

MINI-ENVIRONMENTAL ASSESSMENT OF THE HEALTH STATUS AND NEEDS OF THE POOR

Ann Zuvekas, DPA

Lea Nolan, MA

Takisha Galaor

Michael Dryer, MPH

Carol Tumaylle, MPH

Jennel Harvey

Mary Anne Baysac

July 21, 1999

METHODS

To produce this environmental assessment, we used several types of information sources. First we conducted a thorough survey of the peer-reviewed literature, other published resources and reference materials. We also reviewed sources on poverty and health available from the internet. In addition, we conducted a series of interviews with experts in the field, as well as key informants from the DCNHS.

The literature reveals a high correlation between socioeconomic status and race/ethnicity. However, the relationship between the two is highly complex, and one does not predict the other. To the extent possible, we sought and used information on socioeconomic status, but where there was no existing data, we have used information on race/ethnicity.

BACKGROUND – POVERTY IN THE UNITED STATES

In 1997, 35.6 million people had family incomes below the official poverty level, and the poverty rate was 13.3 percent.ⁱ In 1994 just over one quarter of the U.S. population was under 200 percent of the poverty level. In the same year, 29 percent of all minorities were found to be living in poverty, and 21 percent of all Americans under the age of 18 were poor.ⁱⁱ

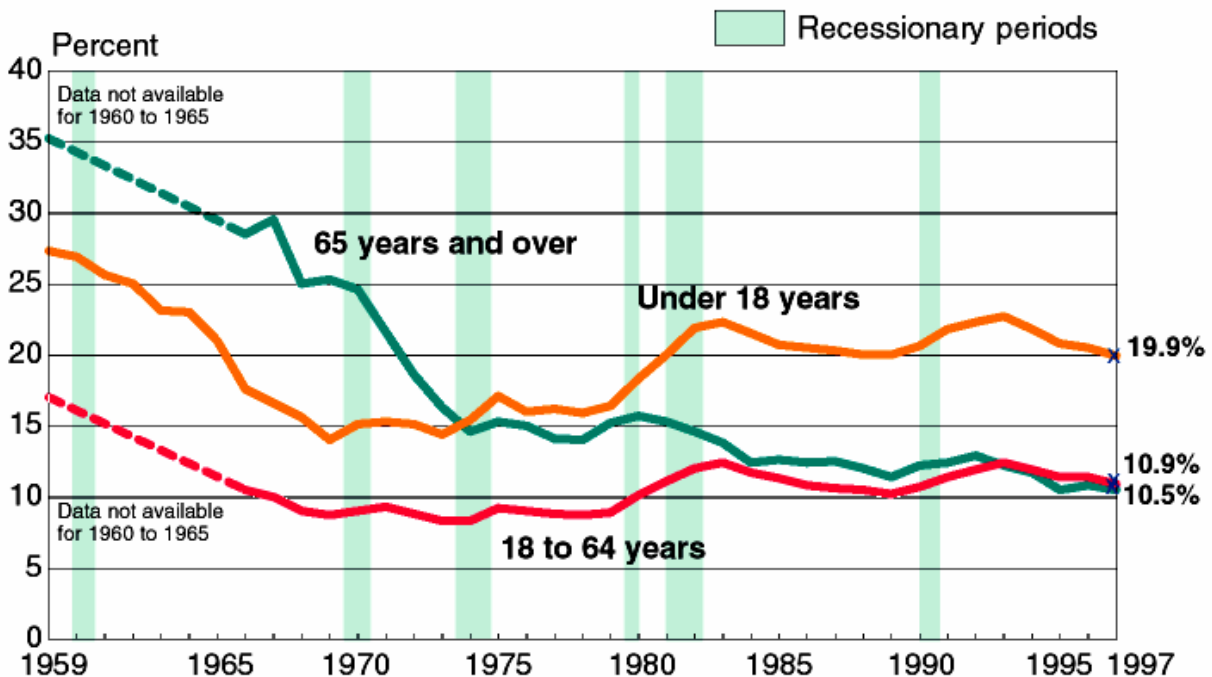
Geography: Many of the poor live in urban, inner-city areas. Of the 71 million Americans who live in medically underserved areas or health professional shortage areas, over half (37.7 million) live in urban areas, usually in inner cities. Many of these inner-city poor are minorities; while 46 percent of Whites live in large urban areas, almost 60 percent of African-Americans and 70 percent of Hispanics live in cities. Moreover, African-American and Hispanic poor are more concentrated in high-poverty areas than other groups.ⁱⁱⁱ Rural areas also have significant numbers of poor people. In 1994, 16 percent of the rural population was living in poverty.^{iv}

Race: Minority Americans are significantly poorer than their White counterparts. In 1997, the poverty rate for African-American individuals was 26.5 percent, and 27.1 percent for Hispanic individuals, compared to 8.6 percent for non-Hispanic White individuals, and 14.0 percent for Asian and Pacific Island individuals. African-American and Hispanic families are also at high risk for poverty. The poverty rate for African-American families was 23.6 percent, and the rate for Hispanic families was 24.7 percent, compared with 6.3 percent of White non-Hispanic families. The poorest families were those with a female householder with no husband present. In 1997, 39.8 percent of African-American families headed by females and 47.6 percent of Hispanic female-headed families were poor. While White female-headed families fared better than minorities, they were still at high risk of poverty: 23.4 percent were poor.^v

Other factors can result in greater poverty. For example, disparities in economic status are positively associated with years of formal education. A lower percentage of African-Americans over the age of 25 (63 percent) had completed high school in 1990, compared to their White counterparts (78 percent); an even lower percentage had completed college (11 percent versus 22 percent). In 1990 the difference between median incomes for Whites and African-Americans who worked full-time and year-round ranged from \$2,200 for those who had not completed high school, to \$6,100 for those who had completed college.^{vi} It is important to note that regardless of education attainment, African-Americans earn less, on average than Whites.

Age: The largest segment of the U.S. population in poverty are children under age 18. Nearly a fifth of children under 18 were poor in 1997, compared to 10.9 percent for adults aged 18 to 64, and 10.5 percent for adults over age 65. Children represent 40 percent of the poor population even though they comprise only a quarter of the total U.S. population. Children aged 0-6 are the most vulnerable. Overall, 21.6 percent of children under six were poor, and 59.1 percent of children 0-6 in female-headed households lived in poverty in 1997.^{vii}

**EXHIBIT 1
POVERTY RATES BY AGE: 1959-1997**



Source: Census Bureau, March Current Population Survey.

Immigrant Status: People born outside the U.S. are at higher risk for poverty than are natives of the United States. Overall, nearly a fifth (19.9 percent) of those not born in the U.S. without at least one citizen parent are poor, compared to 12.5 percent of U.S. natives. Foreign-born people living in the U.S. who are not naturalized are more likely to be poor than those who have become citizens. In 1997, 25 percent of non-citizens were poor versus 11.4 of naturalized citizens.^{viii}

RISK FACTORS FACING THE POOR

Poverty is a predominant social precursor to poor health.^{ix} Compared to the general population, poor people face a plethora of risk factors that have disproportionate, adverse consequences on their health. These risk factors can be grouped into three broad categories: 1) personal health risks; 2) environmental risks; and 3) social risks.

Personal Health Risk Factors

While a constellation of health risk factors can affect the health of the poor, the literature emphasized the following: inadequate nutrition, lack of fitness/exercise, cigarette smoking, substance abuse, and high-risk sexual behavior.

Inadequate Nutrition: Poverty is associated with poor nutrition and subsequently, poor health outcomes, and the inability to purchase and store food on a regular basis.^x Living below the poverty line strains a household budget, and therefore adversely affects the ability to purchase a nutritionally adequate diet. The lack of access to food retailers, minimal knowledge about food and nutrition, insufficient food preparation skills, little time, and cultural food preferences are all factors that may cause the poor to develop “the McDonald’s diet”.^{xi} The purchase of inexpensive foods that are high in fat, cholesterol, and sodium ultimately can have serious health consequences such as obesity, hypertension and diabetes, thus lowering the health status of low-income minorities.

While fatty foods pose a major health threat, malnutrition and hunger also significantly continue to debilitate the health status of low-income children, the homeless, pregnant women, and the elderly.

Children living in poverty suffer from several nutrition-related health problems which include anemia, dental problems, and gastrointestinal complaints, including diarrhea and asymptomatic enteric infections.^{xii}

According to the U.S. Public Health Service, the Surgeon General’s 1990 goal of eliminating growth retardation of infants and children caused by inadequate diets was not met because significant numbers of low-income children continued to suffer

retarded growth. In 1992 almost twice as many low-income children were short for their age compared to children from middle and high-income families.^{xiii}

According to the Food Research and Action Center's Survey—the Community Childhood Hunger Identification Project (CCHIP)—hungry children suffer from two to four times as many individual health problems such as unwanted weight loss, fatigue, headaches, irritability, inability to concentrate and frequent colds. Hunger, and insecurity about whether a family will be able to obtain enough food to avoid hunger, also have an emotional impact on children and their parents.^{xiv}

Homeless children also bear significant health consequences due to their transient status and lack of ability to obtain an adequate diet. When compared with housed children, homeless children have a higher incidence of nutritional deficiencies: more gastrointestinal ailments, and dental problems.^{xv}

Poor teenage mothers who are undernourished are more likely to have low-birthweight babies and experience a higher incidence of infant mortality.^{xvi} These infants are more likely to suffer delays in their development and are more likely to have behavior and learning problems later in life. Several studies reveal that the social class of the mother is inversely proportional to the infant mortality rate.^{xvii}

One study suggests a link between a pregnant woman's poor nutrition and her baby's development of heart disease later in life. A baby who has been affected in the womb by a mother's poor diet may be at higher risk for heart disease and can exhibit one or more of the following characteristics at birth: weight under 5.5 pounds, thinness, a disproportionately large head, or a narrow waist. These characteristics indicate that the baby's organ system may have been compromised in the womb which can affect the way the body regulates cholesterol and blood clotting later in life.^{xviii}

Many homeless people lack spouses or other supports that could provide them with food and shelter. In addition, several factors may increase the homeless person's risk of dietary inadequacy: lack of adequate kitchen facilities, (often coupled) with physical conditions that can alter or increase their nutritional needs, such as growth, pregnancy, or lactation^{xix}.

