E. Richard Brown My work on immigrants' access to health care, which is a relatively recent interest, came directly from three streams. One stream was my life's work, another was generated by American politics, and the third came from my family roots. The first stream emanated from my own professional and social values. I have spent my professional life studying the factors that affect access to health services and working to improve access for disadvantaged populations in the United States. Immigrants were implicitly, but not explicitly, included in my work until anti-immigrant themes became prominent in political and public policy debates. This second stream, a xenophobic fever that periodically infects the body politic, began to change public policy in ways that would dramatically reduce immigrants' access and pushed me to make their needs an explicit focus of my work. The final stream was my family's own immigrant roots. My parents both came to the United States, my mother from Poland and my father from Russia, when they were young children. Their struggles as poor immigrants shaped their lives and made it difficult for me to ignore the viciousness of efforts to make immigrants scapegoats for real and imagined policy problems.

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Access to Health Insurance and Health Care for Mexican American Children in Immigrant Families

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Access to health insurance and to health care are important indicators of socioeconomic opportunity, an ongoing concern in immigration research because social and economic opportunities are important determinants of immigrants' assimilation into U.S. society (Bean et al. 1994; Lee and Edmonston 1994). Access to health services is particularly important for children to ensure that acute and chronic conditions are diagnosed and treated in a timely manner, that health and development are adequately monitored, and that preventive services are provided as recommended (American Academy of Pediatrics 1995). These issues are particularly salient for Mexican immigrants in the United States, who have poorer socioeconomic status than many other immigrant groups.

Health insurance is important because it provides an important degree of financial access to health services. Numerous studies have demonstrated that children who are uninsured—without private health insurance, Medicaid, or any other public coverage—receive fewer physician visits overall, fewer visits for care of chronic conditions, and fewer preventive health services than do insured children (Newacheck, Hughes, and Stoddard 1996; Stoddard, St. Peter, and Newacheck 1994; Wood et al. 1990; Brown 1989).

Although health insurance coverage is important, other factors also influence access. Having a regular provider of care facilitates a connection to the health system; it has been found consistently to increase use of health services (Berk, Schur, and Cantor 1995; Andersen and Davidson 1996). Geographic availability affects use of ambulatory care services and rates of avoidable hospitalizations (Andersen and Davidson 1996; Valdez and Dallek 1991). And cultural factors, including both language barriers and customs, affect access for immigrant and other ethnic and racial minority populations (Aday et al. 1993; Board on Children and Families 1995).

Despite the demonstrable benefits of good access to health care, noncitizens' entitlement to publicly funded health services, as well as to welfare programs and educational services, has become a highly charged policy and political issue (Fix and Passel 1994; General Accounting Office 1995; Clark et al. 1994). In 1996, Congress dramatically reduced the entitlement of both legal and undocumented immigrants to a broad range of federal public assistance programs, including Medicaid. Much of the debate and policy analysis has centered on undocumented and legal immigrant adults, with very little attention to the potential impact of sweeping reforms on children despite the fact that many of the changes taking place disproportionately affect children, particularly immigrant children, and may reduce their access to health care services.

These public policy changes were enacted in the absence of any extensive body of research findings about immigrants' access to health care. The research and theoretical literature on access to health care has focused considerable attention on racial and ethnic disparities, but few studies have examined immigrants' access to health insurance coverage and health care services (Thamer et al. 1997; Edmonston 1996). Latinos have the highest uninsured rates (Mendoza 1994; Valdez et al. 1993; Wyn et al. 1993) and have fewer physician visits for general medical care, acute and chronic conditions, and preventive services than do non-Latino whites (Aday et al. 1993; Wyn et al. 1993; Mendoza 1994; Lieu, Newacheck, and McManus 1993; Vega and Amaro 1994). Studies that specifically focus on Mexicans have found that the percentage of uninsured is higher and health insurance coverage is lower for this group (Trevino et al. 1996; Trevino et al. 1991). However, few studies have examined how immigration and citizenship affect health insurance coverage and access to health care.

This paper examines differences in health insurance coverage and access to health services among Mexican American children living in the United States, comparing noncitizen or immigrant children (first-generation immigrants),

U.S.-citizen or nonimmigrant children in immigrant families, and U.S.-citizen children with U.S.-born parents. The study examines the effects of immigration and citizenship status on uninsurance and access to physician visits among Mexican American children in the United States.

METHODS

The researchers analyzed two large population-based surveys, the March 1996 Current Population Survey and the 1994 National Health Interview Survey, to assess the effects of immigration and citizenship status and other factors on health insurance coverage and on access to health services. The Current Population Survey (CPS) is a national cross-sectional survey conducted by the U.S. Bureau of the Census via phone and in-person to obtain information on employment, unemployment, and demographic status of the noninstitutionalized U.S. civilian population. The March 1996 CPS contains extensive information on household relationships, sources of income, ethnicity, citizenship, immigration status, nativity, and health insurance coverage of each household member. The CPS includes information, usually reported by an adult family member, on approximately 4,600 Mexican American children aged 0 to 17 years in the survey sample.

