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Latino/a Family Health Care Utilization across Destinations

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Abstract

This study examines the association between Latino/a destinations and health care utilization among Latino/a families. Despite a burgeoning literature on new immigrant destinations, few previous studies have examined health outcomes among Latinos/as across new versus established gateways. We integrate public-use data on Latino/a destinations, health care resources, and immigration enforcement with individual-level data on Latino/a family health care utilization in the restricted-access National Health Interview Survey. We characterize differences in health care resources and immigration enforcement across Latino/a destinations, explore how Latino/a family health care utilization varies across destinations, and then determine whether health care resources and immigration enforcement mediate or moderate the associations between destinations and health care utilization. Our initial results show that new destinations have lower health care supply, but are less likely to be classified as health professional shortage areas, have lower rates of uninsurance, and have less stringent immigration enforcement profiles than traditional destinations.

Extended Abstract

Introduction

The geographic diversification of Latino/a settlement represents a major demographic shift over the past three decades, but research has not determined how this spatial heterogeneity relates to health care utilization among Latino/a families. Latinos/as are no longer concentrated in traditional immigrant states (e.g., Texas, California, etc.) but have instead dispersed to new settlement states such as North Carolina, Nebraska, and Oregon (Johnson and Lichter 2010; Lichter and Johnson 2009; Massey and Capoferro 2008). As a consequence of this rapid growth, many health and social services in new Latino/a destinations lack the infrastructure, resources, and institutional support systems to meet the health needs of immigrant-origin families (Derose, Escarce, and Lurie 2007). Additionally, the growth of the Latino/a population in some areas has been associated with increased hostility towards immigrants, which has direct implications for the ways in which immigrant-origin families utilize local health and social services. To the extent that they are associated with fewer health care resources and increased hostility, new destinations could exacerbate the under-utilization of health care among Latino/a families (Flores and Tomany-Korman 2009; Livingston 2009; Livingston, Minushkin, and Cohn 2008).

This study, therefore, examines the interplay of destinations, health care resources, hostility towards immigrants, and health care utilization among Latino/a families with children. We define destinations at the county level, and combine public-use data on county demographic composition (to define Latino/a destinations), health care resources (e.g., health professional shortage, number of non-profit community health clinic clinics), and immigrant hostility (287[g] agreements; Secure Community removals; immigration raids) to determine how health care resources and immigrant hostilities vary across Latino/a destinations. We then merge this dataset with restricted-access data on health care utilization from the National Health Interview Survey (NHIS) to examine whether health care utilization (e.g., place for medical care, delayed medical care, health care visits) varies significantly among Latino/a families across destinations, and to determine whether health care resources and/or immigrant hostility mediate or moderate the associations between destinations and health care utilization.

Literature Review

Background

"Place" is an important social determinant of health, encompassing the social, economic, and physical conditions associated with settings as schools, neighborhoods, and states (Office of Disease Prevention and Health Promotion 2016). For the Latino/a population, "place" has become increasingly diversified over the past three decades, due mainly to the emergence of new immigrant-receiving gateways. Since the early 1990s, a number of factors including industrial restructuring and shifting immigration and border control policies have helped to "pull" Latinos/as into new destinations such as North Carolina, Nebraska, and Oregon (Massey 2008; Zúñiga and Hernández-León 2005). Approximately one-third of the Latino/a population now resides outside of an established Latino/a gateway (Lichter and Johnson 2009; Massey and Capoferro 2008). The diversity of settlement is most pronounced among Latino/a children, who are increasingly born outside of established areas (Johnson and Lichter 2008, 2010).

Destinations may influence health care utilization patterns among immigrant-origin groups because of ecological differences in institutional resources, which help to drive place-based health disparities (Diez Roux & Mair, 2010; Lovasi et al., 2009; Ross & Mirowsky, 2001;

Sampson et al., 2002). The local ecology of health care options is an important determinant of health disparities (Osypuk and Acevedo-Garcia 2010), with recent research on "health care deserts" revealing unequal availability of resources such as primary care physicians across communities (Gaskin et al., 2012; Ko & Ponce, 2013; Ko et al., 2014). Relative to traditional destinations, new Latino/a destinations may have fewer institutional supports for immigrant communities, such as culturally competent health services (Derose et al. 2007; Waters and Jiménez 2005). National research on how health care resources vary across Latino/a destinations, however, is virtually non-existent.

