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SCHOOL OF PUBLIC HEALTH

**Latino Immigrants in Fort Worth: Contributing Factors to Lack of Health Insurance and
Their Impact on Utilization of Health Services**

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Abstract

This quantitative research study consists of a secondary data analysis examining the factors contributing to the lack of health insurance in a group of Latino immigrants in Fort Worth, and the impact it has on their utilization for health care services. The data analyzed was previously collected to assess the needs for health insurance of Latino immigrants in Fort Worth. Bivariate analysis and multivariate logistic regression analysis methods of the sampled population were used to determine some of the main factors for lack of health insurance resulting in underutilization of health care services. Results of the study lacked the strong statistical association expected from the predictor variables, however, results of the study reveal areas where health care policies affect and may improve conditions of the immigrant population in Fort Worth, Texas.

INTRODUCTION

More than one in every three Latinos (37 percent) in the United States is without any public or private insurance; this is more than the two and one-half times 14 percent rate among non-Latino whites. Lack of health insurance creates significant barriers to obtaining needed health services, exacerbating disparities in access and health status between Latinos and non-Latino whites (Suarez-Orozco & Paez, 2002, p. 236).

Non-citizen minorities who do not speak English are more likely to be uninsured than other minorities or white English-speaking citizens. The likelihood of lacking coverage is far higher, however, among non-citizen Latino adults and those who primarily speak Spanish (Ku & Waidmann, 2003). Latino children in English-speaking citizen families have about the same risk of being uninsured as white children in citizen families. However, coverage for Latino children drops considerably when they are members of non-citizen families (Ku & Waidmann, 2003). Minorities face increased barriers to accessing necessary health care, and non-citizen, Spanish-speaking Latinos experience the most significant access problems. Disparities in access to health care are similar to those for obtaining health care coverage. Among low-income English-speaking citizens, about 56 percent of Latino adults saw a physician in the last 12 months compared to 67 percent of whites. Non-citizen Latinos are even less likely than Latino citizens to have seen a physician (Ku & Waidmann, 2003, p. 2).

Understanding the roles of citizenship status and language is important for developing policies to help reduce disparities in health coverage and access for Latino populations. A person's citizenship status (e.g., citizen, legal immigrant, or undocumented immigrant) affects eligibility for benefits like Medicaid or the State Children's Health Insurance Program (SCHIP)

and the ability to obtain a job that offers health insurance benefits. English proficiency affects a person's ability to communicate in our English-dominant society and, more specifically, to discuss medical problems with a physician or nurse or to complete an insurance application (Ku & Waidmann, 2003).

Overlap in the issues of ethnicity, citizenship status and language, and great diversity in the populations is substantial. Some Latinos living in the U.S. are Spanish-speaking immigrants, but the majority of Latinos in the U.S. are native-born and fluent in English, yet there are Latinos in this population of native born citizens who have limited English proficiency. Specific contributions of citizenship and language, as opposed to Latino ethnicity, identify the differences in the health care coverage, access, and quality between citizen Latinos who speak English and non-citizen Latinos who primarily rely on Spanish (Ku & Waidmann, 2003).

Census Bureau data (Mills, 2001) demonstrate that Latinos have the highest uninsured rate of all racial/ethnic groups; over one-third are uninsured. Latinos and Asians have more difficulty accessing medical care than whites; they are less likely to have a usual place to get health care, less likely to have seen a physician in the past year, and less likely to receive preventive health care. Access is particularly limited for those who lack insurance. One result of limited access to primary and preventive health care is an increase in the extent to which patients are hospitalized for conditions, like asthma, that could be avoided with appropriate primary care. In addition to problems accessing medical care, patients often find their experiences with the health care system unsatisfactory. They frequently identify problems in communicating with their physicians, in being treated with trust and respect, and in receiving good care overall (Ku & Waidmann, 2003).

Texas is a large state, in terms of both population and geography. In 2000, almost 21 million people lived in its 262,000 square miles. Despite its vast territory, the majority of people live in urban areas. Immigrants and minorities are an important part of the population and have been increasing in number. Almost one-third of the state's population is of Latino origin, reflecting its proximity to Mexico and other Central American countries. Non-Latino whites make up only about half of the state's population (Weiner & Brennan, 2002).

As public attention has recently focused on racial and ethnic disparities in access to health care, research indicates that Latinos have the highest uninsurance rates among racial/ethnic groups living in the United States. Latino immigrants are a large and growing segment of American society and are disproportionately low-income and uninsured. The status of immigrants has broader implications for national and state efforts to improve access to health care.

The 1996 federal welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) restricted Medicaid eligibility of immigrants, so that those admitted to the United States after August 1996 ("The Personal", 2002) cannot receive coverage, except for emergencies, in their first five years in the country. Historically, legally admitted immigrants were eligible for Medicaid and other benefits on the same terms as citizens were, but PRWORA signaled an important change in the social contract. These policies exacerbated immigrants' fears that began after the enactment of California's Proposition 187 and after publicity concerning "public charge" policies becoming enforced. Traditionally, "public charge" determinations have been highly discretionary judgments by INS or consular officers. These determinations take into account an immigrant's age, health, education and job skills, income, assets, and any money available to the immigrant from family members. Because of the broad

