Mexican Immigrant Health in California: Selective Immigration or Protective Culture?

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Draft: June 23, 2004

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Abstract: Employing 1994 and 2001 random household data from Los Angeles County, 1996-2003 March Current Population Survey, 2000 Summary File 3, and 2000 Mexican Council of Population data, we find little evidence of a Latino self-reported health paradox (relative good health given one's socioeconomic status) among non-elderly adults in California. Mexico-born adults were less healthy than their U.S.-born co-ethnics, and similar proportions of authorized and unauthorized Mexican immigrants reported being in "very good" or "excellent" health. Still, when analyzing whether a foreign-born Mexican in Los Angeles County needed unanticipated medical care, we find that a slightly smaller proportion of unauthorized (34%) compared to authorized (36%) Mexican immigrants did. Even if one interprets this as a health paradox, however, among our proxies for protective culture and healthy immigrant selectivity, one of the latter (having been born in an urban and consequently relatively healthy municipality) was statistically significant in our logistic regression models.

INTRODUCTION

Historic disagreement among public health practitioners and scholars, immigration and welfare policymakers, and the general public regarding the socioeconomic consequences of contagious and chronic disease among immigrants entering or residing in the United States was reinvigorated following Proposition 187, passage of the 1996 welfare and illegal immigration acts, and the events of September 11th, 2001 (Fairchild, 2004) by "growing fears about the germs by Asian and Latin American immigrants and the cost of caring for them" (Abel, 2004); and conversely, in light of recent evidence suggesting that newer immigrants may be positively selected on health-related characteristics and protected by relatively healthy cultural behaviors and conditions that may in turn dissipate over time with host-country integration (Finch & Vega, 2003; Jasso, Massey, Rosensweig, & Smith, 2004; Palloni & Morenoff, 2001; Vega & Amaro, 1994).

Despite much ado about the adverse fiscal effects of insuring and caring for immigrants residing in the United States and exclusionary impulses underlying the 1996 laws (Lofstrom & Bean, 2002; Marcelli & Heer, 1998); however, a considerable amount research on immigration and health pivots around the claim that although persons born in Mexico and other Latin American nations and their descendants have less education, lower earnings, and less access to medical care – and are therefore at higher risk of being less healthy than members of other demographic groups (e.g., non-Latino whites and blacks, U.S.-born co-ethnics) with higher socioeconomic status (SES) – the opposite is actually the case. In short, because Latinos (frequently defined as foreign-born Mexicans) are estimated to be healthier on certain metrics than would be expected in the post-Proposition 187 and 1996 immigration and welfare reform policy environment or predicted by a SES/health disparities analytical framework (Hayes-Bautista, 2002), researchers have begun to try to understand why (Finch & Vega, 2003).

Surprisingly, just as or perhaps because health disparities research and work focusing on the so-called Hispanic or Epidemiological Paradox has begun to blossom, justification for the latter has

been called into question – partly because of differences across studies regarding health outcomes and populations under investigation, partly because the evidence appears to be limited to infant (most neonatal) mortality, and partly because of biases inherent in variable-based and risk-factor methodologies employed by social demographers and epidemiologists.[1]

The purpose of this paper is twofold. First, we estimate whether a self-rated general health gap existed from 1994 to 2002 between non-elderly adults born in Mexico (Mexican immigrants) and three conventional contrast populations (non-Latino U.S.A.-born blacks and whites and U.S.-born persons of Mexican ancestry) and between authorized Mexican immigrants (e.g., legal permanent residents, temporary visitors, naturalized U.S. citizens) and unauthorized Mexican immigrants. Second, having generated evidence of an authorized-unauthorized Mexican immigrant health gap but not between Mexicans and non-Latino whites, we estimate what proportions of the variance in self-reported health among Mexican immigrants by residency status can be explained by health selectivity and by protective culture controlling for other individual and social contextual characteristics. In addition to providing evidence contrary to the conventional (Latino-non-Latino white) paradox, results suggest that the observed authorized-unauthorized Mexican health gap is partly explained by healthy migrant selectivity and partly by protective cultural factors.