Destinations may also influence health care utilization among immigrant-origin groups through differences in immigrant hostility. Research on discrimination and health indicates that hostility towards immigrants is a contextual factor that has important implications for health and well-being (e.g., Samari 2016; Samari, Alcalá, and Sharif 2018; Williams, Neighbors, and Jackson 2003). Even though many established destinations have been described as discriminatory places that have led to "generations of exclusion" (Telles and Ortiz 2008), Latinos/as in new destinations face several contextual barriers related to discrimination. To be sure, the rapid influx of Latinos/as in new destinations is associated with higher levels of Latino-white segregation, out-migration of whites, and a more negative "receptivity climate" (Crowder et al., 2011; De Jong et al. 2017; Hall, 2013; Hall & Crowder, 2014; Lichter et al. 2010).

One of the clearest contextual markers of hostility towards immigrants is the adoption of anti-immigrant policies, which have proliferated in many U.S. communities. During the early 2000s, immigration flows reached peak levels and included a surge of unauthorized immigration, largely from Latin America (Capps et al. 2007). With no federal immigration resolution in site and an economic downturn on the horizon, state and local governments began to use immigrants as "scapegoats" for community economic woes, and adopted their own measures to curb illegal immigration (O'Neil 2011). These efforts coincided with federal Immigration and Custom Enforcements' (ICE) increased focus on interior enforcement that aimed to identify criminal offenders, undocumented workers, and individuals in violation of immigration law inside the U.S.-border (Detention Watch Network 2007).

Often working together, ICE and local communities created a new era of localized immigration enforcement that was marked by increased reliance on federal immigration raids and new federal-local policing partnerships: 287(g) and Secure Communities. As a consequence of these combined efforts, arrests and detention rates of unauthorized immigrants increased dramatically, and by 2008 ICE was arresting nearly 250,000 individuals on an annual basis (Chishti and Bolter 2017). Many localities were using their new immigration policing partnerships as a universal means to deport as many immigrants as possible (Capps et al. 2011). Local law enforcement conducted raids on homes and businesses, set up roadblocks to check driver's licenses, and conducted traffic stops for minor offenses (Chaudry et al. 2010). In fact, 287(g) and its successor program, Secure Communities, were both eventually rescinded (in 2012 and 2014, respectively), due to wide-spread concern of abuse and misuse. The chilling effects of these programs, has likely persisted, however, especially in the wake of the Trump administration's revival of these programs and reliance on immigration raids.

Qualitative research finds that deportations have a profound effect on immigrant families (Chaudry et al. 2010; Rhodes et al. 2015). Typically, fathers are deported, and the remaining single mother-headed households must face lost income, legal fees and family reunification costs that make it difficult to meet basic needs. A heightened sense of "deportability" also leads to widespread fears among immigrant families in these communities. To be sure, localized

deportation efforts can create fear that has broader spillover effects, such as a general mistrust of public agencies, many of which provide essential support and services to immigrant families (Chaudry et al. 2010; Rhodes et al. 2015). Consequently, children in these families experience more food insecurity, emotional/behavioral problems, and school failure (Capps et al. 2007). Large-scale quantitative research, however, has yet to examine how immigration enforcement efforts vary across destinations, and whether these enforcement efforts are associated with lower health-care utilization among immigrant-origin families.