discretion INS and consular officials have to decide whether to admit or adjust the status of immigrants, few standards have constrained what they could ask or what benefit programs they could consider in making a determination. Following passage of the 1996 welfare law, some INS and consular officers took an aggressive interpretation, which sometimes went beyond what the law permits, of what could count towards this determination. Widespread confusion about the relationship between public benefit receipt and the public charge test caused numerous immigrants and their families to avoid using benefits for which they were eligible. In May 1999, the Immigration and Naturalization Service issued important new guidance that should have greatly eased the public charge concerns of immigrants eligible for public benefits. The guidance narrowly limited the situations in which receipt of public benefits is relevant to a "public charge" finding. Under the guidance, the receipt of any non-cash benefit, with the sole exception of institutionalization for long-term care at government expense, is never a factor in a public charge determination. Thus, immigrants could accept Medicaid, food stamps, WIC, housing benefits, child care subsidies or other non-cash benefits without endangering their immigration status. In addition, although receipt of certain types of cash assistance remains relevant to a public charge determination under the guidance, the vast majority of immigrants should not have reason to avoid cash assistance because of concerns about adverse immigration consequences related to public charge. With a few rare, albeit important, exceptions, immigrants who remain eligible for cash assistance under either the Temporary Assistance for Needy Families (TANF) program or the Supplemental Security Income (SSI) program can freely accept that assistance without endangering their immigration status. Collectively, these policies signaled that legal immigrants should avoid Medicaid, even if they were uninsured and eligible (Ku & Matani, 2001).

The Medicaid participation of low-income noncitizens fell and uninsurance rates climbed from 1995 to 1998 (Ku & Waidmann, 2003). Since PRWORA changed eligibility for only the fraction of immigrants admitted after 1996, many analysts ascribe these changes as a “chilling effect” that affected immigrants who still were eligible. These fears affected U.S. born children of immigrants (who were legal citizens), impeding efforts to enroll children in Medicaid and the SCHIP. About one fifth of all children in the United States are immigrants (3 percent) or U.S. born children of immigrants (16 percent) (Ku & Matani, 2001).

Immigrants provide an extraordinary array of assets to the Dallas-Fort Worth metroplex. Low-wage workers in areas such as construction and gardening as well as physicians and high-tech engineers define the region’s economic growth. They are a significant labor force with extensive consumer potential. Immigrants also offer their rich cultural traditions in music and the performing, visual, and culinary arts. They are a significant basis of the area’s growth and development (Sanchez & Weiss-Armush, 2003).

During one of his early visits to Dallas, Mexico’s President Vicente Fox (the former governor of Guanajuato state) reminded us that the immigrants his country sent to ‘The North’ were Mexico’s finest. Only the most courageous, the risk takers, he said, would leave the security of their homes and their traditions to seek better lives in a foreign land. “We are sending the United States our strongest and most dynamic, our hardest working men and women” (Sanchez & Weiss-Armush, 2003).

“Unfortunately many immigrants’ noteworthy contributions and substantial needs go unacknowledged by the majority of the population. Their presence is overlooked and little is known about their work environments, community activities, beliefs and value systems, and daily lives in general. The many challenges that immigrants face, the roles they fulfill, and the

issues that motivate them will form the basis for our future level of success and sustained growth. A great portion of the North Texas immigrant population suffers challenges on a daily basis that remain unrecognized and unaddressed. Many live in poverty, do not speak English, have no legal status, and are the victims of prejudice and stereotyping. With the exception of refugees, low-income immigrants receive limited assistance from local, regional and state governments or from the social service organizations in the area” (Sanchez & Weiss-Armush, 2003). The purpose of this study is to answer the research question: What factors contribute to the lack of health insurance and how it impacts the utilization of services? This study takes an inductive approach to develop an explanation of factors contributing to the lack of health insurance in a group of Latino immigrants in Fort Worth. Fort Worth has a growing population of Latino immigrants entering the city to live and work. Access to health care is an ever growing concern nationally as well as in areas affected by the population growth of the immigrant population. The significance of this study is to add to the knowledge base aimed at determining the growing concerns of health care accessed by Latino immigrants and address the issues of proper utilization of health care services through policies affecting health insurance and services available.

METHODOLOGY

Secondary data analysis was performed with data collected in a cross-sectional survey used to assess the needs for health insurance of Latino immigrants in Fort Worth, Texas. Data elements collected and analyzed from the database included the following demographic characteristics of the participants which entailed monthly income, education, occupation, health insurance coverage and difficulty of purchasing health insurance, accessibility to health care, residency status, and length of time in the United States. The data is stored in a SPSS database

and resides at the UNTHSC School of Public Health. This survey instrument was developed during Capstone class of the spring and fall semesters of 2002 under the supervision of Dr. Ximena Urrutia-Rojas. Data was collected by Master of Public Health (MPH) students enrolled in the Capstone class. The population sampled is a convenience sample of men and women who identified themselves as non-U.S. born Latinos, eighteen years of age or older. Participation was entirely voluntary, and participants were able to refrain from answering any questions and withdraw at any time during the interview. The sample consisted of 323 participants consisting of 126 males and 197 females. The age range of the participants involved in the study was 18 to 78 years old with a mean age of 34.3 years. No names or identifiers were included in the interview. In order to obtain a broad sample of Latino immigrants living in Fort Worth, interviews were conducted at five locations frequently visited by the targeted participants, such as the City of Fort Worth Health Department, laundromats, flea markets, shopping centers, and Catholic and Protestant churches. Consequently, this data does not constitute a probability sample.

The variables analyzed in this report measure health insurance coverage, difficulty of purchasing health insurance, facilities accessed for health care, frequency of health checkups, unmet health needs, length of time in U.S., and basic demographics as well as other barriers to access such as language limitations and transportation. Univariate statistics such as frequencies, means, and median were analyzed to determine the pattern and integrity of the data. and presented in this report. Bivariate analysis were also performed to examine the significant associations between the dependant and independent variables (Table 4 – Table 14 in Appendices) with relationships between insurance coverage, factors for lack of insurance and the underutilization of health care services.

To meet ethical and regulatory responsibilities of this study, a request for exempt status and waiver of informed consent was granted by the Institutional Review Board (IRB) for the protection of human subjects at the University of North Texas Health Science Center.

Bivariate regression analysis methods were used to test the significance of the relationships of predictor variables examined.