A comparative study of the eating habits of housed low-income families and homeless families revealed that homeless families reported obtaining more meals from fast food restaurants and convenience stores.^{xx} Other studies of low-income children have identified higher-than-expected levels of overweight, low height-for-age, and iron deficiency anemia. Homeless children therefore appear to experience patterns of potential malnutrition similar to those seen in other children of similar age and income. Moreover, homeless children with growth and nutrition problems may be less likely to receive timely attention than housed children, given their transience.^{xxi}

Malnutrition is also a major concern among low-income elderly. Special nutritional requirements and malnutrition increasingly become significant issues as

people age. Therefore, lack of available funds to meet the increasing demand for a nutritious diet can pose much difficulty for poor elderly. Hunger and malnutrition exacerbate chronic and acute disease, and can speed the onset of degenerative diseases. National data of people ages 65 to 75 show that the majority is not consuming even two thirds of the nutrients they need to stay healthy.^{xxii} Moreover, heart attacks, strokes, gastrointestinal problems, declining cognitive function and increase in dementia resulting from an inappropriate diet are major concerns.

Lack of Fitness/Exercise: An inadequately nutritious diet coupled with physical inactivity can severely affect health status. Poor eating habits, combined with physical inactivity present a major risk factor for diabetes among minorities. Regular physical activity can act as a protective factor against Type II diabetes. Researchers suspect that a lack of exercise is a factor that contributes to the high rates of diabetes among African-Americans. In the NHANES III survey, 50 percent of African-American men and 67 percent of African-American women reported that they participated in little or no physical activity.^{xxiii}

Smoking: Cigarette smoking is the leading preventable cause of disease and death in the United States.^{xxiv} American Indians/Alaska Natives, Latinos, and African-Americans may use tobacco (nicotine) as a coping response to environmental stressors such as poor living conditions and violence in their community, more often than their White counterparts.^{xxv}

The Surgeon General's report on minorities and smoking stated "we are witnessing the first steps of a potentially tragic reversal of the health of American minorities. Where we once saw hopeful signs of declining lung cancer among minorities in the early years of this decade, we now see striking increases in smoking by minority youth. Unless we can reverse these trends, they are bound to result in more lung disease and early death for these populations." While there is no single factor that determines patterns of tobacco use among minority groups, socioeconomic status does impact its use.

The Surgeon General reported the following:^{xxvi}

- If the number of African-American youth who smoke cigarettes continue to increase, an estimated 1.6 million now under the age of 18 will become regular smokers. Therefore, about 500,000 of those smokers will die of a smoking-related disease.
- The report surveyed tobacco use and its health consequences among all four major U.S. racial and ethnic minority groups: African-Americans, American Indian/Native-Alaskan, Asian American/Pacific Islander, and Hispanic. According to the report, cigarette smoking is a major cause of death and disease in all four groups. African-American men have death rates from lung cancer that are 50 percent higher than those of White men.

- Nearly 40 percent of American Indian and Alaskan Native adults smoke cigarettes, compared with 25 percent of adults in the overall U.S. population.
- Estimates of smoking among Southeast Asian American men range from 34 percent to 43 percent, which is higher than other Asian American and Pacific Islander groups. Living in poverty was one of the factors associated with smoking among this population.
- After increasing in 1970s and 1980s, death rates from respiratory cancers decreased slightly among Hispanic men and women from 1990-1995. However, for Mexican American adults there has been an increase.
- Direct and passive exposure to smoke poses special health hazards to pregnant women, babies, and young children. Babies and children who are exposed to tobacco smoke have more ear infections and asthma and die from SIDS more often. Mothers who smoke during pregnancy are more likely to have low-birthweight babies.

Substance Abuse: Minority subgroups and inner-city poor populations have a greater prevalence of substance abuse than individuals in the total U.S. population. Illicit drug use by population density for a large metropolitan area age 12 and older, was 6.8 percent compared to only 3.7 percent for the non-metropolitan areas. African-Americans have a higher prevalence of substance abuse than other Americans. According to national data, the racial/ethnic group with the highest prevalence of illicit drug use was non-Hispanic African-Americans at 7.5 percent, compared to their White counterparts at 6.1 percent. In 1996, the prevalence of heavy drinking among Hispanics (6.2 percent) was about the same as that among American Indians and Alaskan Natives (6.4 percent). Puerto Ricans had the highest prevalence of heavy drinking among Hispanics (7.3 percent).^{xxvii}

The adverse consequences to minorities' use of substance abuse include substantial health risks. For example, the death rate from alcohol-related causes is three times higher among African-Americans than among Whites. Similarly, cirrhosis mortality among Native Americans has been estimated to be at least four times the rate of the general population. Substance abuse also increases the likelihood of violence. It is estimated that African-American men were five times more likely than White men to be victims of homicide, and that at least half of both offenders and victims had been drinking alcohol at the time of the homicide.^{xxviii}

Drug abuse is a serious behavioral risk factor for homeless youth; in a study of homeless youth in Los Angeles, California, 71 percent were classified as having an alcohol and/or illicit drug abuse disorder;^{xxix} a study of street youth in Baltimore, Maryland, showed that 71 percent currently drink alcohol regularly; 63 percent currently smoke marijuana regularly; and 63 percent currently use other drugs regularly.^{xxx} According to a key informant at Covenant House, 80 percent of youth receiving services

have a substance abuse history; however, most do not have the resources to sustain a serious drug or alcohol addiction.^{xxxix}

High-Risk Sexual Behavior: Those living in poverty are at increased risk for sexually transmitted disease and social outcomes. According to a survey of 1,389 sixth-grade students from an urban public school district, of those attending a poorer school, 87 percent reported having already initiated sexual intercourse during the sixth grade school year.^{xxxix}

Impoverished women of color now represent the fastest growing category of persons affected by AIDS in the United States. Poor women are reportedly at increased risk for HIV infection as a result of heterosexual exposure to multiple sexual partners at risk (specifically men who have been in jail or prison and bisexual men); rape; and personal use of injection and non-injection drugs.^{xxxix}

Homeless youth also engage in high-risk sexual behavior. Many homeless youth trade sex for food, clothing, and shelter because they have few means of legally earning money on which to survive.^{xxxix} Twenty-seven percent of the street youth interviewed in one study had a chart history of a sexually transmitted disease.^{xxxix} Many homeless youth have a history of sexual abuse. Of those participating in a study held in Denver, Colorado, New York City, and San Francisco, 40 percent reported ever being sexually abused, 34 percent were sexually abused before leaving home, with 9.4 years being the mean age at first sexual abuse incident.^{xxxix}

Environmental Risk Factors

The following environmental risk factors are prevalent among the poor: poor housing conditions (and the subsequent adverse conditions it can cause), pollution, pesticides and hazardous wastes.

Poor Housing Conditions: The substandard living conditions of the poor make them more susceptible to a variety of illnesses, particularly of the respiratory and central nervous systems. A recent study indicates a correlation between poor housing and injuries, chronic diseases (asthma, cystic fibrosis, HIV/AIDS), malnutrition, and lead poisoning. More than 1.2 million U.S. households live in housing with significant physical problems.^{xxxix}

Poor housing conditions can contribute to the incidence of the following conditions: asthma, injuries, anemia, and other respiratory and physical problems. Poor housing conditions can also increase the incidence of asthma among those living in poverty. Poor indoor air contaminants such as dust mites, cockroach allergens, molds, and tobacco smoke can cause or contribute to the development of chronic diseases such as asthma. In addition they can cause an array of other acute conditions such as headaches, dry eyes, nasal congestion, nausea, and fatigue.^{xxxix}

Asthma has been associated with an increase in morbidity in poor inner-city children. A study of 476 children with asthma between the ages of four and nine from eight inner-city areas in the United States, revealed that 37 percent were allergic to cockroach allergens, 35 percent to dust mites, and 23 percent to cats. After controlling for other variables, it was found that the combination of cockroach sensitivity and exposure to high levels of cockroach allergen was highly associated with increased asthma severity. Children with that combination had more hospitalizations, unscheduled asthma visits, days of wheezing and nights with lost sleep.^{xxxix}

Data for 1979 to 1994 reveal an overall increase in the estimated average rates of hospitalization with asthma as the principal diagnosis: a rate of 17.6 per 10,000 in 1979-1980; and increasing to 18.1 in 1993-1994. In addition, death rates due to asthma increased from 8.2 per million in 1978 to 17.9 per million in 1995.^{xi}

An estimated 1,485 children are burned by radiators, and 187 die each year from electrical- and heating-related fires.^{xli}

Over 21,000 U.S. children ages zero to three years have stunted growth and about 120,000 have iron deficiency anemia due to poor living conditions. According to the Centers for Disease Control and Prevention, anemia remains a significant health problem among low-income children and can lead to developmental and behavioral disturbances that can affect a child's ability to learn.^{xlii}

Exposure to lead is also a serious health hazard, particularly for infants, toddlers and preschool-age children, whose developing nervous systems are sensitive to lead. The prevalence of elevated blood lead levels is lower for children who live in housing built after 1973. However, reflecting the age of the housing, poor children age one through five in families with annual incomes less than or equal to 130 percent of the federal poverty threshold, have elevated blood lead levels, (8 percent) while children living in middle-income and high-income families have a lead level of 1.9 and 1.0 respectively. Non-Hispanic African-American children have an 11.2 percent-elevated blood lead levels, compared with 2.3 percent of non-Hispanic White children.^{xliii}

Elevated blood lead levels in children have been associated with lower cognitive levels and language skills and IQ, a finding which is very controversial. Children who have elevated blood levels are frequently subject to other neurologic risk conditions including; poverty, low maternal intelligence (IQ) and education, poor nutrition, and anemia. Therefore it is difficult to separate the effect of lead from the confounding variables.^{xliv} However, there is consistent literature that indicates a 3 to 5 IQ point drop in those children with elevated blood lead levels, possibly, omitting the prenatal factors.