Focusing on self-rated health of persons of Mexican origin by place of birth and residency status has several distinct advantages and disadvantages when viewed in the context of past research on the Hispanic Paradox. On the unfortunate side of the equation, the cross-sectional Mexican residency status data employed here prohibit saying much about the possible attenuation duration of residency in the United States has on any biological or cultural health advantage Mexican immigrants may have upon entry. Second, we are unable to adequately address the importance of several alternative

[1] Regarding methodologies, whereas epidemiologists tend to rank risks to highlight the most salient "downstream" cause of a disease and view time (accept as measured by age) as a nuisance, social demographers incorporate a number of time variables (e.g., age, period, cohort) into more comprehensive models that include "upstream" factors but often interpret estimated coefficients in

explanations for the observed paradox conditioned on residency status – poor or insufficient data, modified self-assessments of one's health as duration in the United States rises, and migrant selection based on residency status.[2] Although foreign-born Mexicans may modify assessments of their overall health upward to some extent as they become more integrated in the United States, should such bias exist it would only strengthen our finding of an authorized-unauthorized Mexican immigrant epidemiological paradox. Nonetheless, any one of these alternative factors could diminish or reverse conclusions reported below.

Keeping these limitations in mind, on the benefit side of the equation, the idea of an Hispanic Paradox emerged and has been mostly supported by analyses of Mexican populations but without attention to unauthorized residency status (Acevedo-Garcia, 2004; Palloni & Morenoff, 2001). Specifically, although Latinos have higher rates of mortality due to diabetes, HIV/AIDS, homicide, chronic liver disease and cirrhosis, and obesity – accompanying their relatively low neonatal mortality and low birth weight, Mexicans (and other Latinos) are estimated to have lower rates of mortality attributable to heart disease, cancer, stroke, pulmonary disease, pneumonia, influenza and suicide (Hayes-Bautista, 2002). We are unaware of any study to date; however, that attempts to estimate directly how unauthorized residency status influences specific health outcomes or overall health despite evidence that this status appears to have an independent depressive effect on hourly wages (Marcelli, 2004b), perceived discrimination among Mexican-origin adults may positively affect depression (Finch, Kolody, & Vega, 2000), and stress concerning one's unauthorized status may reduce self-rate health (Finch & Vega, 2003). Indeed, if for no other reason than altered exposure to various behavioral and environmental risks (Kasl & Berkman, 1983), one of the most potentially harmful aspects of migrating from Mexico exists for those attempting to enter, or residing in, the

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an universal manner that ignores the theoretical context in which variables were introduced (Palloni & Morenoff, 2001).

2 Several hypotheses point to deficiencies among immigrants (e.g., underreporting) and others to "proectective" factors which include both selective migration and protective culture (Guendelman, 1998).

United States illegally (Cornelius, 2001; Marcelli, Power, & Spalding, 2001). A second benefit of the present study is its simultaneous estimation of migrant selectivity on health and culturally protective factors such as the character of one's social relationships and participation in local community events and groups. This is important because recent econometric models combining multiple data sources (Jasso et al., 2004) and health selection simulation models (Palloni & Morenoff, 2001) generate strong selection effects, and immigrant cultural or social capital has been shown to augment well- or ill-being (Hayes-Bautista, 2002; Menjivar, 2000; Portes, 1998). Finally, despite potential biases resulting from self-reported data, a nontrivial amount of research suggests that self-rated health is a strong predictor of both morbidity and mortality (Benyamini & Idler, 1999; Finch, Hummer, Reindl, & Vega, 2002; McGee, Liao, Cao, & Cooper, 1999).

There has been an almost complete lack of attention to where one would think to look first for evidence of either health selectivity or protective culture – the country or community of origin (Frank & Hummer, 2002), and thus although we are unable to directly measure the health characteristics of sending areas, we employ a proxy for their average healthfulness based on the idea that healthier locals tend to send more migrants and receive fewer remittances for purposes of basic necessities that correlate with health (Marcelli & Lowell, 2005).

DATA AND METHODS

1994 and 2001 Los Angeles County Mexican Immigrant Residency Status Surveys

November 1994 and July 2001 Los Angeles County Mexican Immigrant Residency Status Survey (LAC-MIRSS) data are employed first to generate residency status predictors from four demographic variables (age, sex, educational attainment, time residing in the United States). These are subsequently applied to Mexican-born persons in the 1995-2002 February and March CPS data to estimate the number and characteristics of unauthorized Mexican (and other Latino) immigrants

in California, as well as self-rated health, using the survey-based residency status estimation methodology pioneered by David Heer and colleagues (Heer, Agadjanian, Hammad, Qiu, & Ramasundaram, 1992). In a third and final stage of the analysis, we combine and analyze the 2001 LAC-MIRSS, 2000 U.S. Census, and 2000 Mexican census data to estimate how health selectivity and culturally protective social capital – controlling for individual characteristics and state- and neighborhood-level factors on both sides of the Mexico-U.S. border.

