Appendix D: Annotated Bibliography

**RACIAL/ETHNIC MINORITIES**


This article is a discussion of the use of race/ethnicity, gender, and socioeconomic status as explanatory variables in research, specifically on research involving children. The authors hope to improve the understanding of these variables; they discuss how race/ethnicity, gender, and socioeconomic status are considered to be primarily biological variables but also need to be viewed as social constructs. The committee concludes that careful research is needed to disentangle the sociology and psychology of race/ethnicity, gender, and socioeconomic status from the biology of these variables, to better understand the health effects of these variables on children and other populations.


This article presents a qualitative analysis (with some descriptive statistics) based on December 1997 through December 2000 interviews of 300 volunteers residing in one of two urban counties in California. The participants came from one of three racial/ethnic minority groups (African American, Latino, and Filipino American) and had at least one chronic illness such as diabetes, asthma, or heart disease. Results: “Compared with insured respondents, uninsured respondents...had poorly controlled illnesses, frequent health crises, difficulty procuring medication, used medication incorrectly, demonstrated poor understanding of their illness, and displayed little knowledge of self-care measures or risk awareness.”


Authors use the 1977 National Medical Care Expenditure Survey (MEPS) and the 1989 and 1992 National Health Interview Survey to describe to what degree the growth in the Hispanic population over these years contributes to rising rates of the uninsured. They find that Hispanics constituted 8% of the uninsured population in 1977, compared with 20% of the uninsured in 1992. The growth in the number of non-Hispanic uninsured has not been as rapid as that of Hispanic uninsured.


Brown, et.al. use March 1995 and 1998 Current Population Survey (CPS) data, February 1997 CPS, and 1994-1996 National Health Interview Survey (NHIS) data to focus on racial and ethnic minority groups nationwide. They confine their analysis to cross-tabs and frequency distributions. This report explores uninsurance levels among Latinos, African-Americans, Asians and Pacific Islanders, and American Indians/Alaskan Natives. The findings are similar
to other reports: Latinos experience the highest uninsurance rates of all ethnic groups and most of this disparity occurs because a scant 43% have access to employment-based health insurance. Other racial and ethnic minorities are also disadvantaged in their levels of insurance coverage and access to health insurance at their places of work.


Using March 1998 CPS data and 1995-1996 NHIS data, this report “…examines differences [using frequencies and cross tabs only] among urban areas in the U.S. in their rates of job based health insurance and how those differences affect their residents’ overall health insurance coverage and access to health care services.” The authors find great variance in the rates of uninsurance and employer-sponsored health insurance among the urban areas studied. Also, the uninsured living in areas with high levels of uninsurance have worse access to care than those who live where uninsurance levels are low.


This paper addresses the issue of the decrease in participation in employer-based insurance coverage that is occurring, despite the fact that more firms are offering health insurance to employees. One explanation discussed by the authors is the increasing cost of employment-related insurance and the decreasing premium percentage contributed by the employer. Another explanation is the increase of people covered by Medicaid, which serves as a potential substitute for private insurance. The data for this study comes from the 1996 panel of the MEPS and the 1987 National Medical Expenditure Survey (NMES). The individuals in the samples are between 21 and 64 years old and employed (but not self-employed).


As opposed to characterizing the uninsured by individual demographic variables, this article sought to define the community-level variables (i.e., average health care costs in community, employment rates, state policies and Medicaid eligibility) that cause a low percentage or high percentage of uninsured in the population. The regression analysis, using the Community Tracking Study (CTS) from 1996 to 1997, found that differences in rates of uninsurance ‘between ‘high uninsurance’ and ‘low uninsurance’ communities are the results of differences in the racial/ethnic composition and socioeconomic status of the population (33%), differences in employment characteristics (26%), and state Medicaid eligibility requirements (12.7%).”


This brief centers on the 20% of all uninsured people who are offered health insurance by their employer but choose not enroll in the plan(s). The authors present new findings on who is included in these 7.3 million uninsured persons. They advise policy makers to “consider ways to address the problem identified by this study: low take-up rates among lower-income
workers.” The data presented are from the CTS, which contains observations on 33,000 families and 60,000 individuals.