Research Questions

Our research advances inquiry into new destinations and health among Latino/a families in two ways. First, we determine how Latino/a family health care utilization varies across destination counties. Large-scale research has found that educational outcomes of immigrant-origin groups differ across new and traditional destination areas (Ackert 2017; Dondero and Muller 2012; Fischer 2010; Potochnick 2014; Stamps and Bohon 2006), but there has been limited large-scale research on how Latino/a health care utilization differs by settlement location. Most research comparing health across destinations has been based on smaller-scale surveys and provides mixed evidence on whether immigrants fare worse or better in health-related domains in new versus traditional destinations (e.g., Potochnick, Perreira, and Fuligni 2012). Second, we explore health care resources and local immigration enforcement as mechanisms that could link destinations to Latino/a family health care utilization. The theoretical literature on new destinations suggests that differences in institutional arrangements and intergroup relations should lead to differences in outcomes among immigrant-origin populations across destinations (Waters and Jiménez 2005). Little is known, however about how health care resources and immigrant enforcement policies vary across destinations, much less whether these characteristics explain differences in health care utilization across destinations or generate variability in health care utilization within destinations.

To address these gaps, our study will answer the following research questions:

1) How do health care resources (e.g., health professional shortage area, number of non-profit community health clinics) and immigration enforcement (adoption of 287g program, number of Secure Communities removal, presence of immigration raids) vary across new, traditional, and other Latino/a destination counties?
2) How does health care utilization (e.g., place for medical care, delayed medical care, health care visits) of Latino/a families differ by residence in new, traditional, and other Latino/a destination counties?
3) Do health care resources and/or immigration enforcement mediate or moderate the associations between Latino/a destinations and health care utilization outcomes?

Data and Methods

Data

To address these research questions, we use individual-level data from the National Health Interview Survey (NIHS) and a unique and comprehensive county-level dataset with detailed information on county-level health care resources and infrastructure, immigration enforcement conditions, population demographics, and economic and political conditions. We measure Latino/a destinations at the county level in order to capture within-state variation in Latino/a settlement patterns, immigration enforcement, and healthcare resources.

National Health Interview Survey (NHIS). To measure health care utilization and individual-level controls, we use the restricted-access 2014 NHIS conducted by the National Center for Health Statistics (NCHS), which is the principal source of population health in the United States. Using a multi-stage stratified sample, NCHS collects yearly information on a broad range of health and healthcare topics from approximately 40,000 housing units containing 100,000 individuals. The survey contains a set of core demographic and health questions that all household members answer and supplementary questionnaires from one randomly selected child and adult from each household. We use the restricted-access NHIS, which we are accessing at the NCHS Research Data Center (RDC) at the Missouri Federal Statistical Research Data Center (FSRDC), because it allows us to identify county of residence in the NHIS.

County Context Dataset. For our county-level measures, we use a uniquely compiled county-level dataset that integrates county-level information from the following data sources: the American Community Survey (2014 5-year estimates), U.S. Decennial Censuses (1990-2010), Health Resources and Services Administration data (2014 & 2015), and the Bureau of Labor Statistics (2014). We combine these data with a self-compilation of immigrant enforcement policies, including 287(g), Secure Communities, and federal raids. These data are based on a variety of cross-checked sources, including FOIAs, ICE website data, and organizations that track immigration enforcement policies (e.g., Syracuse Transactional Records Access Clearinghouse, Detention Watch Network). These data are comprehensive and span from 1997 to 2015.

Sample

Because we are interested in the well-being of Latino/a families as a whole, we have three main samples of interest: a) young children (Ages: 0-8), b) middle-childhood/youth (Ages: 8-18), and c) parents of these children. With NHIS data we are able to identify these direct family relationships. For each of these samples, we will also use non-Hispanic white and black comparison groups in order to discern whether results are due to general geographic conditions or are specific to the Latino/a population. Note that the restricted access NHIS data merge with our county-level data has recently been completed. Even though we have not worked with this specific data merge yet, we have prior publications using restricted-access NHIS data and are confident that we will have a sufficient sample size for our analysis (Potochnick, May, and Flores Forthcoming).

Measures

Health Care Utilization. We will measure health care utilization based on the following NHIS survey items: a) individual has a usual place for medical care, b) individual has experienced delayed medical care, and c) number of health care visits in the past year. We will create individual measures for each and a combined measure of overall health care utilization.