The 1994 LAC-MIRSS has been employed and discussed extensively elsewhere (Marcelli, 2004c; Marcelli & Heer, 1997), and because the 2001 LAC-MIRSS is designed similarly and simply extends the 1994 LA-MILSS, in what follows we only briefly describe the latter.

The 2001 LAC-MIRSS consists of 829 foreign-born Mexicans who resided in Los Angeles County in July 2001 and were randomly selected from 456 households in 125 census blocks. The questionnaire was available in English and Spanish, took approximately 35 minutes to administer on average, and was developed and piloted by researchers from UCLA, El Colegio de la Frontera Norte (COLEF) and the Coalition for Humane Immigrants Rights in Los Angeles (CHIRLA). Overall, the household response rate was 62 percent and fully 98 percent of all respondents answered our relatively sensitive residency status questions. Slightly less than half of adult respondents admitted to residing in the United States without being a naturalized citizen, a legal permanent resident or a temporary visitor (e.g., non-immigrant visa holder).

For instance, there was a series of six residency status questions that were asked of each foreign-born Mexican adult (n=780) to determine whether he or she was a U.S. citizen (20.1 percent), legal permanent resident (29.0 percent), non-immigrant visa holder (4.9 percent), or an unauthorized immigrant (46 percent). Of the 359 persons categorized as unauthorized immigrants, the majority (330 or 92 percent) "admitted" their legal status by disclaiming being in the country under one of the several legal categories about which we inquired. The remaining 29 (or eight percent) were categorized as unauthorized immigrant because a response for at least

one legal status question was left unanswered or because a subsequent response to a legal status question conflicted with a previous one. We also use the residency status of the household head to assign Mexican-born children a legal status. As a result, 28 of 49 children (or 57 percent) are tagged as unauthorized immigrants. In sum, 387 of 829 (or 46.7 percent) of all foreign-born Mexicans in the LAC-MIRSS sample are estimated to have been unauthorized immigrants (Marcelli & Lowell, 2005).

Self-Rated Health among Mexican Immigrants in California from the 1994-2002 March CPS

Demographic predictors of residency status for Mexican adults are generated by regressing whether one was assigned the residency status of unauthorized Mexican immigrant (UMI) on AGE, SEX, educational attainment (EDUC), and years residing in the United States (YEARS) for the 780 Mexican adults in our 2001 LAC-MIRSS data (equation [1]). We do this for household heads and other household members separately, and the percent concordant pairs produced from logistic regression analyses are 82 and 76 respectively.

$$\text{UMI} = f(\text{AGE, SEX, EDUC, YEARS}) \qquad [1]$$

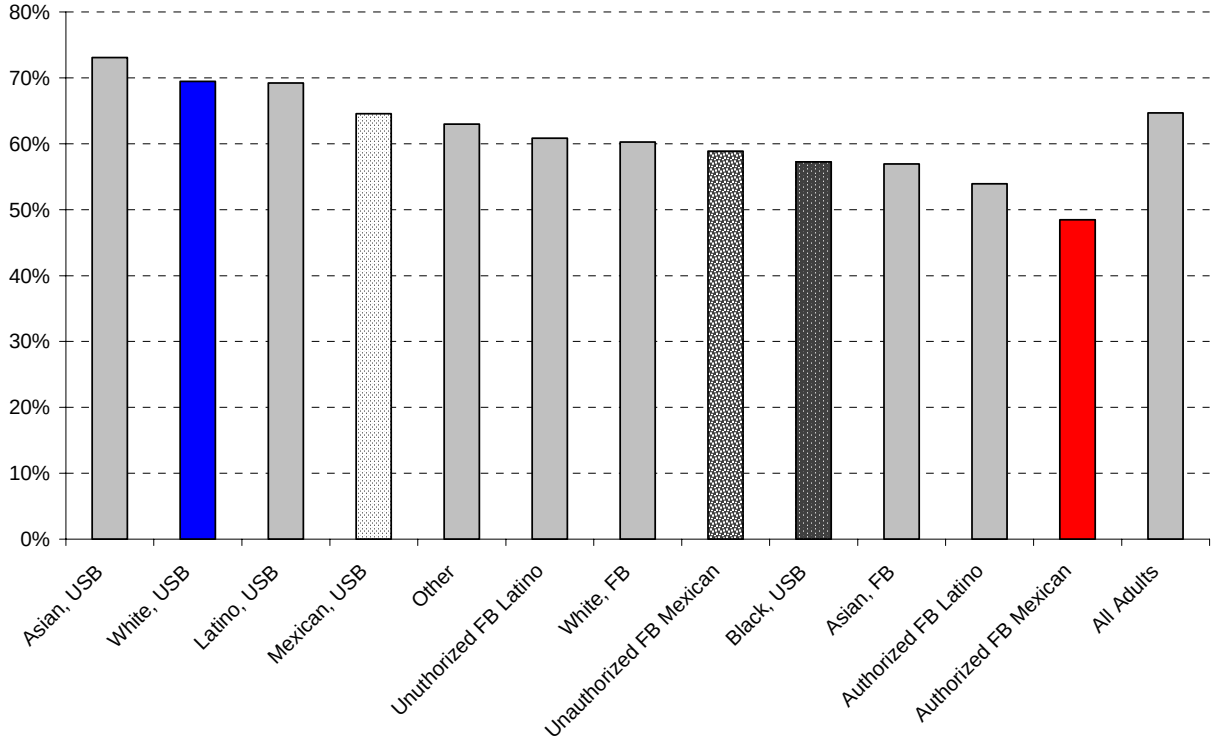
These predictors are consistent with those produced in earlier studies (Heer et al., 1992; Marcelli & Heer, 1997, 1998; Marcelli, Pastor, & Joassart, 1999), which when applied to Census Bureau public use data generated aggregate estimates of the number and characteristics of unauthorized Mexican and other Latino immigrants residing in Los Angeles County that are very similar to those imputed from Census Bureau and Immigration and Naturalization Service estimates obtained using the completely different residual or components-of-change methodology (Heer & Passel, 1987; Marcelli, 1999).