There are many papers describing and trying to pin down why the Hispanic population has such high rates of uninsurance, but few have looked into the causes of the varying rates between Hispanics of different national origin. “The purpose of this paper is to identify factors associated with differences in the probability of having private health insurance coverage among Mexican-Americans, Puerto Ricans, and Cuban-Americans.” The authors use March 1989 through March 1994 CPS data and a linear probability model to examine the demographic and occupational characteristics that lead to Mexican-Americans having a higher rate of uninsurance than their Latino neighbors of Puerto Rican and Cuban descent. The difference between Mexican-Americans and Cuban-Americans in probability of having private health insurance coverage is due to Cuban-Americans having higher hourly wages, having more education, being older, working in industries with higher employer-sponsored insurance rates, and their occupations. The differences between Mexican-Americans and Puerto Ricans are due to industry, hourly wage rates, firm size, and education. The results indicated, however, that these attributes could only account for about half of the differences between the subgroups of Hispanics.


This report “offers the most detailed picture yet of the uninsured working population—now numbering more than 16 million—and examines the policy implications.” The report uses descriptive statistics based on the February and March 1999 CPS. Among the findings, “firm size is more important than industry as a determinant of coverage possibilities for workers.” Other findings link individual demographics rates of uninsurance, i.e. income determines employer sponsorship, employee eligibility, and employee take-up of insurance more strongly than marital status, family size, or labor force participation of the spouse. Policies such as tax credits, subsidies, and the expansion of public programs are discussed and compared as means to reduce the number of the working uninsured.


The report notes that about one-third of adult Latinos working in California are uninsured, 44% of which have never had health insurance at any time. The California HealthCare Foundation (CHCF) interviewed 1,000 randomly selected working Latinos in early 2001 in order to “compare the validity and importance” of the many proposed causes for the lack of health insurance among Latinos. The cost of health insurance and the lack of an offer of insurance from the employer emerged as the two most important factors preventing Latinos from having health insurance. The survey also found that language and cultural barriers, as well as recent immigration, decreased the chances of working Latinos having health
insurance. List of reports on uninsured that have been funded by CHFC are at:
http://www.chcf.org/topics/index.cfm?topic=CL109&PgNum=2&order=pubdate

http://www.iom.edu/IOM/IOMHome.nsf/Pages/Consequences+of+Uninsurance#HCS

The authors put together a literature review (1985-2000) of publications addressing vulnerability as defined by race/ethnicity and socioeconomic status. They examined several dimensions including access to care, quality of care, avoidable hospitalizations, preventive care/cancer screening, mortality, and outcomes for specific conditions (such as cancer, cardiovascular disease, diabetes, HIV, etc.). “Measures of health care utilization and process of care are more strongly and consistently influences by insurance status than are measures of health status. While health insurance may alleviate financial barriers to care and improve the choice of providers, it does not address other individual and societal determinants of poor health that are experienced by ethnic minorities and the disadvantaged.”

http://www.cmwf.org/programs/minority/hall_minorityinsur_314.asp

This report includes a “multivariate logistic regression analysis modeling the likelihood of having employer-based health insurance among workers.” Descriptive statistics on the distribution of the uninsured are presented. The results from the March 1997 CPS show that race and citizenship lower the odds of having employer-based health insurance; also, higher education and higher wages increase the odds of being insured through the employer.

http://www.kff.org/content/2002/4007/4007.pdf

This report uses data from the March 1999-2000 CPS to describe health insurance coverage in the United States for the non-elderly population. In addition, this report includes multiple tables describing the uninsured on both the national and the state levels, with breakdowns of racial/ethnic minorities.

http://www.urban.org/Template.cfm?Section=ByAuthor?NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6480

Using data from the 1997 National Survey of American Families (NSAF) “…this brief provides a snapshot of adults lacking health insurance coverage examining factors such as income level, family structure, race/ethnicity, employment, health status [self-reported health status based on a condensed, 3-point scale, and presence of a limiting condition], and access to and utilization of health care.” The report has many descriptive tables for the nationwide uninsured population, and for some selected states, but no regression analysis. “Findings show that younger, low-income adults, particularly Blacks and Hispanics, have the highest uninsurance rates. At the same time, half of low-income uninsured adults are White, and the
majority of uninsured low-income adults reside in households with at least one full-time worker.”


This report “serves as a guide to a broad range of issues related to the lack of insurance coverage in America and provides background data of use to policy makers and health services researchers.” It highlights demographic disparities in rates of uninsurance. The appendix includes an excellent multivariate analysis of the uninsured (from the 2000 Current Population Survey) using socioeconomic characteristics, race and ethnicity, immigrant and nativity status, and geographic areas as the independent variables. Their results show disparities between African-Americans, Hispanics, and other minorities (as a group) when compared to Non-Hispanic Whites, disparities not fully explained by other socioeconomic variables.