The National Health Interview Survey (NHIS), administered by the National Center for Health Statistics, is a national in-person survey of the noninstitutionalized population that includes demographic, health status, and utilization information in the core survey. Special supplements were administered in 1994 to provide additional information on health insurance coverage, reported reasons for lack of coverage, and access to health care services. The 1994 NHIS includes information, also reported by an adult family member, on approximately 2,800 Mexican American children aged 0 to 17 in the sample. The NHIS does not contain information on citizenship status, and it contains only limited information on national origin, although it does provide information on whether the child was born in Mexico.

Uninsurance, Immigration, and Citizenship

This study examines Mexican-origin children living in the United States and answers the following questions: Are noncitizen Mexican-origin children at higher risk of being uninsured than U.S.-citizen children in immigrant families? Are U.S.-citizen Mexican-origin children in immigrant families at higher risk of being uninsured than those whose parents were born in the United States? How does the health insurance coverage of Mexican-origin children compare with non-Latino white children?

To answer these questions, we compared the health insurance status of Mexican-origin children who are (1) immigrant noncitizens, (2) U.S. citizens in families with one or more immigrant parents, and (3) U.S. citizens with U.S.-born parents. We used data on children and their families from the March 1996 Current Population Survey to examine health insurance coverage.

Variables Used in the Analysis of Health Insurance Coverage

Our analytic approach is based on the premise that family characteristics strongly influence children's health insurance coverage. We therefore structured the variables, when feasible, to reflect this focus on the family by including information that characterizes the family as well as the child.

Health Insurance Status The child's health insurance coverage was the outcome variable in this portion of the study. The March CPS asks respondents about health insurance coverage for each family member during the previous calendar year. Children insured by any source at any time during 1995 were counted as insured. Because a person may have multiple sources of coverage reported for 1995, a single hierarchical variable was created to reflect rank ordering of reported health insurance coverage. We counted persons who reported having coverage through their own or a family member's employment at any time during 1995 as covered by employment-based health insurance. Children who did not have any private coverage, but who had Medicaid coverage at any time during the year were counted as having coverage through that federal-state program. Persons who had other public coverage or privately purchased health insurance (i.e., not obtained through employment) were counted as other coverage. Those with no reported coverage of any kind during the year were categorized as uninsured.

Ethnicity We classified the ethnicity of the child based on parent-reported race and information about origin or descent. Children were categorized as Mexican American if their origin or descent was identified as Mexican American, Mexican, or Chicano, regardless of reported race. For simplicity, in this paper we refer to all children of Mexican ethnicity or national origin as Mexican American. Non-Latino white children were categorized according to parent-identified race.

Immigration and Citizenship Status We classified children into three immigration and citizenship categories: (1) noncitizen immigrant child, that is, a child who was not born in the United States and is not a U.S. citizen; (2) U.S.-citizen child (U.S. born or naturalized) in an immigrant family (i.e., one or more parents foreign born, regardless of whether they are U.S. citizens); and (3) U.S.-citizen child with both parents born in the United States (or, in a single-parent family, the one parent U.S. born).

We examined potential differences in access to public or private health insurance coverage among noncitizen children, citizen children in immigrant families, and children in nonimmigrant families. First, we hypothesized that a child's citizenship status would affect whether they received private health insurance or Medicaid coverage. Although legal immigrants, regardless of citizenship status, were entitled to Medicaid in 1995, we anticipated that noncitizen children may have had less access to these benefits. The CPS does not distinguish between legal and undocumented immigrants or refugees and asylees; noncitizens as defined in this paper include all immigrants who are not citizens.

Second, we hypothesized that, even among citizen children, parents' immigration status would affect the child's access to coverage. We expected that citizen children with U.S.-born parents were likely to have the best access to health insurance through employment or private purchase and, in the absence of private coverage, through Medicaid and other public programs. We compared immigrant children's uninsurance rates with those of U.S.-born children, a relative standard.

Family Income Related to Poverty Children were classified into one of four family-income groups measured in relation to the poverty level, a standard set annually by the federal government and based on total family income from all sources and the number of persons in the family. The groupings used to classify children were below poverty (i.e., less than 100 percent of the federal poverty level), 100 to 199 percent of poverty, and 200 percent plus of poverty. In 1995, the year reflected in the CPS questions on health insurance coverage, the poverty level was set at $15,569 for a family of four.

Family Structure We categorized a child as living in a two-parent or single-parent family. We expected that single-parent families would, on average, provide fewer opportunities for children to receive health insurance coverage through the employment of a parent. On the other hand, children in low-income single-parent families would be more likely to qualify for Medicaid.

Family Work Status To examine the effects of labor force participation and employment characteristics on children's health insurance coverage, we classified the family's work status on the basis of the adult (parent) whose labor force

participation provided the best opportunity for family members to receive health insurance coverage (we sometimes call this person the primary worker or primary breadwinner). A family was classified as a full-time, full-year employee family if at least one of the parents reported working for an employer at least 35 hours per week for 50 to 52 weeks in 1995; a full-time, part-year employee family if a parent worked for an employer full time for less than 50 weeks; a part-time employee family if no parent worked as a full-time employee but one worked for an employer less than 35 hours a week; self-employed if a parent was self-employed; or nonworking if no parent worked during 1995.

