Poverty and Health of Children from Racial/Ethnic Minority and Immigrant Families in the Midwest

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Keywords: Latino health, minority health disparities, health and poverty
agricultural production that are specific to the geographical and geological context of the region in which they currently live. Strengthening of human capital through the use of appropriate educational tools for this population can considerably improve their gardening success, because in this country they find many natural, economic, and cultural challenges that need to be solved with new knowledge and new skills. The focus on giving away rather than selling the produce by the Latinos is in sharp contrast to the focus on selling and profit of those offering the training. The validity of sharing as an end in itself must be recognized by the Anglo institutions organizing the courses. Spaces provided for learning and gardening allow the transmission of advice and support for healthier agricultural practices, appreciation of fresh and organic products and practices, and channels to access natural capital and high-quality agricultural inputs such as natural fertilizers or pesticides. Human capital, enhanced by education, can facilitate access to financial opportunities such as selling and marketing their produce. However, for all except one of the eight cases, financial gain was not a major motivator for increasing their gardening skills. Enterprises need to be based on the cultural meanings that gardening and farming have for the Latino community.

References

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Abstract

Using data from the 2007–2009 Annual Social and Economic (ASEC) supplement of the Current Population Surveys (CPS), this study explores the relationship between poverty and health of children from various racial/ethnic minority and immigrant families in the Midwest. Findings show that:

1) Racial/ethnic minority children experience poorer health than non-Hispanic White children; (2) Increased poverty among children predicts poorer children’s health; (3) Immigrant children have poorer health than natives; and (4) Second-generation immigrant children have poorer health than first and third-generation immigrant children. This study demonstrates the health disadvantages of Mid-western children from racial/ethnic minority families faced by poverty. The gap in children’s health between non-Hispanic White and minority children persists even after accounting for the effects of immigrant status, poverty, family structure, parental education, health insurance coverage, and metropolitan/nonmetropolitan residence. Improving the economic well-being of all racial/ethnic and immigrant families would improve children’s health.
Studies have shown the harmful influence of poverty on child health and development. Poverty has been linked to numerous negative outcomes for children, including physical health; educational achievement and development; emotional and behavioral problems and depression; and other consequences, such as teenage out-of-wedlock birth, child abuse and neglect, and violent crime (Aber, Bennett, Conley, & Li., 1997; Brooks-Gunn & Duncan, 1997; Duncan & Brooks-Gunn, 1997, 2000; Duncan, Brooks-Gunn, & Klebanov, 1994; Lichter, 1997; Malat, Oh, & Hamilton, 2005; McLeod & Shanahan, 1996; Petterson & Albers, 2001).

Race and ethnicity also continues to be a strong determinant of variations in health status (Williams & Collins, 1995). Health outcomes usually have multiple causes that can be either direct or indirect and are often interrelated and interactive (Kaplan & Bennett, 2003; Williams, 1997). Both racial/ethnicity and social class influence health through complex pathways (Geronimus, 2000; Kaplan & Bennett, 2003; Krieger, 2000; Williams, 1997, 2002; Williams & Collins, 2001).

Much of previous health studies research conducted with immigrants consistently found that acculturation is detrimental to health (Cho, Frisbie, Hummer, & Rogers, 2004; Hummer, Powers, Pullum, Gossman, & Frisbie, 2007; Landale, Oropesa, & Gorman, 2000). The basic premise of those studies is that culturally-based behaviors change over time and deteriorate as a result of acculturation (Ebin et al., 2001; Hummer et al., 1999; Landale, Oropesa, Llanes, & Gorman, 1999; Rumbaut, 1997).

The main objective of this study is to determine the main, relative, and combined influences of poverty, race/ethnicity, and immigrant/generation status on children's health in the Midwest. This study addresses three main research questions: (1) What is the influence of poverty on children's health? (2) What are the influences of race/ethnicity and immigrant/generation status on children's health? (3) To what extent does poverty account for racial/ethnic and immigrant/generation status gaps in children's health?

**Research Hypotheses**

The following hypotheses are tested: (1) Increased poverty among children of all racial/ethnic groups will predict poorer children's physical health; (2) The more difficult economic conditions faced by poor Latinos, African American, and Asian families will lead to poorer physical health among their children compared to non-Latino White children with equivalent poverty levels; (3) Immigrant children will have poorer physical health than others; and (4) Second generation immigrant children will have poorer health than first- and third-generation immigrant children.