A review of the literature cited other unhealthy conditions such as dampness and condensation, poor heating and insulation, poor ventilation, disrepair/lack of amenities, and overcrowding. Dampness and condensation can lead to increased respiratory illness, coughing, asthma, and gastroenteritis. Poor heating and insulation can result in illness and death from hypothermia, ischaemic heart disease and respiratory illness. It

has been estimated that on average 800 deaths occur nationwide per year during winter months due to falling temperatures. Moreover, poor ventilation increases the risk of transmission of infectious disease such as tuberculosis.^{xlv}

A key informant from St Mary's Medical Center in Evansville, Indiana recognizes the desperate need for healthy housing for children. As a result of poor living conditions there is a high rate of infant mortality and morbidity.^{xlvi}

Pollution, Pesticides and Hazardous Wastes. Inappropriate sanitation, exposure to pesticides, and a high concentration of outdoor air pollution can also affect the quality of life of the poor and may cause anxiety, depression, respiratory illness, and transmission of infectious disease.

More specifically, the Agency for Toxic Substances and Disease Registry (ATSDR) notes that Native Americans and other minorities are particularly vulnerable to high exposures to hazardous substances. ATSDR completed an investigation of the Navajo lands in New Mexico, at which unusual amounts of uranium ore was discarded during mining operations in the 1950's. It was discovered that areas around the residences were contaminated with heavy metals.^{xlvii}

Pesticide exposure appears to be prevalent among migrant and seasonal farmworkers due to handling, mixing and applying pesticides to cultivate crops. Chronic effects of pesticides include cancer, adverse reproductive outcomes, and neurobehavioral effects. Children working in the fields may also be susceptible. However, data on this type of exposure are lacking.^{xlviii}

Social Risk Factors

While the poor are subject to a host of health and environmental factors that contribute to their poor health status, there are a vast number of social risk factors as well. The literature expounded upon the following: violence, low educational achievement, and unemployment.

Violence: Poor housing conditions are often associated with an unsafe and insecure environment. Many people living in poverty have limited housing choices and consequently live in high-crime areas. Feeling unsafe in one's community and lacking the necessary resources (employment) to relocate can lead to stress, anxiety, depression and potentially violent behavior. Therefore many low-income individuals are either victimized or involved in violent acts. Violent crimes include assaults, rape, robbery, and domestic and sexual abuse.^{xlix} Particularly vulnerable are the homeless, low-income minority men, women, and adolescents.

Homeless youth are exposed to high rates of violence. Not only are these youth more likely to report fearing victimization or being involved in violent episodes, they are more likely to have previous exposure to violence prior to being homeless.¹ Additionally,

many have attempted suicide: in one study, 54 percent of street youth reported ever thinking about killing themselves;^{li} in another study, 48 percent of females and 27 percent of males had attempted suicide.^{lii}

Many homeless women have been exposed to great degrees of domestic violence. In a study of 436 homeless and poor housed mothers in Worcester, Massachusetts, 67 percent of homeless women reported severe physical violence by a childhood caretaker, 43 percent reported sexual molestation, and 63 percent reported severe violence by a male partner.^{liii} In another study, 22 percent of homeless parents said they left their last place of residence because of domestic violence.^{liv}

Many poor women who endure physical and sexual abuse lack access to the environmental resources to rescue them from harmful situations. The sexual coercion and non-sexual violence that co-occur can place these women at risk for HIV infection.^{lv}

For adolescent African-American males, violence is the single largest public health problem^{lvi}. African-American youth have consistently been more likely than White youth to be victims of violent crimes. In 1994, 136 African-American youths per thousand were victims of violent crimes, compared with 118 per thousand among White youth ages 12 through 17.^{lvii}

Carrying a weapon has strong correlation with violence. In a study investigating the association between weapon carrying and the use of violence among adolescents living in and around public housing, 35 percent of male and 16 percent of female adolescents carried a weapon in the past 30 days. African-American males who carry weapons were more likely to be involved in violence including fistfights.^{lviii}

Low Educational Achievement and Unemployment: Educational attainment is generally viewed as a prerequisite for entry into suitable employment and satisfactory economic status. Many of the nation's poor children live in poor environments where the neighborhood school building might have several environmental hazards and insufficient funds for appropriate educational materials. Along with a host of other social risks, poor children are placed at a major disadvantage to obtain adequate education, therefore lacking the necessary skills to secure satisfactory employment.

Lack of employment is recognized as a severe problem for youth from low-income homes, and as a source of economic and social problems later in life. Unemployed youth often become unemployed or under-employed adults. In Bridgeport, CT only 7 percent of children passed the state's minimum educational competency requirements. Therefore adequate education for the most vulnerable—low-income children is imperative.^{lix}

Adult minorities are also vulnerable to low education and unemployment. Approximately two million American Indians and Alaskan Natives share a number of adverse socioeconomic conditions with certain other U.S. minorities, including lower educational achievement, higher unemployment, and low-income, all of which have

been associated with increased morbidity and mortality. Data from a study of the relationship between socioeconomic status and lifestyle practices of American Indians living on reservations revealed that income and education levels were substantially lower on the reservation, and 9.6 percent of the males rated themselves in fair or poor health.^{lx}

VULNERABLE POPULATIONS

Some groups are particularly vulnerable to the risk factors discussed above and to poor health status. Based on our findings from the literature, we identified the following groups as being among the most vulnerable: immigrants, homeless families and particularly homeless adolescents, the elderly, children with special health needs, farmworkers, and persons with disabilities.

Immigrants: Lack of English proficiency hampers immigrants' ability to navigate a confusing health care system. Often health care providers do not have staff who are linguistically competent to communicate with immigrants. Immigrants have difficulty expressing their symptoms, obtaining instructions for treatment, and are not adequately informed about the side effects of treatment or prescription drugs.

In addition, providers without culturally competent staff are unable to relay information to immigrants in a manner that respects and observes their cultural beliefs and values. Some health practitioners also provide literature to immigrants that is written at a complicated, high-literacy level. Patients who do not speak English as their first language have difficulty understanding how to access services or benefits when reading these materials.^{lxi}

In some cases ignorance and cultural biases can contribute to immigrants' being at risk for poor health status. For example, an American physician treating a Japanese-American woman with a lump in her breast counseled her against receiving a biopsy because he believed that Asian women do not get breast cancer. While women living in Asia are less likely to contract the disease, American-born granddaughters of Asian immigrants have cancer rates that approach those of White women.^{lxii}

Immigrants' cultural norms and beliefs can also contribute to poor health. For instance, Vietnamese immigrant women rarely seek a physician's care unless they are very ill. Therefore, they are not likely to seek preventive care if they are not experiencing symptoms. Many do not understand the importance of receiving yearly Pap smears and are embarrassed to discuss such a procedure with a physician. Such preventive care could reduce the high numbers of cervical cancer among Vietnamese women.^{lxiii} Many South Asian immigrants choose not to seek health care services because they believe that suffering is inevitable, and therefore, it is useless to see a physician. Some believe an illness is caused by organic problems like a weakening of

nerves or an obstruction of *chi*; others believe illness can be brought on by angry or evil spirits to punish people. As such, these problems cannot be treated with Western medicine. Finally, since some Southeast Asians believe that they have physiological make-ups distinct from Whites, Western medicines and dosages will not work on them. Some politely accept a prescription from a physician, but either do not have it filled, or do not take the medicine.^{lxiv}

Immigrants who leave their native environment and families often experience culture shock that can lead to loneliness and depression, which sometimes leads to suicide. Representatives from immigrant service providers in New York City testified they have observed an increase in suicides among immigrants in general, and particularly among those from the former Soviet Union. Immigrants in their late 50's and 60's and between the ages of 12 and 24 are especially vulnerable to attempting suicide.^{lxv}

The last major factor that increases immigrants' health risk is a decline in Medicaid coverage and other government benefits. Passage of two laws in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Illegal Immigration and Immigrant Responsibility Act of 1996 have contributed to a decrease in Medicaid use among immigrants. PRWORA established new and complex eligibility rules for public benefits for legal immigrants, and made several categories of previously eligible legal immigrants ineligible for federal public benefits. The Illegal Immigration and Immigrant Responsibility Act of 1996 established certain procedures for determining the admissibility of immigrants and heightened fears that the use of public benefits, even the legitimate use of Medicaid, could jeopardize immigrants' ability to become legal permanent residents/citizens. It was anticipated that the combined effects of these two laws would result in a substantial reduction in the use of Medicaid as well as in the use of needed health services by immigrants.