Parent's Educational Status We examined the effect on health insurance coverage of the family's educational status. The educational attainment of the parent whose employment characterizes the family's work status (the primary worker) was used to categorize the family's educational status.

Parent's Duration of Residence in the United States We also examined the effects on health insurance coverage of duration of residence in the United States, measured by the year in which the parent who is the primary worker immigrated to the United States.

UNINSURANCE, ETHNICITY, IMMIGRATION, AND CITIZENSHIP

Noncitizen Mexican American children are much more likely to lack coverage compared with U.S.-born Mexican American children. Over one-half (55 percent) of Mexican noncitizen immigrant children lack coverage—nearly twice the rate for citizen children in immigrant families (29 percent) and three times the rate for citizen children whose parents were born in the United States (18 percent; see Table 7.1).[1] Much of this disparity in uninsured rates is due to differences in access to employment-based coverage through a parent's job. Only 20 percent of noncitizen immigrant Mexican American children have this coverage, in contrast to 34 percent of citizen children in immigrant families and 49 percent of citizen children with U.S.-born parents. However, even this latter group, which has the best employment-based coverage rates among Mexican American children, fares much worse than comparable non-Latino white citizen children with U.S.-born parents, 74 percent of whom have job-based coverage and only 10 percent of whom are uninsured. In fact, noncitizen, non-Latino white children and citizen Mexican American children with U.S.-born parents have comparable employment-based health insurance rates (53 and 49 percent, respectively).

The low rates of employment-based insurance among Mexican American children are partially offset by Medicaid, which covers from one-quarter to one-third

TABLE 7.1

Health Insurance Coverage of Mexican Americans and Non-Latino Whites by Immigration and Citizenship Status, Ages 0–17, United States, 1995

	Uninsured %	Employment Based Insurance %	Medicaid %	Other %	Total %
Mexican American Children					
Citizen child with U.S.-born parents	18 (15, 21)	49 (46, 52)	30 (27, 33)	3 (2, 4)	100 (*N*=2,470,000)
Citizen child in immigrant family	29 (26, 32)	34 (31, 37)	35 (32, 38)	2 (1, 3)	100 (*N*=3,549,000)
Noncitizen child	55 (49, 61)	20 (15, 25)	23 (18, 28)	2 (0, 4)	100 (*N*=842,000)
Non-Latino White Children					
Citizen child with U.S.-born parents	10 (10, 10)	74 (73, 75)	10 (10, 10)	7 (7, 7)	100 (*N*=43,210,000)
Citizen child in immigrant family	13 (11, 15)	68 (65, 71)	12 (10, 14)	7 (5, 9)	100 (*N*=2,465,000)
Noncitizen child	14 (8, 20)	53 (45, 61)	23 (16, 30)	10 (5, 15)	100 (*N*=400,000)

Note: Parentheses provide 95% confidence interval for estimate.

Source: March 1996 Current Population Survey.

of children within each immigrant group. Without Medicaid, these children would have even higher uninsured rates. It is noteworthy that equal proportions of noncitizen, non-Latino white children and noncitizen Mexican American children are covered by Medicaid, but non-Latino white children are more than twice as likely to have employment-based health insurance, which results in a much lower uninsured rate than their Mexican American counterparts.

Uninsured rates vary by social and economic factors, particularly for citizen children (Table 7.2). Noncitizen children whose primary working parent has less than a high school education are particularly disadvantaged: Over one-half (57 percent) of these children are uninsured. Only among Mexican American and non-Latino white citizen children with U.S.-born parents does the primary working parent having at least some college education make a statistically significant difference in reducing the risk of uninsurance.

Among noncitizen children, those with incomes below poverty are more likely to be uninsured. Yet, among these children, uninsured rates are much higher for noncitizen Mexican American children (60 percent of whom are uninsured) than for non-Latino white noncitizen children. A different pattern

TABLE 7.2

Percentage of Children Uninsured by Sociodemographic Characteristics for Mexican Americans and Non-Latino Whites, by Immigration and Citizenship Status, Ages 0-17, United States, 1995

	Mexican American Children			Non-Latino White Children		
	Noncitizen Child	Citizen Child in Immigrant Family	Citizen Child in U.S.-Born Family	Noncitizen Child	Citizen Child in Immigrant Family	Citizen Child in U.S.-Born Family
All Children in Group	55	29	18	14	13	10
Age						
0–5	53 (37, 69)	27 (23, 31)	15 (11, 19)	4 (0, 12)	14 (10, 18)	10 (9, 11)
6–11	53 (44, 62)	30 (25, 35)	18 (13, 23)	15 (5, 26)	14 (10, 18)	10 (9, 11)
12–17	57 (48, 66)	33 (27, 39)	23 (18, 29)	18 (8, 28)	12 (8, 16)	10 (9, 11)
Family Structure						
Married couple with children	57 (50, 63)	31 (28, 34)	19 (15, 22)	13 (7, 19)	11 (9, 13)	9 (8, 9)
Single adult with children	47 (33, 60)	24 (18, 29)	18 (14, 22)	21 (3, 38)	27 (19, 35)	16 (14, 17)
Educational Status of Parent						
Less than high school graduation	57 (50, 63)	32 (28, 35)	22 (17, 27)	24 (8, 40)	22 (15, 29)	23 (21, 25)
High school graduate	37 (20, 55)	23 (17, 29)	21 (16, 25)	13 (0, 27)	15 (10, 20)	13 (12, 14)
At least some college	[a]	26 (19, 33)	11 (7, 15)	11 (4, 18)	10 (8, 13)	6 (6, 7)

Note: Parentheses provide 95% confidence interval for estimate.
[a] Sample size too small to make a reliable estimate.

