Health Insurance and Health Care Use Among Older Mexican Immigrants in the U.S.: Comparison with their origin-country counterparts

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Abstract

The Hispanic population in the U.S. continues to gain importance as the most numerous minority group, and Mexico has been the leading sending country of migrants to the U.S. in recent years. Thus, international migration from Mexico to the U.S. shall gain more importance for policy makers in both origin and destination countries. Accurate counts of net immigration from Mexico are difficult to obtain but conservative estimates of net immigration, documented or not, in the decade of the 1990's range from 300,000 to 500,000 immigrants per year (Bean et al. 2001, Hill et al. 2004). The long-term consequences of migration need to be understood, to design policies that help ameliorate or minimize the negative consequences of such volume of population movements.

International economic migration is traditionally perceived as taking place with long-term gains in mind. The migrants themselves may or may not reap the majority of the benefits of the movement immediately or shortly after the move, perhaps not even in their own lifetime. The benefits could well be perceived as being for other members of the family network or even for future generations of the migrants' families.

One policy concern is the long-term consequences of Mexico-U.S. migration regarding the own health of migrants at old age. Although it is assumed that there should be health gains for populations migrating from Mexico to the U.S., we know little about the health in old age of those who migrated to the U.S. compared to those who remained in Mexico, and the mechanisms through which these differences may operate are still largely unexamined. One possible explanation for differences is that the health care system of the destination is of higher quality than the origin. While others hypothesize that the population of migrants observed at old age in the destination country are the result of selection processes – they are healthier to begin with, and the healthier ones tend to stay. Access to health insurance and the patterns of utilization of health care are also perceived as mechanisms through which health gains could be obtained. The argument being that perhaps because of the differential quality of services, migrants change the patterns of utilization of services and tend to use more services in the destination than in the origin populations. An alternative argument is that the lack of knowledge, language barriers, and costs would deter Mexican migrants from using health services in the U.S.

The older immigrant population in the U.S is a particularly important group to study for various reasons. First, this group may be less likely to have used health care services than the native population during their young and middle-age years. Second, the immigrant population tends to have low socioeconomic status and at old age may be less likely to use health care services even under conditions of full health insurance coverage. Third, the immigrant population may have been more exposed to hard physical labor conditions during their young age. Because of these factors, the immigrant elderly may be in a particularly vulnerable position, with health outcomes that may produce old-age with higher disability burden, more-costly health care, and lower quality of life than the native population.

To better understand the patterns of health care utilization of Mexican immigrants in the U.S., we examine the behavior of comparative groups of populations in the origin (Mexico) and destination (U.S.) countries. Controlling for factors that measure health care need, preferences

for health and health-care, and enabling factors, we estimate the marginal effect of having health insurance on the propensity to use health care. This comparison shall shed light on the possible mechanisms through which health differentials are obtained, and allow for a better understanding of the health care behavior of the populations on both sides of the border. In particular, we seek to inform public policy on the health behaviors of the populations of Mexican immigrants to the U.S. who at old age, are found still residing in the U.S.

We also provide descriptive statistics on the health status and health insurance coverage of the comparison populations, followed by the specification of the health care use models. We apply the results of these models to estimate the propensity to use health care by Mexicans in the U.S. and in Mexico conditional on demographic, economic, and health variables.

The overarching hypothesis of this research is that immigrant older adults have better health care coverage in the U.S. than in Mexico, but this enhanced coverage does not necessarily translate into more utilization of health care services. The implications for public policy are vast, in particular because the old-age burden of disease may result in higher health care costs for the U.S. but also in worse old-age well-being of the immigrant populations. In this context, we would expect that the role of health insurance availability on the propensity to use health care would be weaker for Mexican immigrants than native populations in the U.S. On the other hand, compared to their origin-population in Mexico, the effect of health insurance shall also be weaker among Mexican immigrants in the U.S. than among Mexicans in Mexico. This is because the language and trust barriers for utilization should not be present in Mexico.

