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Article

How does legal status matter for oral health care among Mexican-origin children in California?

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A B S T R A C T

This research examines the relationship between legal status and oral health care among Mexican-origin children. Using the 2001–2014 California Health Interview Surveys, the objectives are: (1) to demonstrate population-level changes in the legal statuses of parents, the legal statuses of children, and the likelihood of receiving dental care; (2) to reveal how the roles of legal status boundaries in dental care are changing; and (3) to determine whether the salience of these boundaries is attributable to legal status per se. The results reveal increases in the native-born share and dental care utilization for the total Mexican-origin population. Although dental care was primarily linked to parental citizenship early in this period, parental legal statuses are no longer a unique source of variation in utilization (despite the greater likelihood of insurance among citizens). These results imply that future gains in utilization among Mexican-origin children will mainly come from overcoming barriers to care among the native born.

1. Introduction

Oral health care is important for children's well-being due to the prevalence of dental disease and its role in respiratory, cardiovascular, neurological, and developmental conditions (Dye, Thornton-Evans, Li, & Iafolla, 2015; Institute of Medicine (IOM), 2011a, 2011b). The importance of such care is also amplified by disparities in health and the utilization of health services that reflect the marginalization of ethno-racial groups with few resources (Lee & Divaris, 2015; Link and Phelan, 1995; Schwendicke et al., 2015). The reduction of such disparities is an important health policy objective.

Investigations of ethno-racial disparities increasingly direct attention to Mexican-origin children, a group that is among the least likely to see a dentist and the most likely to have untreated tooth decay (Dye, Arevalo, and Vargas, 2010; Edelstein and Chin, 2009; Gao and McGrath, 2011; Stewart, Ortega, Dausey, and Rosenheck, 2002). However, documentation status is rarely examined due to limited data in the most widely-used health surveys sponsored by the federal government.[1] Federal health policy frameworks largely ignore undocumented residents as well, as exemplified by their invisibility in the IOM (2011b) report on *Improving Access to Oral Health Care for Vulnerable and Underserved Populations*.

This study analyzes data from the 2001 to 2014 California Health Interview Surveys (CHIS) to address three objectives: (1) to describe population-level changes in dental care utilization and the legal statuses of Mexican-origin children and parents; (2) to describe changes in how specific legal statuses matter for dental care; and (3) to investigate whether legal status differences remain after controlling for various forms of capital that reflect the family's financial, educational, linguistic, and social resources. In so doing, this research illuminates the most salient status-related distinctions and the extent to which their importance is intensifying or dissipating.

It should be noted at the outset that the relevance of these issues extends beyond California, but greater geographic scope is precluded by limited data in national health surveys. Regardless, California is important on its own right. The American Community Survey shows that it has the largest shares of the Mexican-origin population (35%, 12.7 million) and Mexican immigrants (37%, 4.3 million) in the United States. Mexican-origin children are also the largest ethno-racial group under age 12 in the state; their share is now 45%, up from 38% in 2001 (https://usa.ipums.org/usa/).[2]

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[1] These surveys do not include questions on the status of non-citizens due to concerns about negative reactions that may adversely affect survey non-response, item non-response, and truthfulness (General Accounting Office, 2006). Human subject protections and public input are also considerations. However, such concerns may be exaggerated (Bachmeier, Van Hook, and Bean, 2014). The National Academies of Sciences, Engineering, and Medicine (2015) recommend that future health surveys directly measure legal status.

[2] This exceeds 41% for whites (25%), African Americans (5%), and Asians (11%) combined.

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2. Perspectives and hypotheses

2.1. Civic stratification

This investigation is theoretically grounded in *civic stratification*, a perspective that emphasizes the hierarchical classification of immigrants by the state to regulate access to the rights of citizenship (Lockwood, 1996; Morris, 2003; Torres and Waldinger, 2015). The top stratum consists of naturalized citizens with all rights of citizenship. The middle stratum holds "lawful permanent residents" with unrestricted authorization to seek employment and to receive public benefits. The bottom stratum consists of undocumented residents who lack authorization to live in the United States.[3]

Typically, the distinction between unauthorized and authorized immigrants who are permanent residents and citizens is of greatest interest (Torres and Waldinger, 2015). The unauthorized are uniquely disadvantaged with limited rights, resources, and opportunities that have implications for health care. *If civic stratification matters, undocumented children and children of the undocumented should be least likely to receive dental care*. Possible reasons include undocumented parents' unique interests in curtailing use of public spaces and contact with institutions to minimize the risk of apprehension. Undocumented parents are also disproportionately concentrated in low-paying, no-insurance jobs (Bean, Brown, Leach, Bachmeier, and Van Hook, 2014; Hall, Greenman, and Farkas, 2010). Uncertainty about children's eligibility for public programs is another possible consideration.

At the same time, the question of whether documentation, citizenship, or nativity is most important for receiving dental care remains open. Some studies show that children of undocumented parents do not necessarily have the lowest levels of medical care. For example, Mexican-origin children of permanent residents are the least likely to see a physician in California (Oropesa, Landale, and Hillemeier 2016).