**Methods**

This study uses data from the 2007–2009 ASEC supplement of the CPS. The following variables are used in the analysis: *Child health* — Respondents were asked, “Would you say your health in general is excellent, very good, good, fair, or poor?” Their responses were coded on a five-point scale, with 5 representing poor health and 1 excellent health. Because of fewer cases in the poor and fair categories among children, child health was dichotomized into “poor” health, grouping poor, fair, or good categories and “better” health for reports of very good or excellent health in multivariate analyses. *Child poverty* — Child poverty is defined as the share of children under age 18 who live in families with incomes below the federal poverty threshold, as defined by the U.S. Office of Management and Budget. A child is considered poor if family income-to-poverty ratio (IPR) is less than 1.25; *Race/ethnicity* — Race/ethnicity is constructed from child's race and Hispanic origin variables. First, Latino children are distinguished from non-Latino children. Latinos include Mexicans, Puerto Ricans, Cubans, Central Americans, South Americans, and other Latinos. For non-Latino households, race is categorized as White, Black, and Asian, including Pacific Islander, or other races (Native Indians or Alaska natives and mixed races). For this study, other racial groups were excluded in the analyses.
Immigrant/Generation Status. Children with at least one foreign-born parent are classified as the children of immigrants, and the remaining as children of natives. Children of immigrants who were born outside the United States are further classified as first-generation immigrant children. Children of immigrants who were born in the United States are considered second-generation immigrant children. Native-born children of native-born parents are considered third or higher generation. Control variables — The following socio-demographic and household characteristics were used as controls: child gender; child age; family structure; parental education; average parental age; health insurance coverage; and metropolitan/nonmetropolitan residence. Multivariate analyses use normalized household weight to compensate for the CPS sampling design.

Results

Table 1 presents the coefficient estimates from nested logistic regression models of poor health on child and family predictors. Model 1 estimates racial/ethnic disparities in children's health, controlling for child's age and sex, providing a baseline of comparison for subsequent models that add other explanatory variables. Mexican American children's odds of poor health are 2.29 [exp (.830)] those of non-Hispanic Whites. Other Latinos' odds are 1.5 those of non-Hispanic Whites. The odds of child poor health for African Americans are 2.38 those of non-Hispanic Whites and for Asians, the odds of poor health are 1.61 those of non-Hispanic Whites. The results in model 1 also indicate that the odds of poor health are 20% lower (100 x [1- exp (-.219)]) for children under six years and 14% lower for children ages 6–11 years than those of children ages 12–17 years.