Below we apply these residency status predictors to non-Cuban foreign-born Mexicans and other Latinos in the 1995-2002 February and March CPS data for California. The 1995-2002 March CPS include the four demographic variables needed to produce a probability of having been unauthorized to reside in the United States as well as others on access to health insurance and medical care, and self-report health (Marcelli, 2004a). Although place of birth began to be asked of respondents in the 1994 March CPS, we begin with 1995 (which reports coverage in previous year) due to changes to the health insurance questions (Swartz 1997). After estimating the proportion of unauthorized Mexican immigrants and members of other ethno-racial groups in California reporting very good or excellent health using this methodology, I return to the 2001 LAC-MIRSS data to estimate the relative influence of immigrant selectivity and protective culture on the probability of having received unanticipated medical care.

RESULTS

Below are my preliminary results only.

FIGURE 1: PERCENT VERY GOOD/EXCELLENT HEALTH AMONG ADULTS BY ETHNO-RACIAL GROUP, CALIFORNIA, AVERAGE, 1995-2000



Although smaller proportions of authorized and unauthorized Mexican immigrants report being in very good or excellent health compared to non-Latino whites and all Californians on average, the higher proportion among unauthorized compared to authorized Mexican immigrants provides initial evidence of a paradox. In short, given unauthorized Mexicans lower socioeconomic status and barriers to health insurance and medical care, one would expect a lower proportion to report being in relatively good health compared to their authorized compatriots.

Figure 2; however, shows that after standardizing by age even the authorized-unauthorized self-reported health gap disappears. Consequently, we find no evidence of a Latino paradox in California – at least between Mexican immigrants and other Californians, nor among Mexican immigrants differentiated by residency status.

FIGURE 2: AGE-STANDARDIZED PERCENT VERY GOOD/EXCELLENT HEALTH AMONG ADULTS BY ETHNO-RACIAL GROUP, CALIFORNIA, AVERAGE, 1995-2000