Source: March 1996 Current Population Survey.

is seen for citizen children. For citizen children in immigrant families, those with family incomes between 100 and 199 percent of poverty are more likely to lack coverage. For citizen children with U.S.-born parents, uninsured rates are similar for those with incomes below poverty and those at 100 to 199 percent of poverty. These higher or equal rates at 100 to 199 percent of poverty reflect the greater protection that Medicaid offers to poor children compared with those above the poverty level. The patterns for non-Latino white children are even more dramatic.

TABLE 7.2 (CONTINUED)

Percentage of Children Uninsured by Sociodemographic Characteristics for Mexican Americans and Non-Latino Whites, by Immigration and Citizenship Status, Ages 0-17, United States, 1995

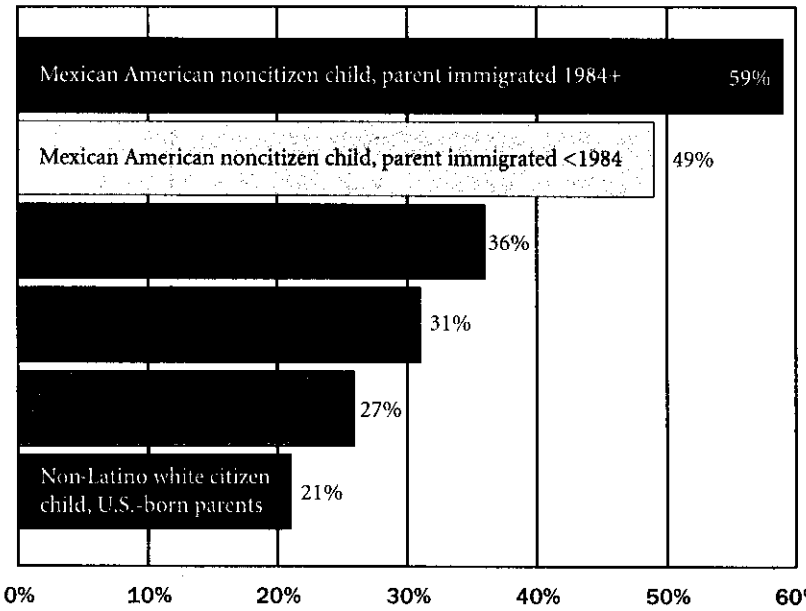
	Mexican American Children			Non-Latino White Children		
	Noncitizen Child	Citizen Child in Immigrant Family	Citizen Child in U.S. Born Family	Noncitizen Child	Citizen Child in Immigrant Family	Citizen Child in U.S. Born Family
Family Income						
Below poverty	60 (52, 68)	27 (23, 31)	22 (17, 27)	25 (11, 38)	18 (11, 24)	23 (21, 25)
100–199% of poverty	46 (36, 55)	36 (31, 40)	24 (19, 30)	14 (2, 26)	31 (24, 39)	19 (17, 20)
200%+of poverty	[a]	20 (15, 26)	11 (7, 14)	7 (1, 14)	7 (5, 9)	6 (5, 6)
Family Work Status						
Full-time, full-year employee	58 (51, 66)	31 (27, 34)	16 (13, 20)	12 (5, 18)	11 (9, 14)	7 (7, 8)
Full-time part-year employee	45 (32, 58)	29 (23, 35)	25 (16, 34)	18 (0, 37)	11 (4, 18)	16 (14, 18)
Part-time employee	[a]	22 (12, 33)	21 (11, 31)	7 (0, 35)	14 (3, 25)	19 (16, 21)
Duration of Parent's Residence						
Pre-1979	46 (32, 61)	29 (25, 33)	na	10 (0, 38)	12 (9, 15)	na
1980–1983	48 (30, 66)	26 (20, 32)	na	21 (0, 44)	22 (13, 31)	na
1984–1989	56 (46, 65)	33 (27, 39)	na	33 (16, 50)	20 (12, 28)	na
1990–1996	60 (50, 69)	33 (23, 43)	na	7 (2, 13)	16 (5, 27)	na

Medicaid also provides important protection to Mexican American citizen children in immigrant single-parent families; their uninsured rate is lower than for similar children in married-couple families (Table 7.2). This pattern is reversed for non-Latino white citizen children, with lower uninsured rates among those in two-parent families.