The first section reports on the health insurance status of Hispanic, Black, and White Americans, while the remainder looks at access to care and differences in health status among racial and ethnic groups. The data are taken from 1996 MEPS and presented in descriptive charts and graphs. There is little analysis, but the conclusion points out that Blacks and Hispanics fare worse than Whites in levels of employer-sponsored health coverage and rates of uninsurance.


Literature review of studies published from 1985 to 1998. The review focuses on health outcomes by race and ethnicity sorted by condition or source of care: asthma, cancer, cardiovascular disease, dental services, diabetes, emergency care, eye disease, heart disease, HIV/AIDS, hypertension, infectious disease, maternal and child health, mental and neurological disorders, osteoporosis, preventive and therapeutic services, and renal disease. “Access [including insurance coverage], availability, and utilization of health services received only a limited treatise.” Conclusions: “Despite the limitations [of the articles]…the literature well documents poorer access to medical care among racial and ethnic minorities for several disease groups and types of health services.”

The authors use 1987 NMES and 1996 MEPS data (descriptive statistics as well as econometric analysis with linear probability models) to study how the health insurance status of White, Black, and Hispanic Americans has changed and to make comparisons between the groups. The authors identify gaps in minority health care coverage relative to that of White Americans. They also investigate the access of workers in these groups to employment-based health insurance. Over the studied time period, health insurance coverage decreased for all groups, but Hispanic males had the largest decreases, resulting from a change in the composition and economic status of Hispanics as a whole. Hispanics in 1996 were poorer than in 1987, and a larger percentage were from Latin America.


The authors use 1979-2000 CPS data to demonstrate how and attempt to explain why labor force participation and employment rates for young Black men are declining over the years and also why they are considerably lower than those for similar White and Hispanic young men, especially in cities (as opposed to suburban and rural areas). There is no mention of health insurance, but the paper shows an employment gap that could explain some of the lack of insurance for Black Americans.


Information for this report comes from eight focus group sessions conducted in urban and rural areas in early 2000 with a total of 81 low and moderate-income Hispanic workers, 22 of whom were insured and 59 of whom were uninsured. Among the conclusions from these sessions is the finding that securing a job, with or without health coverage, is the first priority when seeking employment. Barriers to coverage include the fact that many employers do not offer health coverage, particularly for workers in small firms with fewer than 50 employees. For other workers, language barriers posed problems to obtaining health insurance. Additionally, immigration concerns prevent some workers from enrolling themselves or family members in private or public programs.


The authors set out to discover the causes of lack of insurance coverage for vulnerable populations, based on a broad literature search. The first section defines the population being studied and considers components of their vulnerability. The next sections present basic demographic information, and review literature focusing on the different vulnerable populations. The last section focuses on unsettled questions in the existing literature.

The author used data from the March 1999 CPS and the Commonwealth Fund 1999 National Survey of Workers’ Health Insurance. Methods are limited to frequencies and cross-tabs. Important findings include the fact that four states—California, Florida, New York, and Texas—account for 73 percent of all uninsured Hispanics. In total, one-fourth of all uninsured people in the U.S. are Hispanics, a number that has doubled from 1987 to 1998 and now numbers 11.2 million. Only 43 percent of Hispanic adults and children are insured through employer-sponsored coverage, as compared with the national average of 64 percent.


With data from a study of over 28,000 new cancer patients in Florida in 1994, the authors tested how type of health insurance (including lack of any insurance) and race affect the stage at which cancer is first diagnosed in the patient. Uninsured patients and those insured by Medicaid, as well as Blacks, were more likely to have a late-stage diagnosis of cancer. However, these two variables were not tested as potential confounders. For example, African-Americans are more likely to be covered by Medicaid, but this was not controlled for in the study.


These findings are reported from The Commonwealth Fund 2001 Health Care Quality Survey (frequency distributions and cross-tabs). There is included a small section (section VI, page 45) on health insurance. Once again, findings reveal that Hispanics and African Americans are much less likely than Whites or Asian Americans to have health insurance. Even with insurance, African Americans, Hispanics and Asian Americans reported higher rates of problems communicating with physicians than insured Whites.


This study investigated whether objective health indicators explained lower self-rated health among Hispanics compared with non-Hispanic Whites. It also considered socioeconomic and cultural explanations. Health ratings of 429 Hispanics and 583 non-Hispanic Whites aged 20 through 74 were analyzed with logistic regression. Findings indicated that Hispanics were 3.6 times more likely to report fair or poor health, for which the strongest explanation was acculturation.