According to Census Bureau data, non-citizens accounted for a disproportionately large share of the overall decline in welfare caseloads between 1994 and 1997. Non-citizens' use of welfare benefits fell 35 percent during the three-year period, compared to a 15 percent decline among citizen recipients.^{lxvi} Non-citizens' use of Medicaid has decreased dramatically since the 1996 laws were enacted. In 1994, 26.5 percent of all non-citizen households received Medicaid; by 1997 that figure had dropped to 20.8 percent, a 22 percent decrease. Non-citizen households falling under 200 percent of the federal poverty level had a similar decline: in 1994, 39.8 percent received Medicaid benefits; by 1997 32 percent were enrolled, a 19 percent decline.^{lxvii}

Homeless: The homeless are particularly vulnerable to poor health status, especially homeless women and youth. Due to the temporary nature of homelessness and to the transience of many people who are homeless, it is very difficult to estimate how many homeless people there are in the U.S. On any given night, there could be anywhere between 500,000 to 700,000 homeless people; it has been estimated that approximately 7 million people were homeless in the latter half of the 1980s; and that 12 million adult U.S. residents have been homeless at some point in their lives. Homeless

families represent a rapidly growing segment of the homeless population. Homeless families with children make up approximately 40 percent of the overall homeless population.^{lxxviii}

Being homeless precludes people from having good nutrition, personal hygiene, and basic first aid. It also makes it difficult to obtain comprehensive and uninterrupted medical care to treat conditions like tuberculosis. Homeless people are at high risk for both chronic and acute health problems; they are more likely to suffer from every chronic health problem except obesity, stroke, and cancer. Multiple health problems such as frostbite, leg ulcers and upper respiratory infections are common. In addition they are at greater risk of trauma: muggings, beatings, and rape.^{lxxix} In addition, they are likely to engage in high-risk sexual behavior.

Homeless youth are also at tremendous risk for poor health status. The estimated number of homeless youth ranges from 100,000 on any given night, and 2 million per year.^{lxxx} Homeless youth are likely to be sicker than non-homeless youth and lack a regular source of care. One study found mothers of homeless children were more likely to report their children had fair or poor health (12 percent) versus mothers of housed children (6 percent). Fewer mothers of homeless reported that their children were in excellent health (67 percent) than did mothers of housed children (75 percent). Homeless youth are more likely than housed youth to have a higher number of acute illness symptoms such as fever, ear infection, diarrhea, and asthma. They are more likely than housed youth to seek outpatient care (5.6 mean visits per year versus 3.8); to be hospitalized in the past year (11 percent versus 5 percent); and to have had two or more emergency department visits in the past year (38 percent versus 20 percent).^{lxxxi} According to a key informant at Covenant House, it is not unusual for youth seeking health services to not be able to recollect their last office visit.^{lxxxii}

Finally, homeless mothers are also likely to suffer from mental health problems. In a study of mothers and children living in homeless shelters in Los Angeles, California, 72 percent of mothers reported high current psychological distress or symptoms of a probable lifetime major mental illness or substance abuse. Only 15 percent of those needing services received mental health care.^{lxxxiii}

Elderly: Since 1970, the poverty rate for the elderly has dropped significantly. As of 1997, 10.9 percent of adults over age 65 were poor, a relatively low poverty rate. However, the elderly were more likely than the non-elderly to have incomes just over the poverty threshold, and a higher proportion were classified as near poor because their incomes fall between 100 and 125 percent of poverty.^{lxxxiv} The elderly are at higher risk of poverty because their incomes are fixed and have little opportunity to increase their economic status. In addition, they spend a greater proportion of their total income on health care relative to other expenses than those under the age of 65. Health problems like restricted activity days, bed days, and chronic conditions requiring ongoing care, are more frequent in low socio-economic groups, creating more demand on their incomes to pay for health services.^{lxxxv}

The frail elderly, usually those over age 75 with limitations of activities of daily living are a vulnerable subset of the elderly population. There are an estimated 2.6 million frail elderly in the United States.^{lxxvi} Survey data suggest that 15 percent of those aged 75-84 are unable to climb stairs, 23 percent are unable to walk half a mile, 7 percent are unable to walk across a small room, and 24 percent are unable to lift 10 pounds. These limitations are more common among persons over the age of 85. A substantial proportion of otherwise healthy old persons have limitation in gait speed severe enough to prevent crossing an intersection quickly enough to comply with traffic signals.^{lxxvii}

Farmworkers: More than 4 million migrant and seasonal farmworkers work on U.S. farms and in factories each year.^{lxxviii} The health risks discussed above for immigrants also apply to farmworkers. Moreover, farmworkers face additional issues that threaten their health status. Since they live and work in several geographically diffuse areas, it is difficult for migrants to obtain continuity of care. Often they do not have access to regular medical care for preventive services or for urgent or non-urgent symptomatic care. Migrants also face poor housing and nutritional problems as well.

Children with special health needs: More than 12.6 million American children have special health care needs. In 1994, 18 percent of U.S. children had a chronic physical, developmental, behavioral, or emotional condition. These children required health services beyond those required by children generally. African-American children were most likely to be categorized as having an existing special health need; and children from families with incomes at or below the poverty level were about a third more likely to have an existing special health care need. In 1995-96, the care of some 1.5 million children with chronic conditions was covered by Medicaid.^{lxxix}

HEALTH STATUS OF THE POOR

When combined, the risk factors discussed above contribute to lower health status for the poor. People living in poverty are more likely to be susceptible to a higher prevalence of certain conditions. The following are discussed in this section: hypertension, cardiovascular disease, cerebrovascular disease, diabetes, breast cancer, cervical cancer, infectious diseases, asthma, infant mortality, immunizations, and oral health.

Hypertension: Hypertension is more prevalent among African-Americans; it appears earlier and has a much more malignant course. Hypertension-related morbidity and mortality are at least three to five times more frequent in African-Americans.^{lxxx} Hypertensive end-stage renal disease (ESRD) is about ten-fold more common nationwide in African-Americans than it is among Whites;^{lxxxii} two-thirds of all patients with ESRD due to hypertension are African-American.^{lxxxii} Furthermore, a strong inverse relationship exists between hypertension and socio-economic status.^{lxxxiii}

Cardiovascular Disease: Diseases of the heart and arteries are the leading cause of deaths in most U.S. subpopulations; however, minorities are disproportionately affected. African-Americans suffer more out-of-hospital deaths from coronary heart disease (CHD) than do Whites.^{lxxxiv} Studies have found that non-Hispanic White men are treated more aggressively for coronary disease than are other groups.^{lxxxv} For instance, Whites undergo a third more coronary angiographies and more than twice as many coronary artery bypass grafts (CABG) as African-Americans.^{lxxxvi} It is likely that socio-economic status plays some role in undertreatment among African-Americans.

Cerebrovascular Disease: Incidence of cerebrovascular disease such as stroke for African-Americans is much higher than for Whites. In an age-adjusted study in Southern Alabama, incidence of stroke was 208 per 100,000 for African-Americans versus 109 for Whites. African-American women are at an especially high risk of stroke: rates were 236 per 100,000 versus 88 per 100,000 for White women.^{lxxxvii} This higher incidence is likely due to African-American's higher frequency of risk factors like hypertension, diabetes, obesity, poor diet, excessive alcohol intake, cigarette smoking, heart disease and sickle cell disease.

Diabetes: Diabetes affects minorities more often than non-minorities. The relative risks for incidence of diabetes for African-Americans is 2.5, Hispanics 2.5, and some communities of Native Americans as high as 40.0.^{lxxxviii} Minorities are also more likely to have complications such as blindness, renal diseases and microvascular disease. Type II diabetics are more likely to have co-morbidities, particularly heart disease: 50-60 percent have hypertension, one-third have hyperlipidemia and 80 percent are obese.