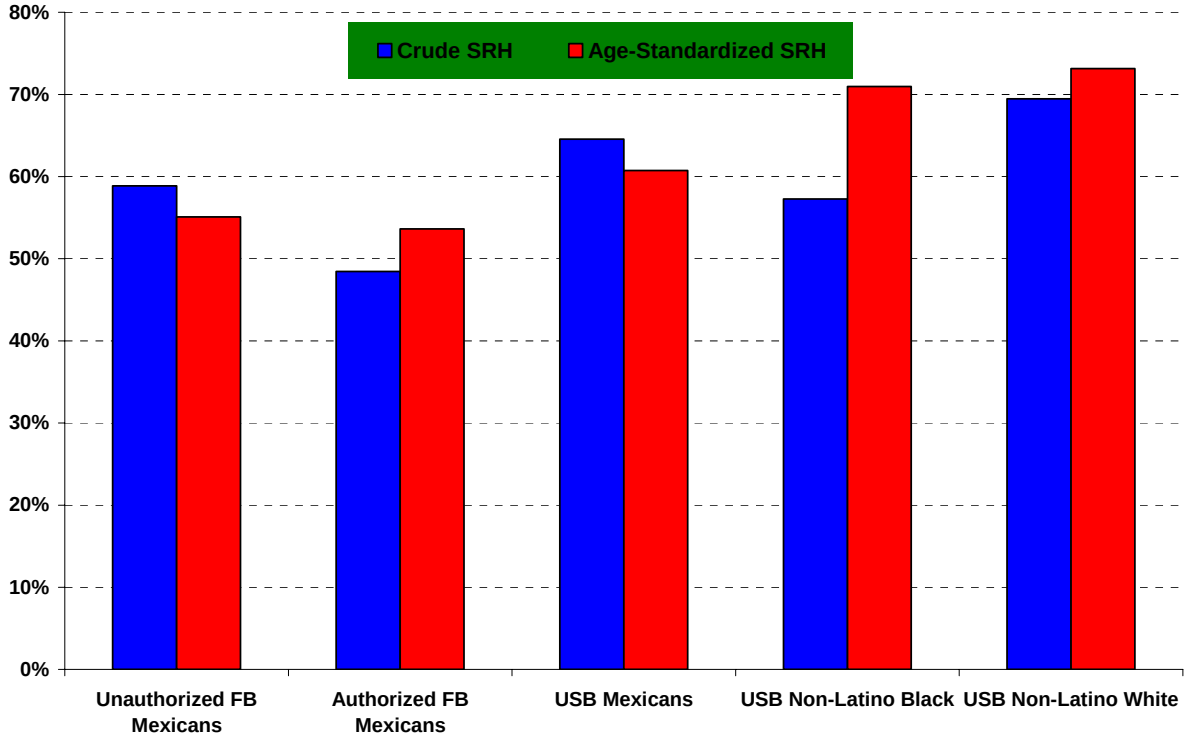


Figure 3 below offers an alternative measure of health for Mexican immigrants residing in Los Angeles County. Specifically, a slightly smaller proportion (34 percent) of unauthorized Mexican immigrants (UMI) reported needing unanticipated medical compared to authorized Mexican immigrants (AMI), 36 percent of whom reported needing care.

FIGURE 3: Foreign-born Mexican Access to Health Insurance and Medical Care During Previous Year by Residency Status, Age 18-64, Los Angeles County, 2001