The author used the Household Component of the 1996 MEPS data and logistic regression models to examine the profile of health insurance coverage for certain vulnerable populations (children, racial/ethnic minorities, low-income families, non-metropolitan statistical area residents, and those with poor health status). Shi analyzed the contributions of various dimensions of vulnerability including need factors, enabling factors, and predisposing factors. He concludes that since Medicaid and other forms of public health insurance target the unemployed poor and the unhealthy, “public insurance helped reduce the employment- and health-related disparities in private coverage,” but “it has not overcome other disparities related to vulnerable characteristics including race/ethnicity, wages, education, and area of residence.” This article purports to describe in detail the characteristics that lead to a decreased likelihood of having health insurance in an effort to aid policy-makers in their decisions.


Using the same data as previously (see above for Shi L., March 2000, Medical Care Research and Review), Shi expands the analyses for this article to examine the convergence of vulnerable characteristics based on the models by Aday. The interaction of race and ethnicity (minority/ethnic non-White), income, and health status was explored using eight categories of converging vulnerability as independent variables (minority, low-income, bad health; minority, low-income, good health; minority, high-income, bad health; minority, high-income, good health; White low income bad health; White low income good health; White high income bad health; White, high-income, good health). Among the findings, “…race and income significantly influence insurance coverage,…there was relatively little disparity in insurance coverage due to self-reported health status.”


This study aims to assess the level of racial and ethnic differences in healthcare, evaluate reasons behind these healthcare disparities, and provide recommendations for eliminating racial and ethnic healthcare disparities. In order to do this study, a 15-member committee was formed to review literature published within the last 10 years that was all peer-reviewed. Four liaison panels were also formed to serve as a resource to the committee, and 9 focus groups were formed for further insight into the topic.


This is a descriptive study using the 1989 CPS and 1982 – 1984 Hispanic Health and Nutrition Examination Surveys (HHANES) to compare the insurance rates of several Hispanic subpopulations with other racial/ethnic groups. The authors find that Mexican Americans have higher rates of uninsurance than either Puerto Ricans or Cuban Americans, and that
Puerto Ricans are more likely to be covered by Medicaid than either Mexican Americans or Cuban Americans.


Using the 1997 NSAF, the authors decompose the effects of various workforce and socio-economic variables on insurance rates for Whites, Blacks, and Hispanics. They find income and citizenship to be particularly powerful explanatory variables with respect to the insurance gap between Hispanics and Whites, and income to be most important in explaining the gap between Blacks and Whites. Authors also present decomposition information on gaps in insurance coverage by racial/ethnic group and state.
This report discusses the changes in health coverage of immigrants due to recent court decisions and legislation, specific to New York. “The New York State Court of Appeals’ June 2001 decision in Aliessa v. Novello restored full Medicaid eligibility to legal immigrants who were eligible for Medicaid coverage before the state implemented federal welfare reform and who meet the program’s income guidelines.” While legal immigrants can access public insurance, undocumented immigrants are denied all but prenatal, postpartum, and emergency services as a result of the U.S. Court of Appeals for the Second Circuit 2001 decision in Lewis v. Thompson. The recommendations include actions and policies to help immigrants understand and receive the benefits for which they are eligible, and increased or re-instated federal funds to assist the states in caring for their immigrant populations.

The authors review data from the 1999 U.S. Census Bureau data. Since the enactment of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), foreign-born immigrants are often ineligible for Medicaid programs; and in New York, the state had not, at the time of this article, decided to extend state funds to immigrants. This paper explores the costs of three policy options designed to extend NY Medicaid funds to all immigrants.

This research proposal addresses the problem of the disproportionate number of uninsured immigrants in the US. It verifies that “immigrants do have lower coverage rates than the native-born” and “defines characteristics associated with immigrants to help explain this.” Data used include those from the March 2000 Supplement to the CPS, Milton Romer’s National Health Systems of the World, the World Health Organization, the World Bank, and the United Nations Statistics Division.

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“This report examines the health insurance coverage of undocumented, or illegal, immigrants who became legal residents under…the Immigration Reform and Control Act of 1986 (IRCA).” Using data from the 1989 and 1992 Legalized Population Survey (LPS), the authors found that despite higher levels of labor force participation among the immigrant population, as compared to the general population, almost half were uninsured, and legalization of their status did not improve their health care coverage at once. Policy recommendations in the report called for broadened Medicaid eligibility, more funding for community safety nets, and another amnesty program to give legal status to undocumented immigrants.


This report presents descriptive data on the immigrants living in the U.S. from the information in the March 2000 CPS. It includes a brief section on health insurance coverage, with a breakdown by country of origin of rates of uninsurance. The author believes that much of the growth of the uninsured population in the last decade is due to “immigrants who arrived after 1989 along with their U.S.-born children [who] account for 60 percent or 5.5 million of the increase in the uninsured population in the 1990s.”