Breast Cancer: Although the overall breast cancer incidence rate for African-American women is lower than that for White women, African-American women have a higher likelihood of being diagnosed with a more advanced stage of breast cancer and of dying from the disease. The relative risk of mortality from breast cancer for African-American women is 2.1 times that for White women; African-American women diagnosed with breast cancer experience a five year survival rate of 62 percent, compared with 79 percent for White women.^{lxxxix}

Cervical Cancer: Cervical cancer incidence and mortality are related to both minority and socio-economic status. African-American women are twice as likely to die as White women, and African-American women ages 45-54 are three times as likely.^{xc} Since African-American women are actually more likely than White women to be screened through a Pap smear (82 percent versus 71 percent), their increased mortality is likely due to disparities in follow-up and treatment.^{xc}

Prostate Cancer: African-American men have a higher incidence of prostate cancer than do White men. From 1980 through 1988 age-adjusted prostate cancer incidence rates increased for both African-American and White men (8 percent and 30 percent, respectively) according to the SEERS data. Although the incidence rate was

higher for African-American men than for White men, the ratio decreased from 1.6 in 1980 to 1.3 in 1988. For each year the age-adjusted death rate for African-American men was approximately twice that for White men. From 1980 to 1988 the age-adjusted death rates increased 2.5 percent for White men and 5.7 percent for African-American men. Both the incidence and death rates remain higher for African-American men.^{xcii}

Infectious Diseases: Infectious diseases also affect minorities and the poor disproportionately. By 1992 African-Americans had a mortality rate with infectious diseases as the underlying cause of 88 per 100,000, or 36 percent higher than the national rate. Minority populations have an average incidence rate for Hepatitis B that is two-fold that for Whites (10.8 for Whites, 18.1 for African-Americans, 20.4 for Hispanics, 16.9 for others).^{xciii}

Tuberculosis (TB) is primarily and increasingly a disease of minorities and the foreign born. Among non-Hispanic Whites TB predominantly affects the elderly, while among minorities and the foreign born, it is mainly concentrated in young adults. In 1953 the incidence in non-Whites was 125.8 per 100,000 compared with 44.0 in Whites; in 1987 the rates were 29.4 and 5.6 respectively.^{xciv}

The incidence of some sexually transmitted diseases is also disproportionately higher in minority groups. Primary and secondary syphilis occurs 45 times as often among non-Hispanic African-Americans and 13 times as often among Hispanics as among non-Hispanic Whites.^{xcv} Prevalence is especially high among those minorities living in inner cities. Reported gonorrhea, chlamydia, herpes, and pelvic inflammatory disease (PID) are all more common among non-Whites.

Incidence of HIV/AIDS disproportionately occurs among minorities and the poor. Although most cases of AIDS reported to the CDC occurred among non-Hispanic Whites, AIDS cases were disproportionately African-American (26 percent) and Hispanic (13 percent), compared with the proportions of African-Americans (12 percent) and Hispanics (6 percent) in the U.S. population.^{xcvi} There is also a high incidence of Hispanic children and adolescents who contract the virus: more than 15 percent of adult and adolescent cases of AIDS and nearly 25 percent of pediatric cases are among Hispanics.^{xcvii}

Asthma: Incidence and mortality from asthma are increasing, especially among minorities. Among African-Americans, rates of death from asthma increased from 1.8 per 100,000 in 1979 to 2.5 in 1984; while asthma mortality among Whites increased from 1.1 to 1.4 during the same time period.^{xcviii} The increase in asthma incidence and hospitalization are also higher among African-American children: the increase was about 180 percent greater than for White children aged 0-4 years.^{xcix} Morbidity and mortality from asthma also strike inner-city residence with greater frequency, which suggests a socio-economic link with the condition.^c The poor lack sufficient resources to ensure regular care, medications, and living conditions conducive to treatment.

Infant Mortality: In 1991 the risk of dying during the first year of life was 2.4 times greater for African-American than for White infants.^{ci} In 1990 nearly three times as many African-American infants as White infants (56 percent versus 20 percent) were members of families with incomes below the poverty level.^{cii} Infant mortality is inversely associated with socio-economic status in both African-American and White populations.^{ciii} The higher the social class membership of the mother, the lower the infant mortality rate. The greater proportion of African-Americans living in poverty is usually advanced to account for the excess infant mortality in the African-American population.^{civ}

Immunizations: Poor and minority children are less likely to be immunized than White, more affluent children. Nevertheless, the insufficient levels of age-appropriate immunizations are a problem for all groups of children. Vaccination coverage of two-year-olds is estimated to be approximately 80 percent of children vaccine doses recommended for administration during the first two years of life. More than 71 percent of children at or above the poverty level were in need of at least one vaccine.^{cv} Coverage rates for DTP, polio, and measles-containing vaccine were lower for children below the poverty level than for children at or above the poverty level.^{cvi}

Oral Health: Poor, minority, and rural children have a disproportionate share of poor oral health. Twenty-five percent of U.S. children have 75 percent of the dental carriers; minority children, rural dwellers, those with minimal exposure to fluoride, and those from less educated or poorer families tend to have greater caries experience. Minority children have a higher DMFT (decayed, missing, or filled teeth) than do White children, and the DMFT of Native American children aged 15 to 17 is twice the national average.^{cvii}

HEALTH INSURANCE STATUS OF THE POOR

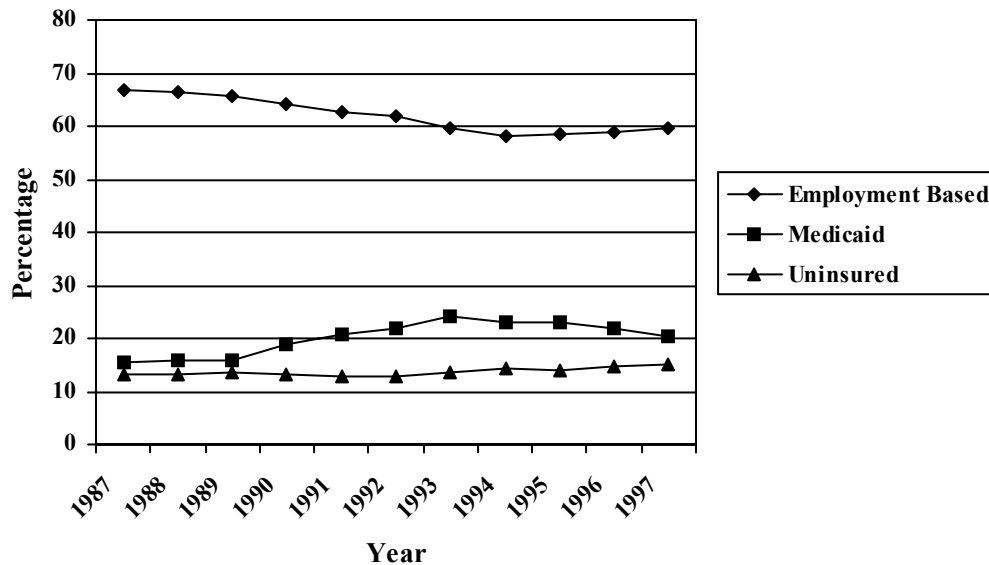
Although nearly one-fourth of the poor currently obtain private coverage for at least part of the year, the poor in the United States are disproportionately represented among the uninsured and those with publicly-funded insurance coverage.^{cviii}

Uninsured

The number of uninsured Americans is increasing. According to the Employee Benefit Research Institute in 1997, 43 million (18.3 percent) of the non-elderly U.S. population was uninsured, up from 32 million (15 percent) in 1987. The increase of uninsured since 1993 can be mostly explained by the decline in public sources of health insurance. For example, between 1996 and 1997, Medicaid enrollment among non-elderly beneficiaries decreased from 12.1 percent to 11 percent, due to the effects of Welfare Reform. Similarly, enrollment in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Civilian Health and Medical Program of the Veterans Administration (CHAPVA) declined from 3.8 percent to 2.9 percent between 1994 and 1996 primarily due to military downsizing.^{cix}

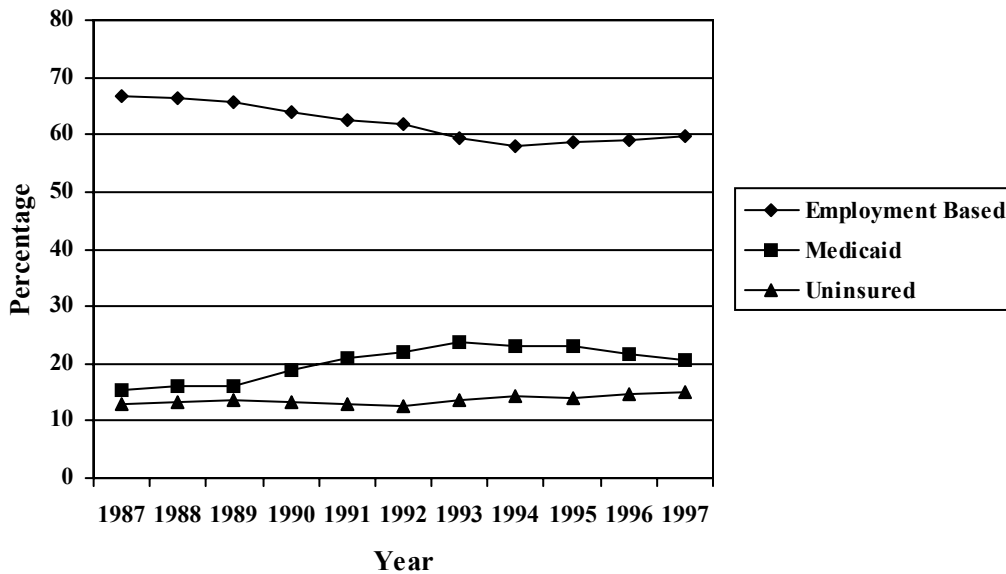
In 1997 fifteen percent (11 million) of children in the United States were uninsured and were either ineligible for, or did not receive publicly financed medical assistance.^{cx} Exhibit 2 illustrates children's insurance trends from 1987-1997.

EXHIBIT 2
PERCENTAGE OF AMERICAN CHILDREN, AGES 0-17,
WITH EMPLOYMENT-BASED HEALTH BENEFITS, MEDICAID AND
WITHOUT HEALTH INSURANCE, 1987-1997^{cx}



Nearly 20 percent of non-elderly adults were uninsured in 1997. During the decade from 1987-1997, the percentage of adults with health insurance decreased from 70.3 percent to 66.2 percent. Exhibit 3 depicts the insurance trends of adults aged 18-64 from 1987-1997.

