of the health care system by immigrant parents are arguably heightened in communities with a more hostile as opposed to a welcoming immigrant receptivity climate by the resident population. Immigrant perception of discrimination by local community residents and by the community health care system is another contextually-related process that may negatively affect access to physician care for children of immigrant parents (Beiser et al. 201, Noh et al. 1999).

In sum, this theoretical and empirical literature lends support to our contextual hypothesis that a negative compared to a more positive local community immigrant receptivity climate is expected to reduce access to physician care for children of Mexican immigrants.

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