The authors used March 1999 CPS data, cross-tabs and frequencies. Among the findings of this report, about 59% of the growth in the number of uninsured is attributable to immigrants who arrived in the United States between 1994 and 1998 and their children. Camarota and Edwards conclude that PRWORA (1996 welfare reform that ended Medicaid funding for more recent immigrants) is not a significant reason why so many immigrants are uninsured since the proportion of immigrants who are uninsured has remained about the same (around 30% of persons in immigrant households lack health insurance). This report also examines uninsurance among a variety of immigrant populations, finding that the country of origin is a significant predictor of uninsurance. For example, immigrants from the Mexico, South and Central America, and Korea are the least likely to have health insurance coverage.

This report provides findings (cross tabs, frequencies, and logistic regression analyses) from LANYCIS, a 1999-2000 survey of 3447 immigrant families in Los Angeles County and New York City, two cities that account for roughly a quarter of the nation's immigrant population. The Survey Research Center of UCLA conducted the survey in five different languages. The report measures housing affordability, food insecurity and hunger among immigrant populations. Health insurance coverage, health care access and self-reported health status are also highlighted. The study uses these measures to assess the need for food stamps, Medicaid and other benefits and services among differing immigrant subpopulations. The survey data were augmented by and compared to data from the March CPS (1997-1999) and the 1999 NSAF.


Using the 1998 March supplement to the CPS, this paper provides cross tabs and frequencies, as well as logistic regression models, to examine the rates of employer-sponsored health insurance among immigrants. The authors also examined immigrant status by country of origin (for the 16 countries with the largest number of immigrants living in the U.S.). The results demonstrate that immigrants from Guatemala, Mexico, El Salvador, Haiti, Korea, and Vietnam were the most likely to be uninsured. Overall, immigrants who are not U.S. citizens are much less likely to receive employer-sponsored health insurance or government coverage; 44% are uninsured.


Using 2000 March CPS data and 2002 initial survey work from the National Immigration Law Center (NILC), “this paper … provide a brief summary of state responses to the restrictions on Medicaid and SCHIP. Specifically, they provide information on whether or not states elected to provide Medicaid to the new optional coverage categories and describe state-funded replacement programs for legal immigrants made ineligible for these federal health insurance programs by the 1996 welfare law.” Twenty-two states provide health coverage programs of some sort to legal immigrants to replace the benefits lost after PRWORA.

The authors used “a cross-sectional, in-person survey of 376 random households with children aged 1 to 12 years” conducted in 1997 in a primarily Latino community to assess their access to care. In the multivariate analysis, the insurance status of the child, the child’s birthplace and the parents’ birthplace were important predictors of the child’s access to care (as defined by having a usual source of care). Immigrant children born to immigrant parents were less likely to have insurance or a regular source of care than U.S.-born children of immigrants, who in turn were less likely to have insurance or a regular source of care than U.S.-born children of U.S.-born parents.


This paper examines “the joint effects of health insurance status and place of birth on access to care and use of health services by children of the working poor.” The regression analysis uses data from the 1997 NHIS. The paper reported that “only 66 percent of the foreign-born children of the working poor had a regular source of care, compared with 92 percent of their U.S.-born counterparts” and that even among children who were insured, the foreign-born children were less likely to have a regular source of care or to have visited a doctor in the year before the survey.


The author uses data from the May and June 1991 CPS and the Quality of American Life Surveys of 1971 and 1978 to show that immigrants and native workers “enjoy very similar packages of amenities” in their jobs, that immigrants and natives do compete for the same jobs, and that immigration does not affect the amenities in the jobs of the natives, though Blacks appear to take jobs that other Americans and immigrants are unwilling to take.


The authors use data from the 1995 and 1999 CPS (cross tabs and frequencies), but also assess statistical significance of factors from T1 to T2. Importantly, using a net change approach, they find that immigrants are not necessarily the cause of increasing uninsurance rates (unlike the Camarota and Edwards paper, see above). Holahan, Ku, and Pohl conclude that most of the growth in the number of uninsured occurred among native and naturalized citizens.

http://papers.nber.org/papers/W6764

This paper looks at “the determinants of the changing skills of new U.S. immigrants.” Analysis shows that new immigrant skill levels increase with changing immigration law and the rise in purchasing power of foreign countries and that the average skill level of new legal immigrants since the mid 1980s has been rising in relation to that of the native population. The analysis is based on a data set assembled by the authors from 1972-1995 annual INS records of all new, legal immigrants.