We argue that the immigrant population, even when they have health insurance will be less likely to use health care than the native population. Under similar conditions of illness, the U.S. immigrant population is more likely to deal with the illness episodes or chronic conditions without seeking formal care. If this behavior were observed, one could argue that this is due to cultural norms or beliefs about the formal health care system. That is, that because of tradition or culture from their country of origin, individuals in old age would not make use of the formal health system to address their health care needs. Indeed, it could be argued that immigrants from Mexico are less likely to use formal health care because they tend to self-medicate or use traditional or alternative medicine methods (Goldman and Smith 2002). If the limiting constraint to utilization is cultural, we would expect that having health insurance should *not* represent a major facilitating factor and should be associated weakly (or not at all) with more health care utilization among Mexicans in Mexico and Mexicans in the U.S. However, if the constraining factors are other barriers to utilization, such as language barriers, lack of trust or knowledge of the health system in the U.S., then the effect of insurance on utilization should be stronger for Mexicans in Mexico compared to Mexicans in the U.S.

We use data from three surveys gathered in Mexico and the U.S. For the population of residents in Mexico, we use the Mexican Health and Aging Study (MHAS, Wave 1- 2001. Population is 50+ in 2001). For non-Hispanic Whites and Hispanics in the U.S., we use the Health and Retirement Study (HRS, 1998. Population is 50+ in 1998), and for Mexicans residing in the U.S. we use the Hispanic Established Populations for Epidemiological Study of the Elderly (HEPESE, 1998-99 Mexican origin or background residing in the U.S. aged 70 or older in 1998).

With the availability of these data sources, we are able to form the following groups for the purposes of comparisons:

In Mexico, using MHAS:
1) Former residents of the U.S. who are now residing back in Mexico (U.S. migrants).
2) Residents of Mexico without a history of residence in the U.S. (non-U.S. migrants).

In the U.S.:
3) With HEPESE, U.S. residents who are Mexican-Americans, born in the U.S.
4) With HEPESE, U.S. residents born in Mexico.
5) With HRS: Non-Hispanic Whites.
6) With HRS: Hispanics.

The size of the Mexican populations aged 50 and above in HRS, HEPESE is small but sufficient to enable use to perform the comparisons we desire. Descriptive and multivariate statistical methods are used. For the descriptive analyses, we make comparisons among two or more sources at a time as the availability of specific variables permits. By design, the MHAS and the HRS are similar in content of the questionnaire and field protocol, thus the two sources of data map a very similar group of variables to use as dependent and explanatory variables in the models of health care utilization. For the HEPESE, we select a sub-group of comparable variables to those we have for MHAS and HRS, and re-estimate the models with all data sets.

We use probit regression methods to estimate the probability of seeking health care across the groups of comparison. Because we need to estimate comparable models over three data sets, we are somewhat constrained in the specification of the model by the availability of variables. However, we can control for the following explanatory variables, and aim to cover at least the following factors (*the variables are listed in parentheses*):

- Preferences for health and health care (*sex, education, migration status*).
- Factors that enable the utilization of services and production of health (*income, education*).
- Prices, or indicators of access to health services (*availability of health insurance, migration status in Mexico, nativity in the U.S., urban/rural area of residence in Mexico*).
- The need for health care services (*age, type of illness reported*).

We estimate the regression models for two different dependent variables of health care utilization: whether the respondent had one or more doctor visits and hospitalizations. To highlight the role of health insurance and contrast its effect across the U.S.-Mexico border, we use the basic regression model estimates and calculate the estimated probability of using health care.

Population in Mexico tends to have low health care coverage compared to those in the U.S. About one-half of the population in Mexico lacks health insurance although the elderly tend to have slightly higher coverage compared to other, in particular young, age groups (INEGI 2000). This is again due to the institutional practice of covering the workers and their dependent family

members. Thus more than children or young adults, the elderly in Mexico tend to be covered either because they are workers or retirees, or dependent spouses, widows, or parents of a covered worker (Parker and Wong 2001). The comparable population aged 70 and older in the U.S. have much higher coverage of health care (over 95%) than the comparable population in Mexico. This is due to the almost-universal health insurance coverage by Medicare.