The number of hours worked and the duration of work does not show a consistent relationship to insurance coverage across Mexican American immigrant

FIGURE 7.1

Probability of Being Uninsured by Immigration and Citizenship Status, Mexican American and Non-Latino White Children, Ages 3–5, United States, 1995



Note: Predicted probabilities are for a child who is female; aged 3 to 5 years; in excellent to good health; living in a two-parent family, having at least one parent who is employed full-time for the full year, a family income of 100 to 199 percent of the federal poverty level; and whose parent is the primary worker has not graduated high school.

Source: March 1996 Current Population Survey.

groups. However, among Mexican American children in full-time, full-year working families, citizen Mexican American children with immigrant parents are twice as likely to lack coverage as are citizen children with U.S.-born parents, and noncitizen children are over three times as likely (Table 7.2).

Coverage opportunities also differ dramatically between Mexican Americans and non-Latino whites. Across all Mexican American immigrant groups, labor force participation does not provide the same degree of health insurance coverage as seen for comparable non-Latino whites. Particularly striking are comparisons between noncitizen Mexican American and non-Latino white children in full-time, full-year employee families. Whereas 58 percent of noncitizen Mexican American children lack coverage, only 12 percent of similar non-Latino whites are uninsured (Table 7.2).

The wide differences in uninsured rates between Mexican American children in immigrant and nonimmigrant families may be due, in part, to differences between these groups in educational attainment, family work status, family income, and other factors that are highly correlated with uninsurance. To better understand these relationships, we used multivariate analysis to examine the independent effects of immigration and citizenship status on the probability of being uninsured. Figure 7.1, based on our multivariate analysis, illustrates the effects of immigration and citizenship status on the probability of being uninsured among Mexican American children and compared with non-Latino white children with U.S.-born parents. The figure shows how each combination of immigration and citizenship status affects the probability that a child with specific characteristics would be uninsured, holding constant factors other than ethnicity, immigration, and citizenship. We illustrate the effects with a child who is female, aged 3 to 5 years, in excellent to good health, living in a two-parent family in which at least one parent is employed full-time for the full year, where the family income is 100 to 199 percent of the federal poverty level, and where the parent who is the primary worker has not graduated from high school. (The probabilities shown in Figure 7.1 and discussed below are specific to this defined set of characteristics, but another set of characteristics would be likely to demonstrate similar relationships of immigration and citizenship status to the probability of uninsurance.)

Immigration and citizenship status dramatically affect the probability of being uninsured. Mexican American children with the defined characteristics who are noncitizens and whose parents immigrated to the United States in 1984 or later have a probability (or risk) of uninsurance of 59 percent compared with a probability of 49 percent if they are noncitizens whose parents immigrated before 1984, 36 percent if they are citizens whose parents are immigrants who came to the United States in 1984 or later, and 31 percent if they are citizens whose parents are immigrants who immigrated before 1984 (Figure 7.1). It is noteworthy that Mexican American children whose parents were born in the United States have a risk of uninsurance of 27 percent, a lower risk than for other children of Mexican ancestry but a higher risk than for similar non-Latino white children.

THE EFFECTS OF IMMIGRATION STATUS ON ACCESS TO CARE

Does immigration status affect the access of Mexican American children to health services? Do factors that are susceptible to public policy intervention ameliorate any disadvantage that immigrant status may bestow?

To answer these questions, we compared the health care access and use of physician services of children who are immigrants, nonimmigrant children in families with one or more immigrant parents, and nonimmigrant children

with U.S.-born parents. We used data on children and their families from the 1994 National Health Interview Survey.

Variables Used in the Analysis of Reasons for Uninsurance, Health Care Access, and Use of Health Services

The NHIS includes measures of health status, reasons for uninsurance, usual source of care, and use of health services, information that is not available in the CPS. In addition, some variables in the CPS are not available in the NHIS. Variables in the NHIS that are similar to those available in the CPS require no further definition, but we describe those that differ from the CPS variables discussed earlier. As with the analyses of health insurance coverage, we structured several independent variables to characterize the family as well as the child.

Physician Visits Information on physician visits was obtained using the NHIS question "During the past 12 months about how many times did (child's name) see or talk to a medical doctor or assistant?" We examined the probability of at least one physician visit per year for all children, newborn through age 17. The American Academy of Pediatrics recommends annual preventive care visits for children and adolescents aged 24 months through 17 years (except for ages 7 and 9), and more frequent visits for children under 24 months of age (American Academy of Pediatrics 1995). Thus, our criteria of at least one physician visit per year is a reasonable measure of recommended physician visits.

Usual Person or Source of Care Information on whether or not the child has a usual person or place for medical care was based on the NHIS question "Is there a particular person or place that (child's name) usually goes to when sick or needs advice about health?" Having a usual source of care has been demonstrated to be a robust measure of access to health services.

Immigrant Status We classified children into three immigrant groups based on the immigrant status of the child, and for U.S.-born children, the immigrant status of the parents: (1) immigrant child, that is, a child not born in the United States; (2) U.S.-born child who has at least one immigrant parent; and (3) nonimmigrant child, that is, a U.S.-born child with U.S.-born parents (or in a single-parent family, the parent is U.S. born). A child not born in the United States, but who has U.S.-born parents, is also counted as nonimmigrant. The NHIS does not include any questions about citizenship status.