http://www.kff.org/content/2000/2000802a/Pub2203.pdf

This is a chartbook that originated from the work done on behalf of the Kaiser Commission on Medicaid and the Uninsured. Using 1999 data from the U.S. Census, as well as 1999 INS data and March 1998 CPS data, the report describes the demographic characteristics of immigrants, the policy changes and citizenship issues that have affected immigrant health care coverage, and access to health care for immigrants. The descriptive statistics indicate that immigrants lack health insurance coverage at much greater rates than the native population, and they have less access to and less use of services.


http://www.kff.org/content/2000/2000802a/Pub2201.pdf

This is a policy brief prepared for the Kaiser Commission on Medicaid and the Uninsured. This paper examines the insurance status of immigrants after the 1996 PRWORA. The information is national in scope, looking at the Federal laws and exploring other non-Medicaid welfare programs (WIC, SCHIP, TANF, etc.). The brief amount of descriptive statistics come from the March 1999 CPS, but the focus of the report is more on the legislative framework surrounding immigrants and access to government benefits.


http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6233

Early examination of the likely impact of PRWORA on health care access for immigrants, using Medicaid Quality Control database for the first half of 1994 supplemented with SSI data. These data provide a snapshot of the number and cost of immigrants to Medicaid prior to PRWORA. The authors admit, however, that “…“The data presented in this paper are for 1994. It is difficult to predict how these distributions will apply in the future. There have been, and will continue to be, changes in the rate of immigration to the U.S. and in the composition of immigrants.”

The authors used CPS data from March 1997, 1998, and 1999 for background frequencies, along with in-depth interviews of providers, administrators, and clients in the four cities, and tabulations of state and local regulations, laws, and policies, to describe the healthcare safety-nets available in each community and also the effects of 1996 welfare reform on those safety nets. The report contains an interesting narrative about the various problems providers and non-citizen immigrants are facing in these four communities.


This article used the 1997 NSAF to look at the prevalence of uninsurance among immigrants. The methodology included not only cross tabs and frequencies but also logit models. This article reiterates other studies that show non-citizens and their children have worse access to both regular ambulatory and emergency care, even when insured.


“This report presents new estimates of the undocumented population in the United States” as relevant to migration proposals being presently considered by the U.S. and Mexican governments. The estimates on unauthorized persons in the U.S. are broken down by place of origin (Mexico, Central America, other), and the unauthorized labor force is compared by industry and by average work days in a year. The focus is on undocumented workers from Mexico and how they and their industries would be affected by proposals to allow some undocumented migrants to gain legal status, to legalize migration linked to employment, and to deal specifically with the migration issues in the agricultural industry.


This paper reports on the results from 1996-1997 in-person interviews with 533 undocumented Latino immigrants living in Fresno and Los Angeles counties. The interviews were conducted in Spanish on undocumented workers, residing in California for 6 months or more. This study was conducted in order to provide better information about the use of health care services by undocumented workers. In Section VI there is a brief summary of rates of uninsurance among undocumented Latino immigrants in California’s metro areas. Findings indicated that most undocumented Latinos were uninsured and not participating in public programs; language was perceived as a major barrier to access.


This article used data from the 1997 NHIS, 1996-1998 Survey of Income and Program Participation (SIPP), and 1999 CPS in order to examine how immigrant status, job characteristics, and family structure influence health insurance coverage among the Hispanic
immigrant population. Analyses limited to cross tabs and frequencies. The authors found that although employment accounts for much of the difficulty faced by Hispanics seeking health insurance, family structure and immigrant status play smaller but still significant roles. “Mexican-American families and families of noncitizen Hispanics are particularly vulnerable because they are the least likely to have two workers.”


Aggregating data from the 1989 and 1990 NHIS, the authors conducted a logistic multivariate analysis to predict the probability of health insurance coverage for immigrants compared to those born in the US. “There was no statistical difference in the proportion of Whites without health insurance according to nativity status.” From their analysis, the remainder of the foreign-born were twice as likely as the US-born to be uninsured. Hispanic immigrants fared the worse; those immigrants in the country for less time also had a higher probability of being uninsured. “Foreign-born US residents—especially Hispanics and persons residing in the United States for less than 15 years—are vulnerable to not having health insurance, which may limit their access to medical services.”