Latino/a Destination. Following prior research on immigrant destinations (Ackert 2017; Hall 2013), we use a group-specific typology (i.e., county Latino/a presence and growth) to categorize destinations. We define destinations based on the size of the "base" Latino/a population in 1990 and percent Latino/a population growth from 1990 to 2010, which is consistent with the prior literature (see Lichter and Johnson 2009; Stamps and Bohon 2006). We identify 3 different destination types: Established, New, and Minor. Established destinations are

counties that were 10% Latino/a or more in 1990 with any Latino/a growth rate from 1990 to 2010. New destinations are counties that were <10% Latino/a in 1990 and had median or higher Latino/a percent growth (among only non-established destination counties) from 1990 to 2010. Minor destinations are counties that were <10% Latino/a in 1990 and had less than median Latino/a percent growth (among only non-established destination counties) from 1990 to 2010.

County Health Care Resource Measures. To comprehensively capture health care resources, we use five different measures. We create three measures using data from the U.S. Health Resources & Service Administration (HRSA). We calculate the number of MD physicians per 1,000 residents and the number of hospitals per 10,000 residents (with number of residents based on census data). We create a dummy indicator based on whether an HRSA classified a county as not having any health professional shortages (1=no health shortage; 0=part or whole county health shortage). Health professional shortage areas (HPSAs) are areas that have any shortage in primary care, dental care, or mental health providers in all or part of the county. Finally, using American Community Survey data, we calculate the percent of children (under age 18) and adults (age 18-64) who are uninsured in each county.

County Enforcement Measures. We identify 3 different county enforcement measures. First, we create a dummy indicator if a county has ever had a 287(g) agreement (1=ever had an agreement; 0=no agreement). For Secure Communities, the program that succeeded 287(g) and was adopted by almost all counties, we create a continuous measure of the total number of individuals in the county put into deportation proceedings. This number is the total for all program years. Finally, we include a dummy indicator if a county ever had a federal immigration raid during the years 2007-2009 (1=ever had a raid; 0=no raid). We use these years due to data availability and because these were the peak years (prior to 2016 changes) that the federal government relied on workplace and community raids as a main interior enforcement strategy.

Individual and County Control Measures. We will control for a wide-range of individual and county-level factors. At the individual level, we will control for basic demographic (e.g., age, gender, race/ethnicity), socio-economic (education, income levels), and immigrant-related (e.g., citizenship/mixed status family, years in the U.S.) factors. At the county-level, we will control for general population and Latino-specific demographics (e.g., population size, education levels, racial/ethnic and age composition), economic conditions (e.g., unemployment rate, % poverty), and political conditions (e.g., % voted Republican).

Analysis

We us a combination of descriptive statistics and regression analyses. We use descriptive statistics to examine overall differences in Latino/a family health care utilization by Latino/a destination type (Established, New, and Minor) and to assess how these Latino/a destinations differ in terms of their health care resources/infrastructure and immigration enforcement context.

We then use regression analysis to examine how overall differences in Latino/a family health care utilization and destination type are shaped these differences in healthcare resources and immigration enforcement. We use the following general model:

$$Y_{ij} = \alpha_0 + \beta_1 Dest_j + \beta_2 Ind_{ij} + \beta_3 HC_j + \beta_4 Enf_j + \beta_5 Cnty_j + \varepsilon_{ij}$$

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where *i* indexes individuals and *j* indexes counties. Y_{ij} is the outcome variable of interest; $Dest_j$ is a vector of three dummies indicating our classification of Latino/a destination type (Established is the reference category); Ind_{ij} is a vector of individual-level controls; HC_j is a vector of county-level health care resources; Enf_j is a vector of county-level enforcement measures; $Cnty_j$ is a vector of county-level controls; and ε_{ij} is an error term. All analyses correct for NHIS survey design effects and sample weights.

In this model, the coefficients on the $Dest_j$ variables will capture the mean differences in health care utilization between Latino/a destination types, controlling for other factors in the equation. We estimate the analysis for each of our 3 subsamples—young children, youth, and adults—and for our Latino/a, non-Hispanic white, and Non-Hispanic black samples separately. To make direct comparisons across racial/ethnic groups, we will combine racial/ethnic samples and adjust the model to include interaction terms between destination type and race/ethnicity. We will also assess alternative specifications of the equation, first using a parsimonious specification (i.e., no controls) that captures overall differences in health care utilization. Next, we will add blocks of theoretical constructs in stages to assess the unique and mediating influences of each in explaining the overall association between health care utilization and Latino/a destination type.