Reason for Lack of Coverage This information was based on two questions in the NHIS. The first asks respondents which of a series of statements describes why the child is not covered by any health insurance coverage. The second question asks what is the main reason for lack of coverage.

Main Reasons for Lack of Coverage among Uninsured Children

Regardless of immigrant status, the main reason reported (by adult respondents) for children's lack of coverage is that health insurance is unaffordable (Table 7.3). The expense of health insurance coverage far overshadows any other reason and is reported for 72 percent of immigrant children, 72 percent of U.S.-born children of immigrants, and 76 percent of U.S.-born children with U.S.-born parents. A distant second reason for lack of coverage, and related to affordability, is the unavailability of employment-based health insurance. The dominant role that financial access plays in limiting coverage highlights the need for improving the affordability of coverage, through contributions from employers and/or public programs.

TABLE 7.3

Main Reasons for Lack of Coverage among Uninsured Mexican American Children by Immigration Status, Ages 0-17, United States, 1994

Main Reason for Lack of Health Insurance Coverage	Immigrant Child (%)	U.S.-Born Child of Immigrant Parents (%)	Child and Parents U.S.-Born (%)
Too expensive	72 (63, 81)	72 (65, 79)	76 (68, 84)
Employer does not offer or worker not eligible	9 (3, 15)	11 (6, 16)	10 (4, 16)
Beliefs about coverage	4 (0, 8)	5 (2, 8)	1 (0, 3)
Other options	6 (1, 11)	3 (0, 6)	<1 (0, 3)
Job layoff or unemployed	1 (0, 3)	4 (1, 7)	3 (0, 6)
Other reasons	6 (1, 11)	6 (2, 10)	9 (3, 15)

Note: Parentheses provide 95% confidence interval for estimate.

Source: 1994 National Health Interview Survey.

Belief that coverage is not needed, dissatisfaction with coverage, and lack of belief in health insurance play a minor role in why Mexican Americans do not have coverage, as does the availability of free services or other options to obtain care. Thus, the perceived lack of need for coverage either because of beliefs or other options is not an important reason for lack of coverage for any of the immigrant groups.

USUAL PERSON/PLACE OF CARE

One-third of immigrant Mexican American children (35 percent) lack a usual person or place for health care, compared with 12 percent for Mexican American U.S.-born children with immigrant parents and 8 percent for Mexican American nonimmigrant children (Table 7.4). Within each immigrant status, non-Latino white children are more likely to have a regular connection to the health care system than are comparable Mexican Americans.

For children, having access to a health care provider is critical for reasons beyond treatment for acute care needs. Children need a regular connection for

TABLE 7.4

Percentage of Mexican American and Non-Latino White Children with No Usual Person or Place for Medical Care and Percentage with No Physician Visit during Past Year by Immigration Status, Ages 0–17, United States, 1994

	Mexican American			Non-Latino White		
	Immigrant Child %	U.S.-Born Child of Immigrant Parents %	Child and Parents U.S.-Born %	U.S.-Born Child of Immigrant Child %	Immigrant Parents %	Child and Parents U.S.-Born %
No Usual Source of Care	35 (28, 42)	12 (10, 14)	8 (6, 10)	23 (17, 29)	5 (4, 6)	5 (5, 5)
Did Not Have Physician Visit During Past Year						
All ages: 0–17	42 (35, 49)	23 (20, 26)	21 (17, 24)	27 (21, 31)	16 (13, 18)	17 (16, 18)
Ages 0–2 years	[a]	8 (4, 12)	3 (0, 6)	[a]	4 (1, 8)	4 (3, 5)
Ages 3–5 years	22 (5, 39)	13 (8, 18)	11 (5, 16)	19 (4, 34)	9 (5, 13)	10 (9, 12)
Ages 6–17 years	46 (38, 54)	34 (29, 39)	30 (25, 34)	29 (22, 36)	22 (19, 26)	22 (21, 23)

Note: Parentheses provide 95% confidence interval for estimate.
[a] Sample size too small to make a reliable estimate.

Source: 1994 National Health Interview Survey.

well baby and child checkups, preventive care, and developmental assessment visits.

Among children with a usual source of care, the physician office or private clinic is the most frequently reported site of care across immigrant groups, although it is less common for immigrant children to have this source (Table 7.5). Immigrant children (38 percent) and to a lesser extent children with immigrant parents (20 percent) use public and community clinics at a higher rate than do nonimmigrant children (11 percent), suggesting the critical importance of these safety net providers to Mexican American children in immigrant families.

USE OF HEALTH SERVICES

Among Mexican American children, those who are immigrants are less likely than either those with immigrant parents or those who are nonimmigrants to have had a physician visit during the past year (Table 7.4). Forty-two percent of immigrant children did not have a recent physician visit, compared with 23 percent of children of immigrants and 21 percent of nonimmigrant children. Among children aged 6 to 17 years, immigrant children remain the least likely to have had a physician visit. Mexican American immigrant children and nonimmigrant children in immigrant families are also more likely not to have had a physician visit than similar non-Latino white children.