Two dichotomous logistic regression equations were formulated. The first equation tested the first hypothesis: “Immigrants are more likely to have health insurance depending on years in U.S., health status, income, gender, and ability to speak English.”

$$(Y)=\beta_0 + \beta_1 \text{ Years in U.S. } X_1 + \beta_2 \text{ Health Status } X_2 + \beta_3 \text{ Income } X_3 + \beta_4 \text{ Age } X_4 + \beta_5 \text{ Gender } X_5 + \beta_6 \text{ Language } X_6 + e$$

The respondents surveyed were asked whether they were covered by insurance either by government or privately purchased. *Health Status* is the health status the respondents answered regarding how they rated their overall health (excellent, good, fair, and poor). *Income* was asked to determine their monthly income. *Age* is the age of the respondents at the time of the survey. *Gender* was whether the respondents were male or female, and *Language* determined to what extent the respondent spoke English: none, some, or yes. The predictors used in the equation were selected based upon existing literature for their probable impact on the respondents’ likelihood of having insurance (Ku & Waidmann, 2003) (Sanchez & Weiss-Armush, 2003).

The second logistic equation tested the hypothesis: “Immigrants are more likely to use a doctor’s office (primary care) over the emergency room care depending on whether they have health insurance, as well as, health status, age, income, gender and ability to speak English:

$$(Y)=\beta_0 + \beta_1 \text{ Health Insurance } X_1 + \beta_2 \text{ Health Status } X_2 + \beta_3 \text{ Age } X_3 + \beta_4 \text{ Income } X_4 + \beta_5 \text{ Gender } X_5 + \beta_6 \text{ Language } X_6 + e$$

where *Health Insurance* determined whether they had health insurance or not, *Health Status* is the health status the respondents answered regarding how they rated their overall health (excellent, good, fair, and poor). *Age* is the age of the respondents at the time of the survey. *Income* was asked to determine their income. *Gender* was whether the respondents were male or female, and *Language* determined to what extent the respondent spoke English: none, some, or yes.

The dependant variable was categorized to form a dichotomous value of doctor's office (primary care), which was used as the reference value and second value being emergency room care. The predictors used in the equation were selected based upon the literature for their probable impact on the respondents' likelihood of utilizing care at a doctor's office, which served as the reference value and utilizing care from an emergency room facility (Ku & Waidmann, 2003) (Sanchez & Weiss-Armush, 2003).

Table 1 provides the description of the variables used in the logistic regression analysis. The categories used in the equation are reflected in the table. The categories are shown in Tables 4-15 which gives a description of the values used in the equation.

Table 1

<i>Descriptive Statistics</i>					
	N	Minimum	Maximum	Mean	Std. Deviation
Do you have health insurance?	322	0	1	.26	.440
How would you describe your own health?	322	1	4	2.34	.698
Categorical Age	325	1	5	2.03	1.097
Categorical of years in the US	320	1	4	2.30	1.174
Categorical income	283	1	7	2.64	1.248
Gender	323	.00	1.00	.3901	.48853
Language	322	.00	2.00	.5714	.72957
Valid N (listwise)	273				

RESULTS

Table 2 shows regression coefficients, Wald statistics, odds ratios and 95% confidence intervals for odds ratios for each of the predictor variables. Overall, the results reflect how most of the variables did not significantly predict the probability of having insurance as conditions changed. Gender and length of time in country are the only variables with a significant predictor in the output. Categorically, the variable of *how long in the country* showed a significance of .001 ($p < .05$) in the equation. The category of five to nine years showed a significant p-value of .03 and 10-14 years showed a significant p-value of .010. *Health Status* did not show any significant association as a predictor value. *Monthly income* and *age* did not show any significant associations in the values generated. *Gender* category showed a significant p-value of .005 as females were referenced to males. Language did not show a significant association in the equation.

Table 2 **Equation 1: Health insurance and Sociodemographic Characteristics**

Variables in the Equation	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
How long in the country:			15.820	3	.001			
0-4 yrs								
5-9 yrs	-.533	.524	8.564	1	.003	.216	.077	.603
10-14 yrs	-.359	.529	6.588	1	.010	.257	.091	.725
15+ yrs	.171	.473	.131	1	.717	1.187	.470	2.999
Health status:			.927	3	.819			
excellent								
Good	-.837	1.126	.553	1	.457	.433	.048	3.932
Fair	-.421	.999	.178	1	.673	.656	.093	4.650
Poor	-.593	.979	.367	1	.545	.553	.081	3.763
Monthly income \$0-500			12.238	6	.057			
501-1000	-9.420	17.265	.298	1	.585	.000	.000	4.03E+10
1001-1500	-8.969	17.259	.270	1	.603	.000	.000	6.25E+10
1501-2000	-9.444	17.259	.299	1	.584	.000	.000	3.88E+10
2001-2500	-8.242	17.259	.228	1	.633	.000	.000	1.29E+10
2501-3000	-8.931	17.278	.267	1	.605	.000	.000	6.73E+10
3001+	-6.328	17.292	.134	1	.714	.002	.000	9.35E+10
Age: 18-29			1.733	4	.785			
30-39	-.702	.837	.704	1	.401	.496	.096	2.555
40-49	-.816	.827	.973	1	.324	.442	.087	2.237
50-59	-.294	.827	.126	1	.722	.745	.147	3.769
60+	-.470	.909	.267	1	.605	.625	.105	3.711
Gender:	1.119	.394	8.060	1	.005	3.062	1.414	6.629
female								
Language:			.212	2	.899			
No								
Some	.242	.534	.206	1	.650	1.274	.448	3.626
Yes	.208	.538	.149	1	.699	1.231	.429	3.536
Constant	8.771	17.287	.257	1	.612	6443.805		

Table 3 Cross tabulation Type of facility * Do you have health insurance?