Table 1. Logistic Regression Coefficients of Poor Child Health on Child Poverty

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coeff. (SE)</td>
<td>Coeff. (SE)</td>
<td>Coeff. (SE)</td>
<td>Coeff. (SE)</td>
<td>Coeff. (SE)</td>
</tr>
<tr>
<td>Intercept</td>
<td>-.1721 (.028)**</td>
<td>-.1741 (.028)**</td>
<td>-.1878 (.030)**</td>
<td>2.621 (.095)***</td>
<td>-.2794 (.096)***</td>
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<tr>
<td>Mexican American</td>
<td>.830 (.044)***</td>
<td>.548 (.057)***</td>
<td>.645 (.068)***</td>
<td>-.373 (.072)***</td>
<td>.298 (.073)***</td>
</tr>
<tr>
<td>Other Latina</td>
<td>.407 (.092)***</td>
<td>.261 (.094)***</td>
<td>.394 (.113)***</td>
<td>.228 (.115)***</td>
<td>.143 (.117)***</td>
</tr>
<tr>
<td>African American</td>
<td>.869 (.036)***</td>
<td>.889 (.037)***</td>
<td>.828 (.052)***</td>
<td>.638 (.054)***</td>
<td>.579 (.055)***</td>
</tr>
<tr>
<td>Asian</td>
<td>.474 (.077)***</td>
<td>.185 (.088)***</td>
<td>.129 (.102)***</td>
<td>.305 (.104)***</td>
<td>.297 (.105)***</td>
</tr>
<tr>
<td>Female</td>
<td>-.046 (.027)***</td>
<td>-.043 (.028)***</td>
<td>-.046 (.028)***</td>
<td>-.046 (.028)***</td>
<td>-.046 (.028)***</td>
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<tr>
<td>&lt; 6 years</td>
<td>-.219 (.034)***</td>
<td>-.219 (.034)***</td>
<td>-.280 (.034)***</td>
<td>-.120 (.039)***</td>
<td>-.179 (.039)***</td>
</tr>
<tr>
<td>6–11 years</td>
<td>-.148 (.033)***</td>
<td>-.151 (.033)***</td>
<td>-.187 (.034)***</td>
<td>-.092 (.035)***</td>
<td>-.114 (.035)***</td>
</tr>
<tr>
<td>First generation</td>
<td>.214 (.109)***</td>
<td>.109 (.112)***</td>
<td>.234 (.113)***</td>
<td>.221 (.114)***</td>
<td>.221 (.114)***</td>
</tr>
<tr>
<td>Second generation</td>
<td>.405 (.055)***</td>
<td>.464 (.064)***</td>
<td>.505 (.066)***</td>
<td>.514 (.067)***</td>
<td>.514 (.067)***</td>
</tr>
<tr>
<td>Mexican x first generation</td>
<td>.491 (.167)***</td>
<td>.529 (.169)***</td>
<td>.431 (.170)***</td>
<td>.388 (.171)***</td>
<td>.388 (.171)***</td>
</tr>
<tr>
<td>African American x second</td>
<td>-.478 (.154)***</td>
<td>-.380 (.155)***</td>
<td>-.298 (.157)***</td>
<td>-.239 (.158)***</td>
<td>-.239 (.158)***</td>
</tr>
<tr>
<td>Child poverty</td>
<td>.915 (.042)***</td>
<td>.558 (.046)***</td>
<td>.212 (.050)***</td>
<td>.212 (.050)***</td>
<td>.212 (.050)***</td>
</tr>
<tr>
<td>Mexican x child poverty</td>
<td>-.663 (.107)***</td>
<td>-.474 (.108)***</td>
<td>-.368 (.109)***</td>
<td>-.368 (.109)***</td>
<td>-.368 (.109)***</td>
</tr>
<tr>
<td>Other Latino x child poverty</td>
<td>-.755 (.202)***</td>
<td>-.653 (.204)***</td>
<td>-.581 (.204)***</td>
<td>-.581 (.204)***</td>
<td>-.581 (.204)***</td>
</tr>
<tr>
<td>African American x child poverty</td>
<td>-.475 (.076)***</td>
<td>-.406 (.077)***</td>
<td>-.300 (.078)***</td>
<td>-.300 (.078)***</td>
<td>-.300 (.078)***</td>
</tr>
<tr>
<td>Variables</td>
<td>Model 1</td>
<td>Model 2</td>
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<tr>
<td>Asian x child poverty</td>
<td>.206 (.190)***</td>
<td>.014 (.193)***</td>
<td>.036 (.194)***</td>
<td></td>
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</tr>
<tr>
<td>Second generation x child poverty</td>
<td>-.225 (.105)***</td>
<td>-.206 (.106)***</td>
<td>-.212 (.107)***</td>
<td></td>
<td></td>
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<tr>
<td>Two-parent familyf</td>
<td>-.271 (.035)***</td>
<td>-.192 (.035)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high schoolg</td>
<td>.812 (.057)***</td>
<td>.574 (.058)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High schoolg</td>
<td>.807 (.042)***</td>
<td>.624 (.043)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some collegeg</td>
<td>.555 (.039)***</td>
<td>.423 (.040)***</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Average age of parents</td>
<td></td>
<td>.013 (.002)***</td>
<td>.013 (.002)***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government health insurance onlyh</td>
<td></td>
<td>.759 (.044)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government + private insuranceh</td>
<td></td>
<td>.683 (.040)***</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Uninsuredh</td>
<td></td>
<td>.625 (.062)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonmetropolitani</td>
<td></td>
<td></td>
<td>.152 (.035)***</td>
<td></td>
<td></td>
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<tr>
<td>Model χ²/df</td>
<td>803.82***/7</td>
<td>870.35***/11</td>
<td>1384.82***/17</td>
<td>1949.61***/22</td>
<td>2395.97***/26</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001

Notes:
- Non-Hispanic White = reference group
- Male = reference group
- 12–17 years = reference group
- Third-generation or higher = reference group
- Child poverty is defined here as family income-to-poverty ratio < 1.25
- Single-parent family = reference group
- College education (i.e., Bachelor's degree or higher) = reference group
- Private insurance coverage only (i.e., provided by private employer or purchased) = reference group
- Metropolitan residence = reference group

Model 2 assesses the effects of immigrant/generation status on children's health. Second-generation immigrant children's odds of poor health are 1.50 those of third- or higher-generation children, and first-generation immigrant children's odds are 1.24 those of third- or higher-generation children. Immigrant/generation status is associated with poor child health for all racial/ethnic groups, especially first-generation Mexican, except for second-generation Blacks, as indicated by the negative interaction coefficients.