Initial Results

The Dramatic, Transformative Latino/a Growth in New Destinations

Table 1 highlights how dramatic Latino/a growth rates have been in new destination counties. Between 1990 and 2010, new destination counties experienced an average growth rate that exceeded 650%. This growth rate is starkly higher than both established and minor destinations, which experienced growth rates of 50% and 96%, respectively. Consistent with the Latino/a dispersion literature, we find that the majority of this growth occurred between 1990 and 2000, but that growth continued throughout the next decade as well. As of 2014, 5% of new destination residents were Latino/a compared to 40% in established destinations. Thus, even though new destination areas have experienced large growth, it is important to note that most Latinos/as still reside in established destinations.

Variation in Health Care Resources and Immigration Enforcement across New, Traditional, and Other Latino/A Destinations

Table 2 provides summary statistics on how demographic characteristics, health care resources, and immigration enforcement characteristics differ by settlement destination type. These results highlight that the Latino/a population in new destination counties is distinct from that in established destinations. Latinos/as in new destinations are more likely to be young, and to consist of foreign-born families with greater financial hardships. They are also, however, potentially more selective in terms of education levels. Lastly, we also find important differences in the more general populations living in new and established counties, as well gaps between Latinos/as and the general population within new destinations. For instance, compared to established destinations, new destinations have a smaller population size, are predominantly non-Hispanic white, and are more likely to have voted Republican in the 2016 presidential election. Within new destinations, Latinos/as have lower levels of education and noticeably higher early childhood poverty rates than the overall general population. Similar but less striking disparities exist between Latino/a families and the general population in established destinations.

We find mixed patterns for health care infrastructure and immigration enforcement context by destination type. In terms of health care, there are fewer hospitals and physicians in new destination counties, but there are lower overall health professional shortages (including dentists, MDs, and mental health professionals) and rates of uninsured individuals. This finding verifies that the package of health care services differs across destinations, and shows that new destinations are not necessarily more disadvantaged health care contexts than traditional destinations. In terms of immigration enforcement, we find that even though immigration enforcement efforts are smaller in new destination counties compared to established destinations—a likely reflection that more Latinos/as still live in established destinations and are targets of such policies—enforcement efforts in new destinations, particularly local efforts, exceed the national average. Overall, these results suggest that established destinations may constitute more disadvantaged health care contexts and more stringent immigration enforcement contexts for Latino/a families with young children than traditional destinations.

Next Steps for PAA

Our preliminary results demonstrate the feasibility of this study (i.e., the comprehensive collection and integration of county-level data and variation in key contextual variables by destination type) and the value of this study (i.e., the interconnections between individual health care utilization and county-level destination type, health care resources, and enforcement measures). Our next steps are to determine how contextual features are associated with Latino/a family health care utilization patterns in order to answer research questions #2 and #3. Note that we have completed the merge between the restricted-access NHIS data and our county-level dataset. We are finalizing variable creation and will be starting data analysis by the end of October. Thus, we are confident that we will have our full results in time for PAA.

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Table 1. Latino/a Growth Rates & Population Size by Settlement Destination Type

	Established Destination	New Destination	Minor Destination
	%/M (SD)	% (SD)	% (SD)
Average Latino/a Growth Rates Between 1990-2010			
% Growth: 1990 to 2010	49.98 (42.36)	666.25 (797.84)	96.21 (71.15)
% Growth: 2000 to 2010	17.26 (34.37)	125.20 (252.99)	49.07 (93.58)
% Growth: 1990 to 2000	28.57 (26.83)	310.42 (437.00)	56.11 (95.40)
Size of Latino Population in 2014			
Size of Latino/as population in 1,000s	119.65 (377.23)	5.03 (14.50)	8.84 (31.34)
% Latino/a	39.23 (19.63)	5.11 (5.37)	4.81 (5.03)
% of All U.S. Counties	9.68	47.06	43.26
Number of U.S. Counties	300	1,459	1,341