Preliminary results show that the unadjusted prevalence of doctor visits in a 12-month reference period is higher among residents of the U.S. (88%) than those in Mexico (65%). A similar higher propensity is found for hospitalizations among Mexicans who are U.S. residents (20%) than those residing in Mexico (10%). Within HEPESE, however, the unadjusted prevalence of doctor visits and hospitalizations is similar for U.S. born and Mexico-born residents of the U.S. Also, utilization seems similar within Mexico if the contrast is between those who are former U.S. migrants and those who are not.

The effect of health insurance coverage plays a dominant role on the propensity to visit a doctor in the U.S. but not so in Mexico. The marginal effect of health insurance is *larger* than the marginal effect of illness in the U.S., while the presence of illness seems to dominate the effect of health insurance in Mexico. This could be explained by the relative lower out-of-pocket cost of doctor visits in Mexico compared to the U.S., and this is due to the fact that the private health sector for medical consultations is quite active in Mexico at all levels of income. This could also be partly a result of the large proportion of the population without health care coverage in Mexico compared to the U.S.

The results are quite different for the use of hospitalizations. Having health insurance is *not* significant on the propensity to be hospitalized in the U.S., neither for Mexican Americans nor Whites. The effect of a health condition seems to be the predominant determinant of hospitalizations, and this holds for all of the four chronic conditions included in the model. In Mexico, however, having health insurance is significantly associated with a higher propensity to be hospitalized.

Therefore, with or without health insurance, the use of hospitalization is higher in the U.S. than in Mexico. The results vary for doctor visits, however. Those *without* insurance are more likely to visit a doctor in Mexico than in the U.S., while those *with* insurance are more likely to visit a doctor in the U.S. Having health insurance is associated with a higher propensity to visit a doctor by 76% in the U.S., while the gain is by 18% in Mexico. The increase in the propensity to be hospitalized associated with health insurance is about the same in both countries (around 50%).

With respect to the health conditions included in the models, we find that having had a heart attack shows the highest marginal effect on hospitalizations across all the comparison groups. On the other hand, having diabetes has the largest marginal effect on visits to the doctor, in particular among Mexicans residing in the U.S. Among those in Mexico and other residents of the U.S., it appears that cancer and diabetes exert similar effects on visits to the doctor.

These results indicate that in both countries, the availability of health insurance associates with higher utilization of health care services, and as expected, the effect of health insurance varies for doctor visits and for hospitalizations. Health insurance increases the propensity to be

hospitalized by almost one-half in Mexico. On the other hand, the lack of health insurance prevents Mexicans in the U.S. from seeing a doctor to a larger extent than it does in Mexico. Or, another way to interpret this result is that the availability of health insurance encourages Mexicans in the U.S. to *visit a doctor* to a larger extent than it does in Mexico, while it enables Mexicans in Mexico to be *hospitalized* to a greater extent than it does in the U.S.

The results indicate also that for individuals aged 70 or older, the gains from having health insurance -- measured by the relative increase in health care utilization -- appears to be larger in the U.S. than in Mexico. Controlling for aspects of health, education, and ability to pay for services, the gains from having health insurance are larger in the country where the cost of out-of-pocket health care is larger. Furthermore, this appears to be even more pronounced for doctor visits than hospitalizations. This could be the case because of the large role played by the private sector – at all levels of income -- in the provision of care in Mexico. And this could apply more to the case of doctor visits than to hospitalizations. The relative cost of care for hospitalizations may be more prohibitive for Mexicans in Mexico, so that the relative gain from having health insurance is larger for hospitalizations in Mexico.

The paper develops fully the empirical estimations for Mexico and the U.S., takes into account the selectivity of migrants, and draws conclusions based on the results obtained.

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