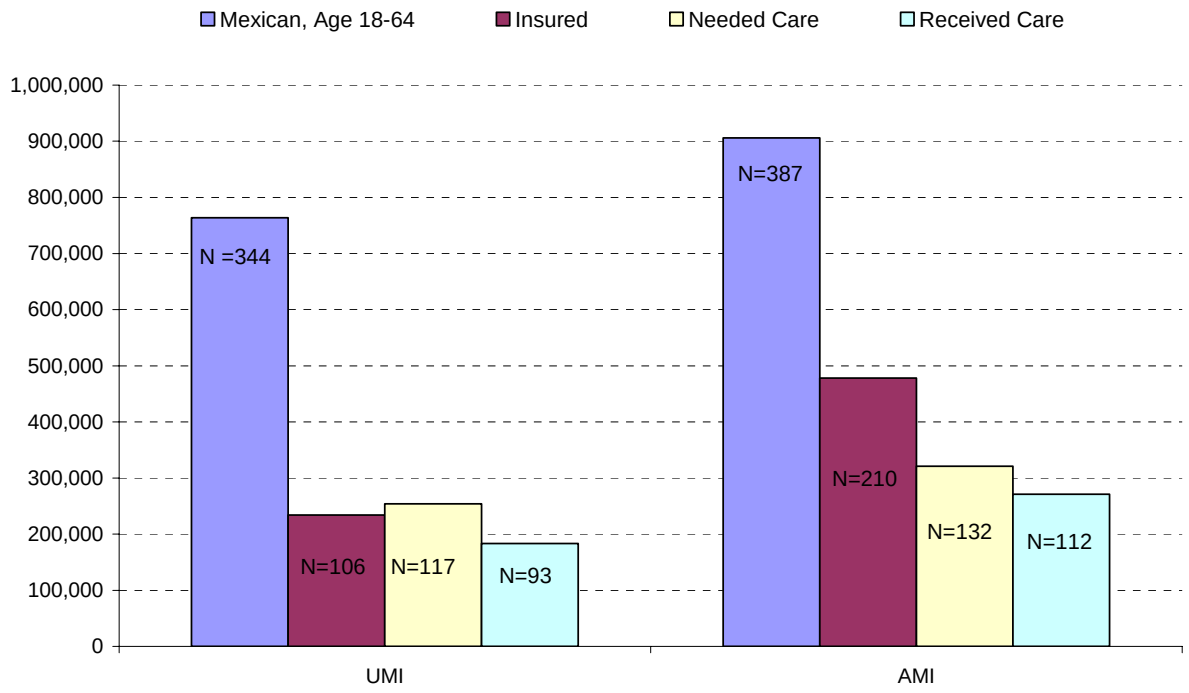
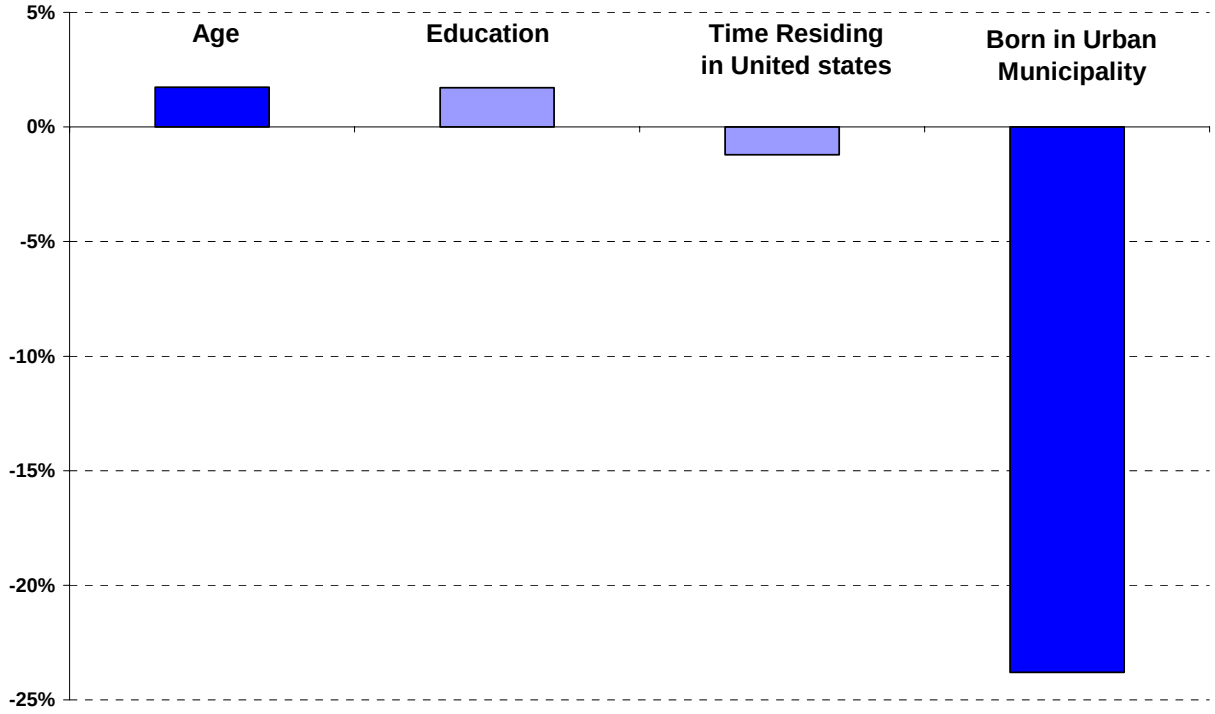


Figure 4 provides evidence supporting the immigrant selectivity rather than the protective culture hypothesis if one believes that needing unanticipated medical care is a proxy for health. We detect no influence of one's social network, participation in various civic or religious groups, or other proxies for Mexican culture on the probability of having needed care; but having been born in an urban rather than a suburban or rural area of Mexico appears to have reduced it by almost 25 percent. In sum, migrating from a relatively healthy area in Mexico had the largest effect on Mexican immigrant health in Los Angeles County controlling for a host of other individual- and contextual-level variables.

Figure 4: Immigant Selectivity rather than Protective Culture Appears to Explain more of the Variation in the Probability of Having Received Unanticipated Medical Care among Mexican Immigrants in Los Angeles County, 2001



CONCLUSION

To be added.

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