			Do you have health insurance?		Total
			0	yes	
Type of facility	Doctor's Office	Count	45	6	51
		% within Type of facility	88.2%	11.8%	100.0%
		% within Do you have health insurance?	27.6%	7.8%	21.3%
	Emergency Room	Count	118	71	189
		% within Type of facility	62.4%	37.6%	100.0%
		% within Do you have health insurance?	72.4%	92.2%	78.8%
Total		Count	163	77	240
		% within Type of facility	67.9%	32.1%	100.0%
		% within Do you have health insurance?	100.0%	100.0%	100.0%

Table 3 shows the dichotomous variable of *Type of facility* used. Doctor's office or primary care is the reference value for the equation.

The second logistic regression in Table 4 was performed with "type of facility" which was used to obtain care as the dependant variable.

Table 4 Type of facility utilized and Sociodemographic Characteristics

Variables in the Equation	B	S.E.	Wald	df	Sig.	Exp(B)	95.0% C.I. for EXP(B)	
							Lower	Upper
Do you have insurance: (Yes)	-1.647	.578	8.117	1	.004	.193	.062	.598
Health status: excellent			2.851	3	.415			
good	1.603	1.289	1.546	1	.214	4.968	.397	62.147
fair	1.929	1.159	2.771	1	.096	6.882	.710	66.703
poor	1.726	1.140	2.293	1	.130	5.620	.602	52.500
Age			8.474	4	.076			
18-29	1.319	.966	1.867	1	.172	3.740	.564	24.816
30-39	2.282	1.013	5.074	1	.024	9.801	1.345	71.415
40-49	.939	1.012	.860	1	.354	2.557	.351	18.599
50-59	.794	1.094	.527	1	.468	2.212	.259	18.864
Monthly income \$0-500			.758	6	.993			
501-1000	-4.867	34.493	.020	1	.888	.008	.000	1.8E+27
1001-1500	-5.006	34.489	.021	1	.885	.007	.000	1.5E+27
1501-2000	-5.092	34.489	.022	1	.883	.006	.000	1.4E+27
2001-2500	-4.602	34.492	.018	1	.894	.010	.000	2.3E+27
2501-3000	-4.877	34.506	.020	1	.888	.008	.000	1.8E+27
3001+	.439	44.905	.000	1	.992	1.551	.000	2.6E+38
Gender: female	.610	.433	1.985	1	.159	1.840	.788	4.299
Language: No			2.780	2	.249			
some	-.791	.649	1.487	1	.223	.453	.127	1.617
yes	-.150	.702	.046	1	.831	.861	.218	3.405
Constant	4.432	34.506	.016	1	.898	84.097		

In the second logistic regression analysis, *do you have insurance* (Table 4) demonstrated a significant association with a p-value of .004 ($p < .05$). *Age* showed a significant association in the category of 30-39 as a predictor value with a p-value of .024. *Health status*, *monthly income*, *gender*, and *language* did not demonstrate a significant association when controlled in the equation. *Health status* was marginal at .076 at the poor category. The following cross tabulation analysis was examined showing a negative bivariate association between having health insurance and using a physician's office for care; however, when controlled with the other variables used in the equation, the variable did not show to be a significant predictor. Type of facility was dichotomized to doctor's or clinical service (primary care) and emergency room or hospital services.

LIMITATIONS

One of the limitations of this study is that the secondary data source will not adequately measure the concept that is critical to the hypothesis that is made here. Additionally, since the data represents a non-probability sample in one city, extrapolation to the foreign born Latino population of Texas is not warranted. A convenience sample was the means for gathering the data. The sample population is homogenous and fall into similar socioeconomic strata. This research is inductive and intended to lay the ground work for future generalizeable studies.

DISCUSSION

The following variables were used to predict the respondent's possession of insurance coverage: income, age, health status, years in the U.S., ability to speak English, and gender. In the first analysis, the most significant findings were for gender where females are more likely to not have insurance than males. The bivariate analysis in Appendix Table 10 of "time in the U.S." with "do you have insurance" demonstrates how a greater percentage of those with more

time in the U.S. have a higher percentage of having insurance than those with 4 or less years in the United States. The majority of those surveyed fell into the category of being in the U.S. less than 4 years with no insurance (34.3%), but the percentage of those insured increased with the immigrants that had more time in the U.S. After controlling with the other variables in the equation, this likelihood remained in our findings. The reference group was chosen as the first in the order of responses in the survey instrument for that question. Time in the U.S. showed some statistical significance ($p < .05$) in the probability of having insurance in relation to the time in the United States. Immigrants in the U.S. 5-9 years were 21% more likely to have insurance than someone in the U.S. 4 years or less (the reference group). Immigrants in the U.S. 10-14 years were also found to be 26% more likely of having insurance of the reference group. The other variables used for prediction did not show a significance when used as predictor variables. According to 2003 reports, there are more uninsured Latino women than any other race/ethnic group (30%), even though many of them are employed or live with someone who is employed. Only 26% have private health insurance, 27% receive Medicaid coverage, and 7% receive Medicare. This lack of insurance is due in part to the fact that Latinos are more likely than non-Latinos to be employed in industries and jobs that do not provide health benefits. Also, within the various industries, Latinos are less likely than non-Latinos to be offered health coverage by their employers. Problems with language, transportation, child care, immigration status, or cultural differences act as further barriers to health care services ("Health Problems", 2003).

The significance of immigrant women being less likely to have insurance than immigrant men would appear to be supported by reported national figures. In 2001, women who were non-citizens were more likely than naturalized citizens and U.S.-born women to lack a usual source of care (18.9 percent as compared to 11.2 and 9.4 percent of naturalized and U.S.-born citizens,

respectively). Non-citizens were also more likely to report having no health insurance than U.S.-born citizens (41.3 compared to 10.3 percent) ("Women's Health", 2003). Latinas have the highest rate of uninsurance (34%) followed by Asian and American Indian/Alaska Native women (17% and 16%, respectively) (Wyn & Ojeda, 2003).