EXHIBIT 3
PERCENTAGE OF AMERICAN ADULTS, AGES 18-64,
WITH EMPLOYMENT-BASED HEALTH BENEFITS, MEDICAID AND
WITHOUT HEALTH INSURANCE, 1987-1997^{cxii}



Health insurance status has been shown to be strongly associated with poverty status, i.e., poor people are more likely to be uninsured. In 1997, 43.5 percent (19 million) of the uninsured were in families with annual incomes under \$20,000 annually. In addition, those who work in low-income jobs are more likely to be uninsured. Thirty-one percent of non-elderly workers making less than \$10,000 per year are uninsured, compared to five percent of those making more than \$50,000 per year.^{cxiii} Sixty-eight percent of all uninsured children come from families with incomes below 200 percent of the poverty level.

Racial and ethnic minorities are also more likely to be uninsured. Hispanics were disproportionately uninsured^{cxiv} (36 percent), as were African-Americans at the lowest income levels. Whites are disproportionately insured – while they make up 70 percent of the non-elderly population, they comprised 53 percent of the uninsured population in 1997.^{cxv}

Non-citizens are also more likely to be uninsured. For example, in 1997 more than 45 percent of non-citizens reported not being insured compared with 16 percent for citizens. The differentials are greater in states with high numbers of non-citizens. In Florida 51 percent of non-citizens are uninsured versus 21 percent of citizens; in Texas, 55 percent of the non-elderly non-citizens population was uninsured versus 24 percent of citizens.^{cxvi}

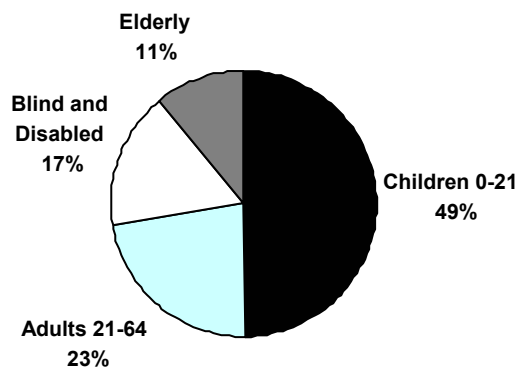
Publicly Funded Insurance

As we discussed earlier, there has been a decline in the use of public sources of health insurance since 1994. In 1994, 16.9 percent of the total U.S. population (38.9 million people) were beneficiaries of either Medicaid, Medicare or CHAMPUS/CHAMPVA. These figures steadily declined to 14.8 percent or 34.9 million people in 1997.^{cxvii}

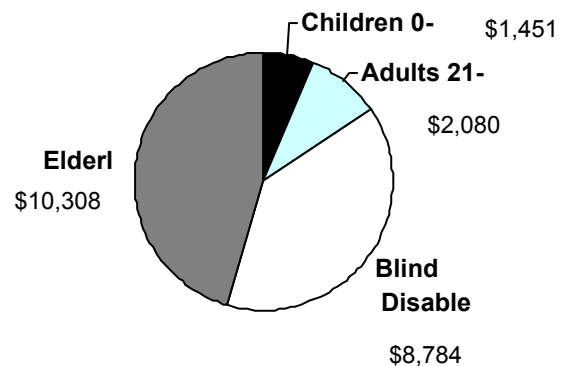
Medicaid is a major insurance source for the poor, especially children. In 1995 nearly half (49.7 percent) of its recipients were children under age 21; 22.6 percent of beneficiaries were adults from age 21-64; 16.6 percent were blind and disabled, and 11.0 percent were elderly. In 1995, 39 percent of all U.S. births were financed by Medicaid. However, Medicaid spends the least amount per beneficiary on children (\$1,451) compared with \$2,080 for adults from age 21-64, \$8,784 for the blind and disabled, and \$10,308 for the elderly.

EXHIBIT 4 DISTRIBUTION OF MEDICAID ENROLLMENT AND SPENDING PER BENEFICIARY, 1995^{cxviii}

Distribution of Medicaid Enrollment



Medicaid Expenditures Per Enrollee



The bulk (45.6 percent) of Medicaid expenditures cover acute care services, followed by long-term care services (35.4 percent), disproportionate-share-hospital payments (12.5 percent), and payments to MCOs (6.5 percent).^{cxix}

Medicaid enrollment has experienced a decline similar to that of all publicly funded benefits. In 1993, 29 million people (12.7 percent of the population) were covered by the Medicaid program; in 1997, the rolls declined to 26 million (11 percent). Children aged 0-17 showed an even greater decrease in Medicaid coverage. In 1997,

20.5 percent of children were enrolled in Medicaid, down from 23.9 percent in 1993. Non-elderly adults' enrollment in Medicaid has experienced a less pronounced decline; 6.9 percent of adults aged 18-64 were Medicaid recipients in 1997, down from 7.8 percent in 1993.^{cxx}

Many Medicaid beneficiaries are presently enrolled in managed care plans. In 1996, 36 percent of recipients were in enrolled in plans; 24 percent joined full-risk plans, while 12 percent were in primary care case management arrangements.^{cxxi}

Although Medicaid is the primary source of health insurance for nearly 34 million low-income people, being poor does not automatically qualify an individual for Medicaid. Only persons who fall into particular categories (e.g., low-income children and pregnant women) are eligible. The Medicaid program covers only 55 percent of poor Americans, and millions of uninsured low-income Americans are beyond its reach.^{cxxii}

In addition, many people who are eligible for Medicaid are not enrolled. For example, in 1996 it was estimated that there were 4.7 million children aged 18 and under who were uninsured despite being eligible for Medicaid.^{cxxiii} Enrollment in Medicaid is further complicated by the fact that enrollees frequently lose their eligibility due to changes in job or income status and are dropped off the rolls. These same individuals, however, often experience a change in their status and are re-eligible for the program. Therefore, the Medicaid rolls experience a fair degree of turnover. This phenomenon has serious potential consequences for affecting the frequency and kind of care low-income people receive.

HEALTH SERVICE UTILIZATION

The deeply entrenched and highly concentrated nature of poverty among the minority inner-city poor has major implications for providers of ambulatory health services. As a result, providers that work in inner-city poor communities have access to neither well-paying private insurers nor patients with the out-of-pocket resources to meet their personal health needs. Supplementation from grants and other sources of public revenue plays a pivotal role in their economic survival.^{cxxiv}

Despite the greater incidence of disease, the poor and near-poor do not access health care services in the same proportions as more affluent people. Reasons for this underutilization range from lack of health insurance, an inability to pay co-payments and deductibles, ignorance of the need for regular preventive care, and a shortage of health care providers either willing or able to deliver needed services.

Uninsurance: As discussed earlier, many poor and near-poor Americans lack health insurance. This lack in turn, leads to underutilization of health care services. According to a study of individuals covered by Medicaid, private insurance, and the uninsured, the uninsured reported more difficulties getting needed care. Twenty-two percent of uninsured reported needing care in the past year, but not receiving it, versus Medicaid enrollees (14 percent), and the privately insured (7 percent). The uninsured

were more likely to not have a regular doctor (58 percent versus 32 for Medicaid and 34 for private); they were also three times as likely to not have a usual source of care (24 percent versus 8 for Medicaid and 8 for private). Finally, when they did obtain care, they were 1.6 times as likely to report receiving fair to poor services (31 percent versus 18 for Medicaid and 17 for private).^{CXXV}

Inability to pay: Even if they are insured, poor and near-poor patients are likely to avoid seeking health services because they can not afford to pay even a small amount towards the cost of their care. A study of health center patients, found that 46 percent had stayed away from the center sometime during the year due to financial reasons.^{CXXVI} Another study concluded that the poor and near-poor had reduced access to health services due to an inability to meet co-payments and deductibles.^{CXXVII}

Lack of awareness: Many of the poor have not been informed about the benefits of regular preventive care. For example, new immigrants from Southeast Asia are unaccustomed to seeking regular Pap smears, especially if they are asymptomatic. In addition, many of the poor do not concentrate on their health needs because they are concerned with other more pressing needs. According to a Covenant House representative, health does not rank as a high priority for homeless youth; they are more concerned about where they will find their next meal.^{CXXVIII}

Difficulty in finding providers: Finding providers who are willing or able to provide care to the poor can sometimes be challenging. Some 43 million Americans live in medically underserved areas; and 14 percent of the population lives in a health professional shortage area (HPSA).^{CXXIX} Many providers choose not to accept Medicaid, the chief source of health insurance for many poor Americans, because it often pays heavily discounted rates for services.

Many providers have reduced the amount of charity care they can deliver. Due to the increase in managed care penetration, payments to providers participating in managed care are decreasing, therefore making it more difficult to shift costs to provide charity care. A recent study reported that physicians who derive at least 85 percent of their practice revenue from managed care plans are considerably less likely to provide charity care and spend fewer hours providing charity care than physicians with little involvement in managed care plans. Additionally, the study found that physicians who practice in areas with high managed care penetration provided fewer hours of charity care than physicians in other areas, regardless of their own level of managed care involvement.^{CXXX}

Safety Net Providers

Many of the poor rely on safety-net providers (SNPs) to deliver the care they desperately need. SNPs include the following types of organizations: community health centers, public hospitals, mission-driven voluntary hospitals, health departments, and limited services providers (e.g., family planning agencies). These providers serve all who seek their care, regardless of the patients' ability to pay. Inner-city SNPs are

typically funded by a combination of direct public funds (mostly for the uninsured), revenues from insurers (e.g., Medicare, Blue Cross/Blue Shield, and especially Medicaid), and patient payments on a sliding-fee scale. Minority physicians and other private-practice health professionals usually do not direct public/private subsidies (except, in some cases, for their initial professional training), but they, too, rely heavily on public and private insurance and sometimes extend credit to their poor minority patients.