2.2. Trends: Declining dental care with increasing salience of legal status

A possible scenario for temporal change is declining dental care utilization coupled with the increasing salience of legal status. This scenario is consistent with alleged shifts in public opinion and government efforts to bolster internal and external border controls. Specifically, increasing public antagonism and enhancements in governmental capacity to apprehend, detain, and deport presumably intensified pressure on the undocumented to avoid the health care system (Berk and Schur, 2001; Chavez, 2013; Hagan, Rodriguez, and Castro, 2011; Heyman, 2014; Kanstroom, 2007). *Such pressure should reduce utilization and exacerbate differences by documentation status.* Nonetheless, "fear and vulnerability" may have also spread through social contagion to authorized immigrants in "the broader community" (Rosenblum and Meissner 2014). If so*, differences should increasingly crystallize around citizen-noncitizen or native-foreign status boundaries, not documentation per* se (Coutin, 2011).

The economy is another consideration. Although a brief downturn occurred in 2001, the Great Recession of 2007–2009 was especially severe. The recession undercut the economic foundations of many families as financial, real estate, and labor markets collapsed. Family budget constraints tightened and "elective" expenditures suffered as a result. This points to the possibility of a shock-induced *decline in dental care utilization* (at least temporarily). *Severe economic shocks should also intensify status-related differences if their impacts are concentrated in some categories.*[4].

2.3. Countervailing trends: Increasing utilization with decreasing salience of legal status

Another possible scenario is increasing utilization with the dissipation of status-related differences due to countervailing trends in immigration, the social climate, and the policy environment. Specifically, net migration fell to zero when cross-border movement collapsed during the recession and border control intensified (Hoefer, Rytina, and Baker, 2011; Passel, Cohn, and Gonzalez-Barrera, 2013; Warren and Warren, 2013). Fewer undocumented arrivals should alleviate downward pressure on utilization rates if these immigrants are particularly unlikely to receive care. *Thus, rates could stabilize or increase through changes in population movement*.

As for the social climate, fear of contact with the health care system may have grown with antagonism towards the undocumented in the nation at large (Derose, Escarce, and Lurie, 2007; Portes, Fernández-Kelly, & Light, 2010). However, California's social climate is increasingly receptive towards the undocumented; fewer residents view them as a threat to the state's economic, social, and cultural fabric. The number who are extremely concerned about the adverse impacts of those characterized as "illegal" immigrants has waned and most residents now favor paths to citizenship and health coverage for undocumented children (Field Research Corporation, 2006, 2013; USC/USC/Los Angeles Times, 2013). *Such favorable shifts in public opinion could facilitate utilization by alleviating concerns about using public spaces and public institutions*.

The policy environment revolves around the most important federal programs for children's health care—Medicaid and the State Child Health Insurance Program (CHIP). California administers these as Medi-Cal and Healthy Families, with dental care offered under each as fee-for-service Denti-Cal and managed care plans.[5] In general, the number and share of children in these programs have increased since 2001 (California Healthcare Foundation, 2012; www.medicaid.gov). For example, public insurance increased from 36% in 2008 to 47% in 2015 for all California children ages 0–11 (https://usa.ipums.org/usa/). Public insurance for California's Mexican-origin children rose from 51% to 64%, mostly during the recession and after 2014.

There are two pillars of eligibility for Medi-Cal and Healthy Families. The first is low income, as determined by the ratio of family income to federal poverty thresholds (CHF, 2006, 2013). This is not a source of change since the upper limit of eligibility for both programs combined has been constant.[6] Second, federal funds have been largely restricted to citizens and non-citizens classified as "qualified aliens." This classification excludes unauthorized residents. This classification also excluded those in their first five years as a permanent resident until the 2009 CHIP Reauthorization Act lifted this ban. Nonetheless, California started using state funds to cover those subject to the five-year ban several years before. This is another indicator of receptivity.

County-based programs also emerged to cover children who were ineligible for state-supported coverage due to legal status, including Calkids, Children's Health Initiatives (Healthy Kids), and the Kaiser Permanente Child Health Program. Calkids was created by a private foundation in 1992, with "virtually all" enrollees undocumented by 2006 (CaliforniaKids Healthcare Foundation, 2006, p. 11). Children's Health Initiatives mobilized local, private, and foundation support to expand the safety net. Starting with one county in 2001, these initiatives peaked at 31 counties in 2007 (CHF, 2012).

The timing of this coincided with a state legislative milestone (AB

[3] Among various admission channels for foreign nationals are those for refugees, asylees, and temporary migrants. The former are in the middle stratum. Refugees must apply for a green card one year after entering. Asylees are encouraged to do so. Few Mexicans are eligible for these statuses.

[4] The incomes of Mexican-origin non-citizen households typically declined while incomes of citizen households increased at the onset of the recession (Kochhar 2008).

[5] CHIP was administered as Healthy Families during most of the period examined here. Healthy Families transitioned to Medi-Cal in 2013-14.

[6] Medi-Cal supports infants in families whose income is 0–200% of the threshold, ages 1–5 whose income is 0–133% of the threshold, and ages 6–19 whose income is 0–100% of the threshold. Healthy Families extends the income limit to 250% of the poverty threshold for all ages (CHF, 2006, 2013). The upper limit is greater in a few counties with a high cost-of-living.