Immigration Enforcement and Immigrants' Health Care Utilization: Evidence of System Avoidance

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September 2018

Extended Abstract for the 2019 Annual Meeting
of the Population Association of America

Abstract: This study uses data from the 2014 Survey of Income and Program Participation to examine the association between restrictive state-level immigration enforcement policies and health care utilization among immigrant adults in the United States. The findings show that restrictive immigration enforcement policies are associated with lower odds of seeking medical and dental care, even when accounting for individual-level demographic and socioeconomic characteristics, citizenship, health status, and inclusionary state-level immigration policies that extend eligibility to immigrants for public benefits. Results support the notion that immigration enforcement is associated with system avoidance on the part of immigrants in ways that can have negative consequences for their health and well-being.

Background

The United States has experienced a dramatic and unprecedented increase in restrictive immigration legislation in recent years (Amuedo-Dorantes, Puttitanun and Martinez-Donate 2013; Hatzenbuehler et al. 2017). The punitive and exclusionary nature of these policies may imperil the health and well-being of immigrants and their families. Indeed, a growing body of research that assesses the impacts of restrictive immigration policies on immigrants' health and well-being points to adverse health consequences of restrictive immigration policies, particularly for immigrants' mental health and overall self-reported health (Hatzenbuehler et al. 2017; Lopez et al. 2017; Vargas, Sanchez and Juárez 2017).

Less research has investigated how restrictive immigration policies affect immigrants' health care utilization. In general, immigrants, especially non-citizen immigrants, have less access to health care than the U.S.-born (Ku and Matani 2001). Restrictive immigration policies may further constrain immigrants' health care utilization by explicitly limiting access to health care services and by indirectly cultivating a climate of fear (Hatzenbuehler et al. 2017). If restrictive immigration policies simultaneously increase the risk of poor health and decrease health care utilization, then unmet health needs among immigrants may grow and compound. The few studies that have investigated this topic suggest that immigration enforcement is associated with lower health care utilization such as Medicaid use (Vargas 2015) and prenatal care (Rhodes et al. 2015). Insights from qualitative studies on this topic suggest that fear of immigration enforcement is a driving motivator for avoiding the health care system (Hacker et al. 2015; Sabo and Lee 2015; Salas, Ayón and Gurrola 2013) .

Yet, we know little about how these processes play out at the national level. The existing research is largely based on non-representative, localized, or limited samples of states. National-level state analyses are important for understanding this question. Although the federal government regulates immigration, states have broad power to enact their own immigration policies. As a result, there is substantial variation across states in immigration enforcement policies. This study exploits state-level variation to understand how immigration enforcement policies influence health care utilization among a nationally representative sample of immigrant adults. I hypothesize that more restrictive immigration enforcement policies will be associated with lower health care utilization among immigrants. I suspect that fear of apprehension and deportation may be associated with system avoidance (Brayne 2014)—the practice of avoiding formal institutions that could heighten the risk of apprehension—among immigrants when it comes to seeking health care.

Data and Methods

This study uses data from Wave 1 of the 2014 Survey of Income and Program Participation, a nationally representative household survey conducted by the U.S. Census Bureau that collects information on a range of topics including health care utilization. The SIPP is well-suited to the research objectives of this study because it is one of the only nationally representative datasets that includes information about health care utilization and state of residence for a large sample of immigrants. The analytic sample consists of 8,055 foreign-born adults age 18 and older.

Dependent variables. The dependent variables come from SIPP's questions on health care utilization. The SIPP asks respondents how many times they have seen or talked to a doctor, nurse, or any other type of medical provider about their health in the last 12 months and how many visits they have made to a dentist or other dental professional in the last 12 months. I collapse these variables into two dichotomous measures of whether the respondent had any visit to a medical provider or any visit to a dental professional in the last 12 months.

Independent variables. State-level restrictive immigration enforcement policies are the key independent variable. The variable represents a summed index of three immigration enforcement polices: 1) whether passed an omnibus immigration bill that includes multiple enforcement measures, 2) whether the state mandates employers to verify the work eligibility of its employees via the E-Verify system, and 3) whether the state has a 287(g) jail enforcement program in place, which allows local and state law enforcement officers to perform immigration enforcement functions in jails. Data on immigration enforcement polices comes from the State Immigration Policy Resource (Gelatt, Bernstein and Koball 2017), a yearly compilation of state immigration policies related to immigration enforcement, public benefits, and immigrant integration.

Individual-level control variables include age, sex (ref=male), race/ethnicity (ref=White), highest educational degree (ref=less than high school), the log of annual household income, citizen (=1), fair/poor self-rated health (=1), and any health insurance coverage (public or private) in the last 12 months. I also control for inclusionary state-level immigration policies that extend eligibility for public benefits to immigrants. This measure is a summed index of 9 policies related to eligibility for Medicaid, public health insurance, the Temporary Assistance for Needy Families program, and food assistance programs.