The relationship of not having insurance attributed to time in the U.S. is corroborated by national reports addressing the same subject. Time lived in the United States was a major factor associated with being uninsured for Latinos, particularly those who had lived in the United States less than 10 years. Undocumented immigrants, individuals without green cards, and in some cases someone who was not a U.S. citizen may not have been eligible for public health insurance ("Workplace factors," 2003).

To compare Fort Worth to a national study, the place of origin of the Latino population makes a major difference in the probability of being uninsured. In a 1992 survey comparing Cubans, Puerto Ricans, and Mexican-Americans, twice as many Mexican-Americans were uninsured. Uninsured Latinos are considerably less likely than Latinos with health insurance to have a regular source of care. Not only are uninsured Latinos more likely to have a regular source of care, but less likely to have seen a physician in the previous year (Trevino, Moyer, Valdez, & Stroup-Benham, 1992).

Comparing Fort Worth's immigrant Latinos findings with national data from comparative studies done at a national level, foreign-born Latinos are twice as likely as U.S.-born Latinos to be uninsured (49% v. 24%). Even within the immigrant population, Latinos have strikingly higher uninsured rates than non-Latinos. The disparity is particularly evident for those who have been in the U.S. less than 5 years: 72% of new Latino immigrants lack health insurance, compared to 28% of new non-Latino immigrants. While rates of insurance coverage increase

with length of residence in the U.S., one-third of Latino immigrants remain uninsured even after living in the U.S. for 15 years—more than double the rate for non-Latino immigrants who have lived in the U.S. for longer than 15 years ("Uninsured Hispanics", 2001).

Table 3 showed a significant relationship in the type of facility utilized to the "do you have insurance variable." The logistic regression analysis of "type of facility" with "do you have insurance" shows a preference of utilizing the emergency room facility over the doctor's office which remains even after controlling for the other variables in the equation.

In the bivariate analysis of facility type and "do you have insurance" a significant association appears on a chi square analysis, but an anomaly of insured immigrants having a preference of utilizing the emergency room was significant in the regression analysis (Table 3). "Latinos are the least likely among all ethnic groups to have a usual provider to go to when they need health care. A quarter of Latino adults living in the U.S.—and half of uninsured Latino adults living in the U.S.—have no usual source of care. Uninsured Latino children are twice as likely as white children to have no usual source of care ("Uninsured Hispanics", 2000, p. 1). The anomalous preference for ER utilization among insured immigrants shown in this study suggests that insurance alone is not the solution to appropriate use of the health care system.

The second significant finding in Table 3 was the age group 30-39 years as more likely to attend the doctor's office than any of the other age groups. This may be attributable to the mean of the respondents age was 34.3 years. Cultural-linguistic barriers interfere with immigrant and refugee health care practice and the subsequent behavior of seeking preventive health care services. Each culture has its own system of concepts about the nature of illness and its place in human existence, and these concepts often differ radically from those upon which western medicine is based (Bacigalupe, 2001).

A personal relationship with physicians is highly valued and expected and it is experienced as the basis for a trustworthy relationship. In a survey taken by the Mauricio Gaston Institute in Massachussets in a study of Latinos and attitudes toward preventive health care, it found that despite Latinos having various degrees of English fluency, language generally constitutes a barrier for adequate health care. Various participants reported having experienced personal problems with receptionist and nurses; in some instances, they referred to “racist attitudes” among African-American staff towards Latinos. Finally, many participants in this study report having migrated in search of better health care and their family and community networks have supported this migration. In the interviews, some of the men suggested that psychosocial and cultural Latino dimensions might inhibit preventive care like prostate cancer screening and continuous management of chronic health conditions. These dimensions include shyness (*timidez*), arrogance (*soberbia*), pride (*orgullo*), and machismo. Physicians with “good manners” (*buenos modales*), but who do not raise these issues, were identified by participants as not necessarily providing quality health services. These psychosocial and cultural dimensions may also contribute to the underutilization of preventive care (Bacigalupe, 2001, p 2). This may have an impact on the Fort Worth results since the cultural differences and communication difficulties occur in the samples area as well.

Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and health systems. How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate care are all affected by cultural beliefs (Suarez-Orozco & Paez, 2002).

Understanding the being sensitive to the culture of Latinos in Fort Worth is essential in providing these immigrants to the proper care for proper diagnosis.

A number of reports, including those issued by the U.S. Civil Rights Commission and the U.S. General Accounting Office have identified factors related to issues of access, equity, quality, and cost of health care that contribute to low service utilization rates. The most often mentioned are institutional policies and procedures that discourage their utilization by the Latino elderly, lack of bilingual and bicultural health care personnel at all levels of the health care system, location of the health care facility, lack of transportation, and inadequate outreach in the language of their preference. Other reports mention the Latino elderly's reluctance to seek health care practices, cultural conflict, discrimination, and lack of information about the various services available. Their limited knowledge of English certainly adds to their lack of understanding of a health care system that in many ways appears to them as uncoordinated, contradictory, and complex (Trevino, et al., 1992).

Most uninsured Latinos report that the main reason for lack of coverage was that they could not afford the cost of health insurance. The majority of immigrants in Fort Worth fell into income categories of 500 to 2000 dollars monthly. Consequently, they are considerably less likely to see a physician, and were the least likely to report unemployment as the main reason for non-coverage. Reports support the finding that the low rates of private health insurance coverage among Latino population groups is primarily the result of their low income and employment in places where health insurance coverage is not provided as a benefit. Fifty-eight percent of the uninsured Mexican-Americans, 40 percent of the uninsured Cuban-Americans, and 51 percent of the uninsured Puerto Rican Americans are living in poverty. Thus, the segment of the population most affected by the cost of medical services is the "working poor

Latinos who are not eligible for government programs and at the same time cannot afford the rising cost of medical services” (Trevino, et al., 1992).