This report estimates the characteristics of the illegal alien population currently residing in the United States, including their state of residence and country of origin. The data sources include the June 1988 CPS, 1982 to 1996 INS I-94 arrival/departure records, and 1988 and 1992 Census Bureau statistics on emigration. This report is cited frequently in the literature on the undocumented immigrant population.
CHRONIC MENTAL ILLNESS


This paper compares the mental and physical health status of three different employee groups: workers who decline employer-sponsored insurance (decliners), workers who take offers of employer insurance, and workers who were not given any insurance offers. Using the 1997 NHIS, the authors found that uninsured decliners “fare much worse than coverage takers on every mental health issue” and on some physical health issues. They also discovered that “decliners who are not healthy appear to have greater difficulty obtaining needed services than do workers who take up employer coverage” and that “decliners tend to have somewhat better access than do the uninsured who are not offered such coverage.”


This chapter provides an overview of the literature linking health, health insurance and labor market outcomes such as wages, earnings, employment, hours, occupational choice, job turnover, retirement, and the structure of employment. The first part of the chapter focuses on the relationship between health and labor market outcomes. The second part of the chapter considers the link between health insurance and labor market outcomes.


This paper uses data from the 1996 MEPS to study the economic burden of five chronic conditions: mood disorder, heart disease, hypertension, and asthma. The “analyses calculated the proportion of persons with a given condition who received any treatment for it and, among those who received any treatment, the costs for treatment for the condition.” The study found that persons with heart disease paid the least out of pocket and were almost twice as likely to experience work loss as a result of their condition compared to the other illnesses. Also, the impact of insurance on the receipt and intensity of treatment was greater for persons with mood disorders than for any of the other diseases.


Using the 1994 NHIS, “the authors studied the association between report of a mental disorder and 1) access to health insurance and a primary provider, and 2) actual receipt of medical care…While people who reported mental disorders [self-reported mental disorder as opposed to clinical diagnosis] showed no difference from those without mental disorders in likelihood of being uninsured or of having a primary care provider, they were twice as likely to report having been denied insurance because of a preexisting condition or having stayed in their job for fear of losing their health benefits.”

This article looks at the effects of mental and substance use disorder on income, work hours, and employment rates, using data from the 1994 National Comorbidity Survey (NCS). Univariate regression and IV estimation found the presence of any psychiatric disorder (as diagnosed in the survey by a modified version of the Composite International Diagnostic Interview) to have (statistically significant) negative effects on employment and income.


“This paper is concerned with the economics of mental health. We argue that mental health economics is like health economics only more so: uncertainty and variation in treatments are greater; the assumption of patient self-interested behavior is more dubious; response to financial incentives such as insurance is exacerbated; the social consequences and external costs of illness are formidable. We elaborate on these statements and consider their implications throughout the chapter. ‘Special characteristics’ of mental illness and persons with mental illness are identified and related to observations on institutions paying for and providing mental health services. We show that adverse selection and moral hazard appear to hit mental health markets with special force. We discuss the emergence of new institutions within managed care that address long-standing problems in the sector. Finally, we trace the shifting role of government in this sector of the health economy.”


The authors look at the effects that emotional/psychological symptoms have on both the income of 408 workers at the sampled manufacturing worksite and on their rates of absenteeism from work. “The analysis consistently finds that workers who report symptoms of emotional/psychological problems have higher absenteeism and lower earnings than otherwise similar coworkers.”


“This article will: (1) provide a brief definition of dual diagnosis and describe gender differences in the prevalence of these disorders; (2) provide brief descriptions of the major mental illnesses affecting women and symptoms associated with perinatal conditions;(3) review the barriers to treatment for dually-diagnosed clients, generally, and specifically for perinatal women; (4) describe models of service delivery to the dually diagnosed; and (5) review federal, state, and local initiatives that coordinate services for the dually diagnosed.”


This paper reviews research on the relationship between health insurance, health, work, income and education. The primary goal was to determine if health insurance improves health, and to assess the hypothesis that lack of insurance imposes significant costs on American society.

This study presents estimates of lifetime and 12-month prevalence of 14 DSM-III-R psychiatric disorders from the NCS. The respondents in the survey were person aged 15 to 54 and were not institutionalized. The findings include that 50% of respondents reported at least one lifetime disorder, and almost 30% at least one 12-month disorder. Less than 40% of those with a lifetime disorder had ever received professional treatment and less than 20% of those with a recent disorder had been treated in the last 12 months. The study also found that most disorders declined with age and higher socioeconomic status.


This article examines the “sociodemographic, need, insurance, and risk characteristics of persons with severe mental illness and the importance of these characteristics for predicting specialty mental health utilization among this group”, using data from The Healthcare for Communities (HCC) survey. The primary findings include that the severely mentally ill are disproportionately African American, unmarried, male, less educated and have lower family incomes. Also, one in five persons with severe mental illness is uninsured, and Medicare or Medicaid insures 37% of the rest of that population.