Analytic strategy. I use logistic regression models to predict any health provider and dental visits within the past 12 months. I report results in the form of odds ratios. I weight all analyses with calendar year person weight.

Preliminary Results

Table 1 shows the weighted descriptive statistics of the variables used in the analysis. Two-thirds of the sample reported having visited a medical provider within the last 12 months, while more than half (58%) of the sample reported having had any dental visits in the last 12 months. Latino immigrants, at 44%, constitute the largest racial/ethnic group of immigrants in the sample. Slightly more than half of the sample are naturalized U.S. citizens, and 72% had either public or private health insurance coverage during the year.

Table 2 presents the odds ratios from the weighted multivariate logistic regression models predicting health care utilization among foreign-born adults. Column 1 shows that immigration enforcement policies are significantly and negatively associated with visiting a medical provider. A larger number of restrictive immigration enforcement policies is associated an 8% (OR=.92) decrease in the odds of visiting a medical provider. Column 2 shows a similar pattern for dental visits. Restrictive immigration enforcement policies significantly reduce the odds of visiting a dental provider by 7% (OR=.93). These results hold when accounting for individual-level

controls and state-level inclusionary immigration policies that extend eligibility to undocumented immigrants for public benefits. Supplementary analyses (not shown) indicate that state-level immigration enforcement policies are not significantly associated with health care utilization among U.S.-born adults. This finding suggests that the influence of immigration enforcement policies on health care utilization is unique to immigrants.

Prior to the PAA Annual Meeting, I will refine the analyses in at least two ways. First, I will use the 2014 American Community Survey to construct other relevant state-level controls, such as the unemployment rate and the percentage of residents who are foreign-born, in order to control for other state-level factors that might influence immigrants' health care utilization. Second, I will test whether the association between immigration enforcement policies and healthcare utilization varies by immigration status by including an interaction between immigration policies and undocumented status. The SIPP is the only nationally representative datasets with reliable information about the undocumented immigrant population. The SIPP asks immigrants about their immigration status when they arrived in the U.S. (permanent resident or other) and if they have since adjusted their status, making it possible to infer if their status is documented or not. This will provide insight into whether most vulnerable group of immigrants are at the greatest risk avoiding the health care system.

Table 1. Weighted Descriptive Statistics, Foreign-born Adults Age 18 and Older

	Mean or Proportion	S.D.
Health Care Utilization		
Any medical visits in the past year	0.66	
Any dental visits in the past year	0.58	
State Immigration Policies		
Enforcement policies	0.88	0.74
Public benefits policies	5.55	2.74
Age	45.57	16.07
Male	0.48	
Race/ethnicity		
White	0.20	
Black	0.09	
Latino	0.44	
Asian	0.26	
Other	0.01	
Education level		
Less than high school	0.26	
High school	0.23	
Some college	0.20	
College degree	0.19	
Advanced degree	0.12	
Annual household income (logged)	10.84	1.11
U.S. citizen	0.55	
Poor health	0.15	
Any health insurance	0.72	
N=8,055		

Source: Wave 1, 2014 Survey of Income and Program Participation

Table 2. Odds Ratios from Logistic Regression Models Predicting Health Care Utilization, Foreign-born Adults Age 18 and Older

Health care utilization	Any medical visits (1)			Any dental visits (2)		
State-level immigration policies						
Enforcement policies	0.92	(0.03)	*	0.93	(0.03)	*
Public benefits policies	1.02	(0.01)		1.01	(0.01)	
Age	1.02	(0.00)	***	1.00	(0.00)	
Male	0.51	(0.03)	***	0.74	(0.04)	***
Race/ethnicity (ref=White)						
Black	0.76	(0.10)	*	0.72	(0.08)	**
Latino	0.81	(0.07)	*	0.94	(0.08)	
Asian	0.82	(0.08)	*	0.70	(0.06)	***
Other	1.31	(0.37)		0.68	(0.16)	
Education level (ref=Less than high school)						
High school	1.09	(0.09)		1.19	(0.09)	*
Some college	1.05	(0.09)		1.42	(0.12)	***
College degree	1.39	(0.14)	***	1.82	(0.16)	***
Advanced degree	1.55	(0.19)	***	1.98	(0.21)	***
Annual household income (logged)	1.13	(0.03)	***	1.32	(0.04)	***
U.S. citizen	1.26	(0.08)	***	1.56	(0.09)	***
Poor health	3.15	(0.32)	***	0.77	(0.06)	***
Any health insurance	2.98	(0.20)	***	2.38	(0.15)	***
N=8,055						

Source: Wave 1, 2014 Survey of Income and Program Participation

Note: Standard errors in parentheses. Analyses are weighted. *p < .05, **p < .01, ***p < .001

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