Financial limitations and an increasingly competitive health care environment have forced many hospitals, both for profit and not for profit, to curtail the amount of uncompensated care they provide and to shift uninsured patients to public hospitals. It is estimated that more than 1 million Americans are turned away from hospitals each year because they lack insurance or other means to pay for care, and many of the uninsured who require emergency care are transferred to public hospitals. While there are no figures indicating the proportion of Latino elderly that are turned away from hospitals, it is assumed that the proportions are quite high simply because hospital emergency rooms have become the treatment of choice due to lack of resources to pay for private care (Trevino, et al., 1992).

To establish a causal link between uninsurance and health care utilization, it is important to eliminate plausible confounding factors. Two important confounders of insurance status are race/ethnicity and socioeconomic status. Each of these factors identifies groups of individuals who are vulnerable to poor health because they face barriers to receiving necessary health care; but they face other circumstances that compromise health status. For instance, since socioeconomic status and race/ethnicity are associated both with uninsurance and with health, to what extent is the association of insurance and health due to this confounding? Does uninsurance mediate the impact of race/ethnicity and socioeconomic status on health or are there other factors involved in the association? (Hass & Adler, 2001).

POLICY IMPLICATIONS

Reforms may have unintended but direct harmful effects on the public’s health and financial well-being. Without system-wide integration of immigrants and refugees into a

comprehensive health care delivery system, it will be difficult to prevent and control the spread of TB and other infectious diseases. Lack of entitlement to health care benefits and perceived lack of access to services impacts health care utilization patterns, discouraging Fort Worth immigrants from accessing preventive care and forcing individuals to defer health care needs until problems are advanced, acute and ultimately more costly to treat. Lack of access to preventive and primary health care services results in increased rates of hospitalizations for preventable conditions. Higher health care expenditures may result as less expensive routine preventive health services are rendered inaccessible and are replaced by acute care services whose larger costs will burden Fort Worth and society as a whole.

It is difficult to assess the impact of immigration and welfare reform on health status. Evidence-based research is needed to document changes in health care utilization, costs, and health care outcomes associated with the recent policy changes. According to figures reported by the Kaiser Family Foundation, 20% of the 44 million uninsured individuals in the US are immigrants. Low-income non-citizens are twice as likely to be uninsured than low-income citizens. Over 58% of low-income non-citizens were uninsured in 1998 with 15% qualifying for Medicaid. 30% of low-income citizens were uninsured in 1998 and a full 30% received Medicaid (Hass & Adler, 2000).

Reasons for migration often include religious persecution, political conflict, war, environmental disasters, depletion of natural resources, and economic hardship—all of which can have devastating effects on health status rendering immigrants a vulnerable population often with acute health care needs immediately upon arrival. Even those arriving in good health face disproportionate risks upon arrival including poor access to health care, adoption of poor health

habits during the process of acculturation, and exposure to environmental risk and high injury work environments (Kramer, Ivey, & Ying, 1999).

Since Fort Worth Latino immigrants are the least likely to have health insurance, they and their families are more likely to experience problems when they need access to care. Latino immigrants in Fort Worth with insurance are more likely to have doctor visits and diabetes tests than immigrants in this sample without insurance. Reducing the barrier of uninsurance is an important step in improving access to care for all persons, including Latino immigrants in Fort Worth. Improved access to preventive services would help reduce the burden of diabetes, which is an exception to the generally favorable health profile of Latino immigrants. Improving access would also help immigrants maintain their generally favorable health profile (Wallace, Gutierrez, & Brown, 2003).

The President's initiative, (Executive Order 13166), acknowledges the vital role that Community Health Centers (CHCs) play in ensuring health care for America's most needy populations, by pledging to double the number of clinics and the people served over the next five years. Fort Worth currently does not have a community health center for the population in need of this service. Fort Worth is one of the larger cities in the nation without a CHC in the city to serve the population. Fort Worth has demonstrated a need in areas of the city that would warrant the CHC in the community and how it would be well served with this facility. Currently, the 501c3 board established for this CHC continues to work toward securing the federal funds.

CHCs provide primary and preventive services while meeting the specific needs of the communities they serve. CHCs efforts to provide health care that is culturally and linguistically appropriate make them vital access points for Latino populations. Through

CHCs, Limited English Proficient (LEP), immigrant, and uninsured populations can access affordable health care. The continued authorization and funding of CHCs are critically important to providing basic health care to the country's most underserved populations ("Increasing health", 2003).

The initiative provides the opportunity for both of these goals, CHC expansion and greater community participation, to be recognized. The rapid growth of the Latino population combined with low wages and rates of insurance make CHCs a primary source of health care for this population. Thus the expansion of CHCs should recognize this expanding population, and be tailored to address the growing need of Latinos. Congress must recognize that such a diverse and rapidly growing segment of the population necessitates that additional funding be appropriated to meet their needs. Additionally the language and culture of Latinos requires linguistically and culturally appropriate services.

If an individual is unable to access health care, that person is more likely to have poor health outcomes, to rely on "safety net" providers, and to have increased rates of preventable death and disability. This is especially true of Latinos with higher rates of poverty and English proficiency issues.

Regular access to health care vastly increases the chances for health education, regular health maintenance, and adoption of preventive health practices and reduces the need for acute care. In addition, funding for enabling services, such as adequate translation and interpreter services, which are provided by CHCs, allow health care providers to reduce the number of misdiagnosis and incorrect or unnecessary treatments, and reduces the overall cost of providing health care in Fort Worth.