TABLE 7.5

Type of Usual Source of Care by Immigration Status among Mexican American Children with a Usual Source of Care, Ages 0–17, United States, 1994

	Immigrant Child %	Child of Immigrant Parents %	Nonimmigrant Child %
MD office/private clinic	52 (43, 61)	63 (59, 67)	70 (66, 74)
County/public clinic	18 (11, 25)	13 (10, 16)	7 (5, 9)
Community/migrant clinic	20 (13, 27)	7 (5, 9)	4 (2, 6)
HMO/prepaid group	5 (1, 9)	10 (8, 12)	13 (10, 16)
Emergency room	1 (0, 3)	<1 (0, 2)	<1 (0, 2)
Other	3 (0, 6)	7 (5, 9)	6 (4, 8)

Note: Parentheses provide 95% confidence interval for estimate.

Source: 1994 National Health Interview Survey.

HEALTH INSURANCE COVERAGE, USUAL SOURCE OF CARE, AND USE OF HEALTH SERVICES

Lower physician use rates may be due, at least in part, to uninsurance or no access to a usual source of care, or both. To understand the factors that influence physician use patterns, we conducted multivariate regression analyses. The models were tested for interactions among key analysis variables by examining the independent effects of these variables on the probability of children receiving at least one physician visit. When an interaction was suspected, based on observed changes in the direction of the coefficient, the presence of an interaction was tested. The models for physician visits account for the interactions found between poverty and immigration status, and education and immigration status.

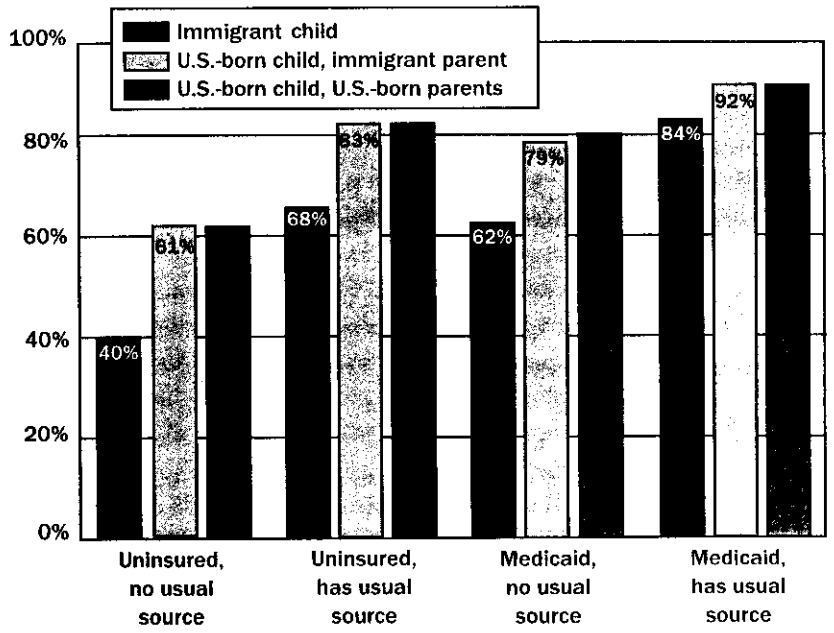
Figure 7.2, based on multivariate analysis, shows the effects of health insurance coverage and having a usual source of care on the probability of obtaining a doctor visit among U.S.-born Mexican American children in each immigration status. The figure presents predicted probabilities for a child who is female, aged 3 to 5 years, in excellent to good health with no activity limitations, living in a family of four, where the family income is 100 to 199 percent of the federal poverty level, and where the mother has not graduated from high school. In this model, only health insurance coverage, having a usual source of care, and immigration status vary.

Among all three groups of Mexican American children, being uninsured and not having a usual source of care substantially reduce the probability of having at least one physician visit in the past year, while having both Medicaid coverage and a usual source of care provides the best assurance that this minimum will be met. Among immigrant children, those who are uninsured and have no usual source of care have only a 40 percent probability of having a physician visit in a year—a 60 percent risk of not having even one physician visit for preventive or sickness care. It is apparent that having either Medicaid coverage or a usual source of care dramatically improves the probability of a physician visit to 62 and 68 percent, respectively. Having both Medicaid coverage and a usual source of care further improves the probability of a physician visit to 84 percent, thus reducing the risk of not meeting this minimum criterion of access to 16 percent.

U.S.-born children, regardless of whether their parents are U.S. born or immigrants, share similar probabilities of obtaining at least one physician visit when their insurance status and connection to the health system are similar. Those who are uninsured and without a usual source of care have a 61 percent probability of having a physician visit in a year—a 39 percent risk of not visiting a doctor—compared with an 83 percent probability if they are uninsured but have a usual

FIGURE 7.2

Probability of a Physician Visit in Past Year by Immigrant Status, Mexican American Children, Ages 3–5, United States, 1994



Note: Predicted probabilities are for a U.S.-born child who has at least one immigrant parent; is female; 3 to 5 years of age; in excellent to good health, with no activity limitations; living in a family of four with a family income between 100 and 199 percent of poverty; and whose mother did not graduate from high school.

Source: 1994 National Health Interview Survey.

source of care and a probability of 79 to 80 percent if they have Medicaid but no usual source. Under the most favorable conditions—having both a usual source of care and Medicaid coverage—their probability of a physician visit increases to 92 percent; their risk of not having one thus falls to 8 percent.