Data Sources: U.S. Decennial Censuses; American Community Survey

Table 2. Summary Statistics of Latino/a Settlement Destinations, Data Year 2014

	Established Destination	New Destination	Minor Destination	Sig.[1]
	Mean (SD)	Mean (SD)	Mean (SD)	
Panel A. Latino/a Population Characteristics				
Demographic & Socioeconomic Characteristics				
% Adults with High School Diploma+	60.32 (14.58)	62.55 (21.04)	68.59 (20.01)	a,b,c
% Adults with BA+	8.79 (7.74)	11.19 (11.47)	14.02 (13.36)	a,b,c
% Population Under Age 5	9.45 (2.31)	11.58 (7.54)	10.00 (7.57)	a,b
Immigrant Characteristics				
% Hispanic foreign-born	26.36 (12.96)	32.40 (17.14)	21.97 (15.28)	a,b,c
% Hispanic foreign-born non-citizen	19.11 (10.17)	25.21 (16.14)	15.06 (13.16)	a,b,c
Economic Characteristics				
% Population Under Age 5 in Poverty	3.55 (1.72)	4.97 (5.31)	3.94 (5.68)	a,c
Unemployment Rate	6.14 (3.41)	6.54 (7.08)	6.56 (7.63)	
Panel B. Health Care Resources/Infrastructure				
Total number MD physicians per 10,000 residents	12.69 (14.96)	11.48 (16.09)	12.68 (16.48)	c
Total number of Hospitals per 1,000 residents	4.32 (10.50)	1.53 (2.20)	2.03 (3.02)	a,b,c
% Persons under 18 Uninsured	18.65 (5.61)	13.03 (4.94)	12.54 (5.15)	a,b
% Persons 18-64 Uninsured	10.98 (5.86)	6.90 (4.71)	6.95 (5.17)	a,b,c
% Classified as Health Prof. Shortage Area	91.67 (27.68)	82.25 (38.22)	88.74 (31.62)	a,c
Panel C. Immigration Enforcement Conditions				
% Counties Ever had a 287g Agreement	3.67 (18.83)	2.12 (14.43)	1.12 (10.52)	b,c
Secure Communities: Total Removal	970.64 (3513.98)	47.91 (199.22)	38.66 (156.56)	a,b
% Counties ever had an Immigration Raid	23.67 (42.57)	7.33 (26.08)	9.32 (29.08)	a,b,c
Panel D. County Control Measures				
Total Population Size				
Size of population in 10,000s	31.00 (89.06)	6.69 (13.13)	9.49 (20.58)	a,b,c
Demographic & Socioeconomic Characteristics				
% Non-Hispanic White	50.00 (17.98)	80.30 (17.21)	81.65 (17.31)	a,b,c
% Adults with High School Diploma+	78.77 (8.31)	84.66 (6.33)	86.81 (5.87)	a,b,c
% Adults with BA+	20.45 (10.03)	19.17 (8.12)	21.02 (9.40)	a,c
% Population Under Age 5	6.94 (1.48)	6.01 (1.04)	5.82 (1.22)	b,c
Economic Characteristics				
Unemployment Rate	6.07 (2.99)	6.20 (2.10)	6.37 (2.29)	b,c
% Population Under Age 5 in Poverty	2.09 (1.02)	1.73 (0.89)	1.57 (0.89)	a,c
Political Context				
% Voted Republican in 2016 Presidential Race	58.95 (20.44)	65.28 (14.00)	63.04 (15.61)	a,b,c
Urbanicity				
% Metro vs. Non-Metro Counties	0.40 (0.49)	0.36 (0.48)	0.39 (0.49)	a
N=	300	1,459	1,341	

[1] Indicates the following mean destination comparisons are statistically different at the p<.10 level: a=Established vs. New; b=Established vs. Minor; c=New vs. Minor

Data Sources: U.S. Decennial Censuses; American Community Survey; HRSA ; Self-Compiled Enforcement Data (FOIAs; ICE Website; TRACS)