Appendices

Cross Tabulations

Table 5

Type Facility and Age

			Age					Total
			18-29	30-39	40-49	50-59	60+	
Type of facility	.00	Count	23	10	9	5	4	51
		Expected Count	20.1	17.1	8.3	3.4	2.1	51.0
		% within Type of facility	45.1%	19.6%	17.6%	9.8%	7.8%	100.0%
		% within Categorical Age	24.2%	12.3%	23.1%	31.3%	40.0%	21.2%
	1.00	Count	72	71	30	11	6	190
		Expected Count	74.9	63.9	30.7	12.6	7.9	190.0
		% within Type of facility	37.9%	37.4%	15.8%	5.8%	3.2%	100.0%
		% within Age	75.8%	87.7%	76.9%	68.8%	60.0%	78.8%
Total		Count	95	81	39	16	10	241
		Expected Count	95.0	81.0	39.0	16.0	10.0	241.0
		% within Type of facility	39.4%	33.6%	16.2%	6.6%	4.1%	100.0%
		% within Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.492	4	.112
Likelihood Ratio	7.573	4	.109
Linear-by-Linear Association	.939	1	.332
N of Valid Cases	241		

a 2 cells (20.0%) have expected count less than 5. The minimum expected count is 2.12.

Table 6

Type of facility and Health status

			How would you describe your own health?				Total
			excellent	good	fair	poor	
Type of facility	.00	Count	5	19	24	3	51
		Expected Count	4.7	24.2	20.8	1.3	51.0
		% within Type of facility	9.8%	37.3%	47.1%	5.9%	100.0%
		% within How would you describe your own health?	22.7%	16.7%	24.5%	50.0%	21.3%
	1.00	Count	17	95	74	3	189
		Expected Count	17.3	89.8	77.2	4.7	189.0
		% within Type of facility	9.0%	50.3%	39.2%	1.6%	100.0%
		% within How would you describe your own health?	77.3%	83.3%	75.5%	50.0%	78.8%
Total		Count	22	114	98	6	240
		Expected Count	22.0	114.0	98.0	6.0	240.0
		% within Type of facility	9.2%	47.5%	40.8%	2.5%	100.0%
		% within How would you describe your own health?	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.038	3	.169
Likelihood Ratio	4.547	3	.208
Linear-by-Linear Association	2.114	1	.146
N of Valid Cases	240		

a 3 cells (37.5%) have expected count less than 5. The minimum expected count is 1.27.

Table 7**Type of facility and Income**

			Income							Total
			0-500	501-1000	1001-1500	1501-2000	2001-2500	2501-3000	3001+	
Type of facility	.00	Count	11	13	14	6	1	0	0	45
		Expected Count	8.1	13.0	13.9	7.0	1.3	.9	.9	45.0
		% within Type of facility	24.4%	28.9%	31.1%	13.3%	2.2%	.0%	.0%	100.0%
		% within Income	28.9%	21.3%	21.5%	18.2%	16.7%	.0%	.0%	21.3%
	1.00	Count	27	48	51	27	5	4	4	166
		Expected Count	29.9	48.0	51.1	26.0	4.7	3.1	3.1	166.0
		% within Type of facility	16.3%	28.9%	30.7%	16.3%	3.0%	2.4%	2.4%	100.0%
		% within Income	71.1%	78.7%	78.5%	81.8%	83.3%	100.0%	100.0%	78.7%
Total		Count	38	61	65	33	6	4	4	211
		Expected Count	38.0	61.0	65.0	33.0	6.0	4.0	4.0	211.0
		% within Type of facility	18.0%	28.9%	30.8%	15.6%	2.8%	1.9%	1.9%	100.0%
		% within Income	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.758	6	.709
Likelihood Ratio	5.344	6	.501
Linear-by-Linear Association	3.016	1	.082
N of Valid Cases	211		

a 6 cells (42.9%) have expected count less than 5. The minimum expected count is .85.

Table 8**Type of facility and gender**

			Gender		Total
			.00	1.00	
Type of facility	.00	Count	30	21	51
		Expected Count	34.6	16.4	51.0
		% within Type of facility	58.8%	41.2%	100.0%
		% within Gender	18.5%	27.3%	21.3%
	1.00	Count	132	56	188
		Expected Count	127.4	60.6	188.0
		% within Type of facility	70.2%	29.8%	100.0%
		% within Gender	81.5%	72.7%	78.7%
Total		Count	162	77	239
		Expected Count	162.0	77.0	239.0
		% within Type of facility	67.8%	32.2%	100.0%
		% within Gender	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.383	1	.123		
Continuity Correction	1.890	1	.169		
Likelihood Ratio	2.315	1	.128		
Fisher's Exact Test				.131	.086
Linear-by-Linear Association	2.373	1	.123		
N of Valid Cases	239				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 16.43.

Table 9**Type of facility and Language**

			ENGL2			Total
			.00	1.00	2.00	
Type of facility	.00	Count	33	13	4	50
		Expected Count	27.1	14.5	8.4	50.0
		% within Type of facility	66.0%	26.0%	8.0%	100.0%
		% within Language	25.6%	18.8%	10.0%	21.0%
	1.00	Count	96	56	36	188
		Expected Count	101.9	54.5	31.6	188.0
		% within Type of facility	51.1%	29.8%	19.1%	100.0%
		% within Language	74.4%	81.2%	90.0%	79.0%
Total		Count	129	69	40	238
		Expected Count	129.0	69.0	40.0	238.0
		% within Type of facility	54.2%	29.0%	16.8%	100.0%
		% within Language	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.742	2	.093
Likelihood Ratio	5.204	2	.074
Linear-by-Linear Association	4.693	1	.030
N of Valid Cases	238		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.40.

Table 10

Do you have insurance and years in U.S.