There are nearly 1000 federally supported primary health care programs (including community, migrant and homeless health centers, urban Indian/Tribal health clinics, and federally qualified health center (FQHC) look-alikes). These programs serve nearly 10.3 million people annually.^{cxxxix} Public hospitals each provide an average of 17,000 admissions and nearly 300,000 outpatient visits annually. Nearly 90 percent of their services are delivered to Medicaid, Medicare, and low-income uninsured patients. Overall public hospitals have a total of 28,560 staffed beds; nearly 1.2 million total discharges; 7.7 million total inpatient days; and an average occupancy rate of 74 percent each year.^{cxxxix} Mission driven, voluntary hospitals also provide a large number of outpatient visits and inpatient care to the indigent.

SNPs too, are under increasing financial pressure from the managed care industry, which naturally prefers to contract with the providers who are perceived to be the least expensive, not necessarily those who have the expertise and capacity (e.g., cultural competence, outreach services) to serve the poor.

Some SNPs have experienced significant financial problems. In January 1997, Louisiana's 10 public hospitals were placed under the authority of Louisiana State University Medical Center,^{cxxxix} and Maricopa Integrated Health Systems, the public health system in Maricopa County, Arizona sought to privatize in 1996 due to severe financial difficulties.^{cxxxix} Others lose significant amounts of money each year on charity care/bad debt; the University of Nevada-Las Vegas' University Medical Center lost \$29.9 million in uncompensated care in 1998;^{cxxxix} likewise doctors at the University of South Alabama have lost \$17.4 million caring for the indigent since 1994 and are on pace to lose another \$4 million this year.^{cxxxix}

Other organizations are also taking the lead for caring for the uninsured. Some private organizations have taken more responsibility for caring for the uninsured regardless of their ability to pay. For example, Seton Medical Center in Austin, Texas has a long history of caring for the uninsured. It opened a primary care clinic for the uninsured staffed by volunteer providers. Seton covers the cost of ancillary expenses (facilities, labs, etc.), and secured the cooperation of its specialists to provide specialty care to the indigent. Subsequently, Seton has assumed operation of Brackenridge, the city's public hospital, and the hospital's outpatient centers.

In New York, voluntary hospitals provide a large amount of the care delivered to indigent and poor patients. In 1996, there were nearly 90,000 self-pay discharges from voluntary hospitals, and more than 500,000 discharges covered by Medicaid. Together,

these discharges accounted for 27 percent of all voluntary hospital discharges in the state. These hospitals also provided a large amount of outpatient care as well; in 1996, 33.3 million self-pay outpatient clinic visits and approximately 9.7 million Medicaid-covered outpatient visits. Furthermore, they provided more than 900,000 emergency room visits to self-pay patients, and in excess of 1 million such visits to Medicaid patients.^{cxxxvii}

SELECTED STRATEGIES ADDRESSING UNINSURANCE AND POOR HEALTH STATUS

Both the public sector and private sector have recognized that the poor lack health insurance and have poor health status, and have implemented programs to address these gaps. Below we list a small sample of such programs, first by discussing some public programs, then by describing programs operated by the private sector. These programs are divided into two sections: 1) financing and financing-related mechanisms; and 2) direct delivery programs. This list is by no means exhaustive, rather, it is meant to illustrate some of the program and policy efforts directed at increasing access to health insurance for the poor, and improving their health status.

Financing and Financing-Related Mechanisms

The public and private sectors have recognized the tremendous need to cover uninsured people in the United States and have implemented some strategies to address this problem. We discuss the following strategies: Section 1931 Medicaid, state funded programs to care for the uninsured, the Children's Health Insurance Program, and a private health insurance program for the indigent.

Section 1931 Medicaid. As discussed earlier, Medicaid is a main insurance source for poor people in the United States. In the early 1990's Medicaid underwent significant eligibility expansions that allowed for greater coverage of the uninsured. Currently, under Section 1931 of the Social Security Act, states are taking advantage of a new mechanism that can allow additional people to become eligible for Medicaid.

To ensure that Medicaid was available to those losing welfare benefits, Section 1931 was added to the Medicaid law to create Medicaid eligibility for families who meet a state's Aid to Families with Dependent Children eligibility requirements that were in effect as of July 16, 1996. Under Section 1931, states have broad flexibility to define what it counts as resources and assets when determining Medicaid eligibility. Therefore, a state could disregard portions of earnings to ensure a family's countable earnings remain below the state income standard that was in effect on July 16, 1996. These more liberal disregards could allow families with incomes at or well above the poverty line to qualify for Medicaid.^{cxxxviii}

Some states also use transitional Medicaid assistance (TMA) as a method of providing health insurance to low-income workers. Under Section 1931, people leaving welfare for work, who fall below 185 percent of the poverty level, can receive a minimum of six to 12 months of TMA (and up to an additional 24 months). Using the less restrictive methodologies option under Section 1931 Medicaid, states can choose to disregard entirely the first three months of earned income for Medicaid eligibility, thus making more people eligible for TMA. TMA is available to those who qualified for Section 1931 Medicaid for the three of the previous six months immediately preceding the individual's loss of AFDC/Medicaid eligibility due to increased income. TMA is also available in those state that opted to continuing an existing AFDC/Title IV-A waiver that included a Title XIX waiver allowing TMA. However, these waivers will expire and due to the budget neutrality requirements, are unlikely to be renewed.

Examples of State Programs to Care for the Uninsured: Several states have implemented programs to help cover the care of the uninsured. One such program in Massachusetts is the Uncompensated Care Pool. The Pool provides access to health care for low-income uninsured and underinsured residents of Massachusetts by paying for free care services provided by hospitals and community health centers. It was established in 1985 and is administered by the Massachusetts Division of Health Care Finance and Policy. The Pool is funded though a \$215 million assessment on hospitals' private sector charges, \$100 million from a surcharge on payments from private-sector payers to hospitals and ambulatory surgical centers, and a \$30 million contribution from the Commonwealth of Massachusetts. Free care is available to patients with incomes below 200 percent of poverty; patients with family incomes between 200 and 400 percent of poverty are eligible for partial free care. Patients at all income levels are eligible for the Pool if medical care costs deplete the family's income and resources to the point that the patient is unable to pay for necessary free care.

In 1996 the Pool paid for an estimated 60,000 inpatient admissions and 1.5 million outpatient visits. The most common users of the Pool are young adults aged 18-44 with incomes below 133 percent of poverty. Men use the Pool to cover costs more often than women, probably due to the fact that more men are ineligible for Medicaid.^{cxxxix}

New Jersey also has a program to cover the cost of care for the uninsured. New Jersey's Charity Care Program is designed to provide coverage for individuals without insurance and who meet certain eligibility requirements. Individuals with family incomes up to 200 percent of poverty are entitled to fully subsidized inpatient and outpatient hospital care; those with incomes between 200 and 300 percent of poverty are eligible for partial subsidies on a sliding scale. In 1996, 141,000 individuals received care under the Charity Care Program.

In 1997 New Jersey proposed a Section 1115 health care reform demonstration called the Managed Charity Care Demonstration (MCCD). Under the program, the state would use a portion of disproportionate share hospital (DSH) funds to cover medical costs of indigent individuals outside the hospital. Hospitals would develop hospital-

centered managed care networks which would deliver case managed care to certain individuals outside the hospital, in physicians' offices and community clinics, in addition to the inpatient and emergency care already provided. The income eligibility requirements would be the same as under the current Charity Care plan, and the assets limit would be \$7,500 for individuals, \$15,000 for families. The plan was approved by HCFA in February 1998 but has yet to be implemented.^{cxl}

Children's Health Insurance Program (CHIP): To address the needs of nearly 10 million uninsured children in the United States, Congress enacted the CHIP program as part of the Balanced Budget Act of 1997 (P.L. 105-33). CHIP is the largest expansion of health insurance coverage since the inception of the Medicare and Medicaid program. To cover the cost of the program, \$20.3 billion in federal matching funds will be allocated over five years to expand insurance coverage either through a separate state program, an expansion of the existing Medicaid program, or a combination of both. Thus far, 46 states have submitted plans for approval under the program; 27 have proposed Medicaid expansions, 14 proposed separate state child health plans, and 8 have proposed combination plans. Twenty-six plans and two state plan amendments have been approved. However, states have not enrolled the numbers they expected: only 828,000 of the 2.5 million anticipated children are now participating in the program.

Substantial outreach efforts are underway to improve children's enrollment in CHIP and Medicaid. One such effort is The Robert Wood Johnson Foundation's (RWJF) Covering Kids health access initiative. RWJF is contributing \$47 million to fund up to 51 state-local coalitions to conduct outreach initiatives and work toward enrollment simplification and coordination of health coverage programs for low-income children.