Using data from the 1991 Epidemiologic Catchment Area (ECA) survey, the authors try to find a link between poor mental health status, specifically job-related stress, and early retirement in older workers. “Our results suggest that mental, not physical, health problems are the most important reasons for the early withdrawal of older workers from the labor market.” However, as noted by the authors, the ECA data has very few relevant economic questions on which to base this analysis.


Statistical reference for the prevalence of various mental health disorders in the United States. Disorders covered include depressive disorders, schizophrenia, anxiety disorders, ADHD, and others.


The authors used data from the Suffolk County Mental Health Project (“an epidemiologic study of first-admission psychosis” on “696 presumed psychotic patients hospitalized in one of the 12 psychiatric facilities in Suffolk County, New York, between September 1989 and December 1995.”) to run logistic regression analysis on the relationship between the type of health insurance held by the patients and the care they had received for their mental illness.
previous to being admitted to a psychiatric facility. The results indicated that the patients with private insurance or Medicare/Medicaid were more likely to have received some type of care or medication for their condition than those with no health insurance at all.


The purpose of this study was to assess the prevalence of mental and addictive disorders and to estimate the use made of different sectors of the service system. The findings include that an annual prevalence rate of 28.1% was found for mental and addictive disorders in the US. In addition, 14.7% of the US population reported used services in one or more component sectors of the de facto US mental and addictive service system.


A review of policy options. “… This paper presents strategies and recommendations for improving the current system so that it better addresses the mental health needs of vulnerable Americans.” The authors look at the mental health care available, or not available, to vulnerable populations such as the working poor, racial/ethnic minorities, and those who live in rural areas. The statistics presented are derived from a variety of other literature and data sources, most notably the 1999 mental health report of the Surgeon General.


This article used 1992-1995 National Ambulatory Medical Care Survey (NAMCS) data to compare the levels of antidepressants prescribed to Whites, Blacks, and Hispanics. The authors found rates of depression diagnosis and/or prescription of antidepressants among Blacks and Hispanics to be less than half the rate for Whites.


The author used the Household Component of the 1996 MEPS data and logistic regression models to examine the profile of health insurance coverage for certain vulnerable populations (children, racial/ethnic minorities, low-income families, non-metropolitan statistical area residents, and those with poor health status). Shi analyzed the contributions of various dimensions of vulnerability including need factors, enabling factors, and predisposing factors. He concludes that since Medicaid and other forms of public health insurance target the unemployed poor and the unhealthy, “public insurance helped reduce the employment- and health-related disparities in private coverage,” but “it has not overcome other disparities related to vulnerable characteristics including race/ethnicity, wages, education, and area of residence.” This article purports to describe in detail the characteristics that lead to a decreased likelihood of having health insurance in an effort to aid policy-makers in their decisions.

This chartbook is a reference on work and disability in the U.S. Each of four sections addresses a different aspect, including prevalence of disabilities among workers, labor force participation, related working factors such as income, race, age and gender, and work-related resources available to people with disabilities. It includes information on various national surveys, including the SIPP, NHIS< CPS, and others.


This is a brief summary of statistics from the 1997-1998 HCC data, showing that “unemployment rates are three to five times higher among persons with mental disorders than among those with no disorder,” even when the data are separated for men and women.


Between the years of 1996 and 1998, the authors find that “among individuals with probably mental health disorders, more have lost insurance in those two years than have gained it and more report decreases in health benefits. Individuals with worse mental health consistently report a deterioration of access to care compared to individuals with better mental health.”

The analysis is based on data from the 1997-1998 HCC survey.


http://www.mentalhealth.org/cre/toc.asp


This report is a supplement to the 1999 Surgeon General’s report on mental health, and highlights the role culture and society play in mental health, mental illness, and the types of mental health services people seek. The volume focuses on the four most recognized racial and ethnic minority groups in the United States: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. There is an overview of definitions of mental health, culture, race, and ethnicity. The focus is on a review of the literature, mainly from the view of mental health services; data comes from a variety of sources, mainly 1999-2001 Census Bureau data but also the NCS (1994) and the Epidemiologic Catchment Area study (1991).


Among the chronic illnesses examined for their impact on labor supply is a conglomerate of mental illnesses, including Alzheimers, schizophrenia, paranoid disorder, obsessive-compulsive disease, drug and alcohol abuse, and memory loss. The results indicate that presence of mental illness reduces the probability of being employed. Though the [significant results] are not very large, the article sets up a good econometric model of the way the
presence of disease affects the probability of employment. The author uses data from the 1991 New Jersey Demographics of Disability Survey, a random sample of 40,000 individuals in 14,000 New Jersey households.