DISCUSSION AND POLICY IMPLICATIONS

Being a noncitizen or having immigrant parents puts a Mexican American child living in the United States at greater risk of being uninsured than is experienced by citizen children in native-born families. And being uninsured and without a connection to the health system exposes children, regardless of immigration status, to substantial risks of not being able to access health services to meet their health needs.

These findings underscore the importance of policies that extend health insurance coverage and improve the availability and accessibility of health services to immigrant and nonimmigrant populations, that is, policies that reduce the structural obstacles to immigrant children obtaining health care. A variety of public policies have been established to reduce the structural barriers to health insurance coverage and to health services that we found in this study. Legal immigrants were entitled to Medicaid when these surveys were conducted. In addition, federal, state, and local governments have helped to support community health centers to meet the needs of low-income communities, including those with large concentrations of immigrants. These efforts to improve access were adopted because of widespread beliefs that good access to health care promotes educational achievement and economic opportunity for children and their families. Our study demonstrates the importance of all these programs—Medicaid coverage and community and migrant health centers—for assuring health insurance coverage and access to health services for Mexican American children and especially for those who are immigrants or living in immigrant families.

Recent policy changes, however, are likely to greatly weaken these efforts to ameliorate structural barriers to access in the health system. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (H.R. 3734), for example, terminated Medicaid eligibility for most new legal immigrants and, at state option, for legal immigrants who resided in the United States when the legislation was enacted on August 22, 1996. U.S.-citizen children in immigrant families will continue to be eligible for Medicaid, and children who were noncitizen legal immigrants already residing in this country when the legislation was enacted will not lose their Medicaid entitlement if their state opts to continue to cover them (as virtually all states have chosen to do). But children who immigrate legally to the United States after August 22, 1996 will not be eligible for Medicaid unless their families are refugees or asylees, a provision that applies to few Mexican American immigrants.

These policy changes thus may increase uninsurance among immigrant children, while threatened cuts in funding for community health centers and programs that finance care for uninsured low-income persons would curtail their access to health services. These changes are likely to have an adverse effect on the health of both immigrant children and U.S.-citizen children in immigrant families.

ACKNOWLEDGMENTS

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NOTES

1. All references in the text to differences in proportions between groups are statistically significant ($p < .05$) unless otherwise stated.

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Commentary

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This chapter should evoke a sense of anxiety. The reality that we live in a wealthy society that permits millions of children to grow up without the security and benefits of health coverage constitutes a moral wrong. The chapter presents detailed and authoritative analyses of two national data sets that include information on the health status of Latino, Asian, black, and white children. One body of data provides information on access of children at different ages to health services and the other covers the proportion and characteristics of children who lack insurance. Of the three competing hypotheses examined, the results favor a structuralist interpretation. That is, as might be expected, the barriers to health care do not diminish with increasing duration of residence in the United States (the assimilation hypothesis) or with increasing education. The percentage of the uninsured varies from a low of 16 percent for Latino children of U.S.-born parents to 53 percent for Latino children born outside the United States. These percentages translate into well over 2 million uninsured Latino children. The largest number represents children who were born in the United States and who are thus citizens. It is also worth pointing out that these figures are conservative, since the surveys from which they were derived underestimate coverage in a volatile market. The data were also collected just prior to the implementation of restrictive federal policies that construct even more formidable obstacles for immigrant families and children.

The epidemiological observation that some groups of recent Latino immigrants may have better health than those from the same country of origin who have resided in the United States for longer periods of time should be cautiously weighed in relation to the data presented in this paper. If, in fact, increasing duration of residence is associated with worsening health status, then there is all the more reason to insure these families.

The concept of "citizen children" as used by the authors should be underscored. The United States has signed but not ratified the UN Convention of the Rights of the Child. Perhaps this implies that it is not yet legally and ethically bound to the principles established in that universally endorsed document.

But the fact that the United States does not use its considerable resources to provide for the welfare of children results in much avoidable suffering. How much suffering and disability is attributable to 2 million children going uninsured is not known, but whatever the estimate, it is too much.

So where do we go from here? Brown and his colleagues have written a valuable paper that provides the United States with timely and alarming evidence that our policies represent a serious breach. How do we overcome the increasing number of disincentives to provide care for immigrant and other disadvantaged groups of children? Would extending insurance to poor and near-poor families result in overutilization? Some answers are provided in a recent study by Bogard et al. (1997). These investigators examined the rate and type of utilization of poor patients who were just entering a large HMO in Denver, Colorado. The study design permitted the investigators to compare utilization between these new patients and a comparison group of nonsubsidized patients already enrolled. The results were encouraging and should allay the fears that previously uninsured patients will stretch the limits of the charity extended to them.

Health insurance has been driven more by the supply side of the capitalist equation than by the demand side. Why do we have 42 million uninsured and 40 million underinsured citizens? Immigrants are the leading edge of what must become a more vocal demand for services. By carefully constructing these secondary analyses of collected national data, Brown and colleagues have provided a solid study on which to base a sense of urgency and definitive action.

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