Model 3 assesses the effects of child poverty and the multiplicative interactions of child poverty and race/ethnicity on child health. The odds of child poor health are significantly higher for poor children than non-poor children regardless of race/ethnicity. When the comparison is restricted to non-Hispanic White of third-generation children (reference groups), the odds of poor health for poor children are 2.50 those of non-poor children. However, the effects of poverty on child health vary by racial/ethnic groups. Restricting the comparison to third-generation children, the odds of poor child health are in respective order higher for poor African American children, followed by those of Asian, Mexican, non-Hispanic White, and Other Latino children. Among the non-poor children, the odds of poor health are in respective order higher for African American children, followed by Mexican, Other Latino, Asian, and non-Hispanic White children.
Model 4 introduces controls for family structure, parental education, and average parental age while Model 5 controls for health insurance coverage, and metropolitan/nonmetropolitan residence. Children living in a two-parent family household and those whose parents have a Bachelor's degree or higher have relatively lower odds of poor health when compared to children in one-parent family household or those whose parents have less than a Bachelor's degree. For children covered by a government health insurance, a combination of government and private health insurance, or uninsured children, the odds of poor health are significantly higher than those of children with only private health insurance coverage. Living in nonmetropolitan as compared to living in metropolitan areas is associated with poorer child health.

Discussion

This results in this study reveal that: (1) Mexican American, African American, and to a lesser extent other Latino and Asian children experience poorer health than non-Hispanic White children; (2) The gap in children's health between non-Hispanic and minority children persists even after controlling for immigrant status, poverty, family structure, parental education, health insurance coverage, and metropolitan/nonmetropolitan residence; (3) Increased poverty among children of all racial/ethnic groups predicts poorer children's physical health; (4) Immigrant children have poorer physical health than natives; (5) Second-generation immigrant children have poorer health than first- and third-generation immigrant children; and (5) First-generation poor children suffer worse child health than second- or third- or higher-generation children, but at the higher end of the income spectrum, second-generation children experience worse child health than first- or third- or higher-generation children.

These results reveal the health disadvantages of Midwestern children from racial/ethnic minority and immigrant families living in poverty. Improving the economic well-being of all children, i.e., tackling the issue of poverty, would improve child health and the overall well-being of tomorrow's adults. Improving the economic well-being of immigrant children, especially second-generation immigrant children, would enhance their health. This will require, among other things, highlighting the importance of healthy lifestyles and reinforcing native and ethnic values and norms that support healthy lifestyles. Other significant factors of children's well-being suggest improving parental education and providing health insurance coverage.

References


The Impact of Social Networks on Well-Being: Evidence from Latino Immigrants

Pedro Dozi, University of Missouri

Introduction

Latino immigrant population in the rural areas has exploded in the last decade; and along the years, many researchers have looked at this phenomenon in many angles. The overall motivation for this research has been the overwhelming diverging ideas about the importance of Latino newcomers in rural regions, and how these Latinos sustain their well-being once in these communities. The impacts, according to the literature, have been either positive or negative. The positive impacts have been, to mention but a few, that Latino immigrants help in income generation and socio-economic survival of rural areas; they help improve the diversity of rural regions, while supplying labor for necessary work in large food processing plants; they help improve the job prospects of locals through indirect and induced effects on local businesses. The negative impacts have been, to mention but a few again, that Latino immigrant deplete local resources, which could be better used elsewhere; their presence creates downward pressure on wages of low skilled local workers (Borjas, 1999) thereby crowding out local labor force.

In light of these positive and negative impacts, there have been also some contradictory justifications on how most Latino immigrants sustain their well-being once in these communities. For instance, some researchers have suggested that Latino immigrants make heavy use of social welfare in order to sustain their well-being. However, the current provisions of the law does not provide for it. Since 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has very strict provisions in regards to who should receive welfare assistance. Alternatively, some researchers assert that Latino immigrants use their own resources to sustain their livelihood. However, this suggestion too is a little unrealistic given that most Latinos earn incomes that are at or below the poverty line as defined by the bureau of labor. In this research, we suggest that there is a third way Latino immigrants might be sustaining their livelihood: using their social networks. However, there is a scarcity of quantitative studies assessing how Latino immigrants use their social networks to sustain well-being.