			Categorical of years in the US				Total
			0-4 years	5-9 years	10-14 years	15+ more years	
Do you have health insurance?	0	Count	93	66	31	43	233
		% within Do you have health insurance?	39.9%	28.3%	13.3%	18.5%	100.0%
		% within Categorical of years in the US	85.3%	82.5%	60.8%	55.8%	73.5%
	yes	Count	16	14	20	34	84
		% within Do you have health insurance?	19.0%	16.7%	23.8%	40.5%	100.0%
		% within Categorical of years in the US	14.7%	17.5%	39.2%	44.2%	26.5%
Total		Count	109	80	51	77	317
		% within Do you have health insurance?	34.4%	25.2%	16.1%	24.3%	100.0%
		% within Categorical of years in the US	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	27.705	3	.000
Likelihood Ratio	27.459	3	.000
Linear-by-Linear Association	25.280	1	.000
N of Valid Cases	317		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 13.51.

Table 11

Do you have insurance and Health status

			How would you describe your own health?				Total
			excellent	good	fair	poor	
Do you have health insurance?	0	Count	25	110	94	6	235
		% within Do you have health insurance?	10.6%	46.8%	40.0%	2.6%	100.0%
		% within How would you describe your own health?	75.8%	72.4%	74.6%	75.0%	73.7%
	yes	Count	8	42	32	2	84
		% within Do you have health insurance?	9.5%	50.0%	38.1%	2.4%	100.0%
		% within How would you describe your own health?	24.2%	27.6%	25.4%	25.0%	26.3%
Total		Count	33	152	126	8	319
		% within Do you have health insurance?	10.3%	47.6%	39.5%	2.5%	100.0%
		% within How would you describe your own health?	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.271	3	.965
Likelihood Ratio	.271	3	.965
Linear-by-Linear Association	.016	1	.898
N of Valid Cases	319		

a 1 cells (12.5%) have expected count less than 5. The minimum expected count is 2.11.

Table 12

Do you have insurance and Income

			Categoric al income							Total
			0-500	501- 1000	1001- 1500	1501- 2000	2001- 2500	2501- 3000	3001+	
Do you have health insurance ?	0	Count	36	69	69	25	5	1	1	206
		% within Do you have health insurance ?	17.5%	33.5%	33.5%	12.1%	2.4%	.5%	.5%	100.0 %
		% within Categoric al income	78.3%	74.2%	80.2%	65.8%	71.4%	20.0%	20.0%	73.6%
	ye s	Count	10	24	17	13	2	4	4	74
		% within Do you have health insurance ?	13.5%	32.4%	23.0%	17.6%	2.7%	5.4%	5.4%	100.0 %
		% within Categoric al income	21.7%	25.8%	19.8%	34.2%	28.6%	80.0%	80.0%	26.4%
Total		Count	46	93	86	38	7	5	5	280
		% within Do you have health insurance ?	16.4%	33.2%	30.7%	13.6%	2.5%	1.8%	1.8%	100.0 %
		% within Categoric al income	100.0%	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.461	6	.005
Likelihood Ratio	16.296	6	.012
Linear-by-Linear Association	8.550	1	.003
N of Valid Cases	280		

a 5 cells (35.7%) have expected count less than 5. The minimum expected count is 1.32.

Table 13**Do you have insurance and Age**

			Categorical Age					Total
			18-29	30-39	40-49	50-59	60+	
Do you have health insurance?	0	Count	102	78	34	17	7	238
		% within Do you have health insurance?	42.9%	32.8%	14.3%	7.1%	2.9%	100.0%
		% within Categorical Age	81.0%	73.6%	64.2%	68.0%	58.3%	73.9%
	yes	Count	24	28	19	8	5	84
		% within Do you have health insurance?	28.6%	33.3%	22.6%	9.5%	6.0%	100.0%
		% within Categorical Age	19.0%	26.4%	35.8%	32.0%	41.7%	26.1%
Total		Count	126	106	53	25	12	322
		% within Do you have health insurance?	39.1%	32.9%	16.5%	7.8%	3.7%	100.0%
		% within Categorical Age	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.827	4	.098
Likelihood Ratio	7.718	4	.102
Linear-by-Linear Association	6.838	1	.009
N of Valid Cases	322		

a 1 cells (10.0%) have expected count less than 5. The minimum expected count is 3.13.

Table 14**Do you have insurance and Gender**

			Gender		Total
			.00	1.00	
Do you have health insurance?	0	Count	141	96	237
		% within Do you have health insurance?	59.5%	40.5%	100.0%
		% within Gender	71.6%	78.0%	74.1%
	yes	Count	56	27	83
		% within Do you have health insurance?	67.5%	32.5%	100.0%
		% within Gender	28.4%	22.0%	25.9%
Total		Count	197	123	320
		% within Do you have health insurance?	61.6%	38.4%	100.0%
		% within Gender	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.653	1	.199		
Continuity Correction	1.333	1	.248		
Likelihood Ratio	1.677	1	.195		
Fisher's Exact Test				.238	.124
Linear-by-Linear Association	1.648	1	.199		
N of Valid Cases	320				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 31.90.

Table 15

Do you have insurance and Language

			Language			Total
			.00	1.00	2.00	
Do you have health insurance?	0	Count	143	68	26	237
		% within Do you have health insurance?	60.3%	28.7%	11.0%	100.0%
		% within Language	78.6%	73.9%	57.8%	74.3%
	yes	Count	39	24	19	82
		% within Do you have health insurance?	47.6%	29.3%	23.2%	100.0%
		% within Language	21.4%	26.1%	42.2%	25.7%
Total		Count	182	92	45	319
		% within Do you have health insurance?	57.1%	28.8%	14.1%	100.0%
		% within Language	100.0%	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	8.178	2	.017
Likelihood Ratio	7.603	2	.022
Linear-by-Linear Association	7.187	1	.007
N of Valid Cases	319		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.57.

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