Caring Program for Children: A program sponsored by Blue Cross and Blue Shield (BC/BS) of North Dakota in conjunction with local hospitals targets the working poor who do not qualify for Medicaid. Participants of the program, Caring Program for Children, receive an insurance card nearly identical to a standard BC/BS care. Physicians and hospitals charge half their standard rates when treating members. The program benefits include dental and mental health services. All administrative costs are covered by BC/BS.^{cxli}

Direct Delivery Programs

Both the federal government and private organizations have implemented direct delivery programs to increase access to health services for the poor. These programs are unique in that funding is targeted directly to the care giving program and its providers; it does not go directly to patients. While this list is far from complete, the following federal programs are discussed: community health centers, maternal and child health programs, school health programs, and Ryan White Programs. We also discuss a limited number of innovative private programs.

Selected Federal Programs: Community health centers (CHCs) as discussed earlier, provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. CHCs have a mission to serve all patients, regardless of their ability to pay. They offer comprehensive services that include primary and preventive care, dental care, as well as essential ancillary services like laboratory tests, X-ray, environmental health, and pharmacy services. They also offer enabling services necessary to increase access to underserved people (e.g., transportation, translation, outreach, health education). In fiscal year 1999, community and migrant health centers were appropriated 25 million dollars.^{cxlii}

The Maternal and Child Health Bureau (MCHB) provides leadership to both the private and public sectors to build the infrastructure for delivery of health care services to all mothers and children in the US, and especially those in low-income or isolated populations who otherwise have limited access to care. MCHB administers Maternal and Child Health Services Block Grants to states and jurisdictions to undertake initiatives such as: reducing infant mortality; increasing the number of appropriately immunized children; increasing the number of low-income children receiving health assessments and follow-up diagnostic and treatment services; providing comprehensive perinatal care to women; and providing rehabilitation services for blind and disabled children under 16 years old. There are 59 grantees; funds are distributed according to a formula that considers the percentage of low-income children living in the state. States are required to match every \$4 of federal funds with \$3 in cash or in-kind. The Block Grant was funded at \$675 million in fiscal year 1996.^{cxliii}

School-Based Health Centers: The Bureau of Primary Health Care (BPHC) has supported and promoted the concepts of school-based health centers since the 1970s. In 1994 Congress established the first federal program to specifically mandate the creation of school-based health centers. The program, called Healthy Schools, Healthy Communities (HSHC) is administered by BPHC, and provides a valuable model of how to use schools effectively as primary care access points for at-risk children. The program provides comprehensive primary care, mental health, and dental services. Currently the program funds 26 organizations to establish new school-based health centers. In fiscal year 1996 the program was appropriated \$4.25 million.^{cxliv}

Ryan White Program: Created in 1990, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act helps states, communities and families cope with the growing impact of the AIDS epidemic. The program, administered by the Health Resources and Services Administration (HRSA), supports systems of care for people with ADIS who do not have adequate health insurance or other resources. The Act supports the development of systems of care that are responsive to local needs and resources. It is founded on strong partnerships between the federal government, states, and local communities in need, and emphasizes less-costly outpatient, primary care to prevent costly emergency room visits and hospitalizations. Ryan White activities received \$1.4 billion in fiscal year 1999.^{cxlv}

Selected Private Programs: The Delaware Valley Health Care Council (made up of 80 hospitals and providers from five counties surrounding Philadelphia) has implemented First Steps for Healthy Kids, a program that matches every newborn infant with a personal physician even if the baby does not have insurance. The infants are given nine checkups and immunizations during the first 24 months of life.^{cxlvi}

The Wee Care program which operates in St. Louis, Missouri, is sponsored by BJC Health System in partnership with Mercy Health System, a Philadelphia-based system. The program attempts to lower infant death rates by improving prenatal and postnatal care. The program combines social services and health care, makes home visits, arranges for transportation, child care and food if necessary. Since the inception of the program, the mortality rate of 1445 babies delivered in 1997 is half that of the rest of the St. Louis population. Another program sponsored by BJC Health System called ConnectCare makes primary care clinics and 24-hour urgent care facilities available to anyone regardless of their insurance status. The program was launched by city officials and community leaders and now serves approximately 100,000 people.^{cxlvii}

Valley Health System, based in West Virginia, sponsors a multi-state partnership to deliver health care and other services to migrant farmworkers. The partnership involves hospitals, large farmers, doctors, and local health departments that provide on-site nursing care in migrant farmworker camps and shuttle services to health clinics. Delivered services include: prevention, well child, prenatal and postnatal care. In addition, the program also pays a migrant mother in each camp to serve as a day care provider. The program has delivered services to 80 percent of the migrants in the area.^{cxlviii}

CONCLUSION

The factors leading to poor health status among people living in poverty include: economic status, poor living conditions, personal health habits, and barriers to accessing health care. The federal government has attempted to address the needs of the poor through public policy by expanding insurance options for the poor, and in direct service delivery programs. Private organizations, including DCNHS, have also undertaken initiatives to improve the health status of the poor.

However, as this environmental assessment makes clear, there is still much to be done. DCNHS will have an opportunity to select and implement new initiatives that consider both public policy and direct delivery approaches.

ⁱ Dalaker, Joseph; Naifeh, Mary. *Poverty in the United States: 1997. Current Population Reports, Consumer Income P60-201. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September, 1998.*

ⁱⁱ NACHC. *Access to community health care: a national and state data book, 1998. Washington: DC, National Association of Community Health Centers. 1998.*

ⁱⁱⁱ Darnell, Julie; Rosenbaum, Sara; Nolan, Lea; Zuvekas, Ann; Budetti, Peter. *Access to care among low-income, inner-city, minority populations: the impact of managed care on the urban minority poor and essential community providers. Prepared for the Commonwealth Fund. December, 1995.*

^{iv} NACHC. *Access to community health care: a national and state data book, 1998. Washington: DC, National Association of Community Health Centers. 1998.*

^v Dalaker, Joseph; Naifeh, Mary. *Poverty in the United States: 1997. Current population reports, consumer income P60-201. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September, 1998.*

^{vi} Centers for Disease Control and Prevention. *Chronic disease in minority populations: African-Americans, American Indians and Alaska Natives, Asians and Pacific Islanders, Hispanic Americans 1994. Atlanta: Centers for Disease Control and Prevention, 1992, p2-6.*

^{vii} Dalaker, Joseph; Naifeh, Mary. *Poverty in the United States: 1997. Current population reports, consumer income P60-201. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September, 1998.*

^{viii} Dalaker, Joseph; Naifeh, Mary. *Poverty in the United States: 1997. Current population reports, consumer income P60-201. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September, 1998.*

^{ix} I. Kliegman RM. *Perpetual poverty: child health and the underclass. Pediatrics 1992; 89:710-715.*

^x Wiecha JL, Dwyer JT, et al. *Nutrition and health services needs among the homeless. Public Health Rep. 1992; 89: 710-713.*

-
- ^{xi} “Real risk from McDonald’s diet”. *The Herald*, April 1, 1999.
- ^{xii} Wiecha JL, Dwyer JT, et al. Nutrition and health services needs among the homeless. *Public Health Rep.* 1992; 89: 710-713.
- ^{xiii} Food Research and Action Center: http://www.frac.org/html/hunger_in_the_US/health.html
- ^{xiv} *Ibid.*
- ^{xv} Wiecha JL, Dwyer JT, et al. Nutrition and health services needs among the homeless. *Public Health Rep.* 1992; 89: 710-713.
- ^{xvi} Heart Information Network: <http://www.heartinfo.org/fetalut.htm>
- ^{xvii} Zuvekas A, Silver K, Nolan L, Scarpulla R. Identifying and selecting gaps in morbidity and mortality rates for low-income and minority populations. Center for Health Service Research and Policy, The George Washington University Medical Center. Written for the Bureau of Primary Health Care.
- ^{xviii} Heart Information Network: <http://www.heartinfo.org/fetalut.htm>
- ^{xix} Wiecha JL, Dwyer JT, et al. Nutrition and health services needs among the homeless. *Public Health Rep.* 1992; 89: 710-713.
- ^{xx} *Ibid.*
- ^{xxi} *Ibid.*
- ^{xxii} Food Research and Action Center: http://www.frac.org/html/hunger_in_the_US/health.html
- ^{xxiii} National Diabetes Information Clearinghouse: <http://www.niddk.nih.gov/health/diabetes/pubs/afam/afam.htm#3>
- ^{xxiv} Key Facts from the Surgeon General’s Report: Minorities and smoking. April 27, 1998.
- ^{xxv} Escobedo LG, Zhu BP, Giovino GA, et al. Educational attainment and racial differences in cigarette smoking. *J National Cancer Institute* 1995; 87: 1552-1553.
- ^{xxvi} Key Facts from the Surgeon General’s Report: Minorities and smoking. April 27, 1998.
- ^{xxvii} Substance Abuse and Mental Health Statistics Source Book 1998. Office of Applied Studies. Department of Health and Human Services.
- ^{xxviii} Prevalence of Substance Use among racial and Ethnic Subgroups in the United States: <http://www.samhsa.gov/oas/nhsda/ethn/etn/etn%Fallb%2D05.htm.l>
- ^{xxix} Kipke MD, Montgomery SB, Simon TR, Iverson EF. Substance abuse disorders among runaway and homeless youth. *Substance Use and Misuse.* 1997;32(7&8):969-86.
- ^{xxx} Ensign J, Santelli J. Shelter-based homeless youth: health and access to care. *Arch Pediatr Adolesc Med.* 1997 Aug;151:817-23.
- ^{xxxi} Personal communication with Sr. Mary Rose McGeady, Covenant House, March 29, 1999.
- ^{xxxii} Kinsman SB, Homer D, Furstenberg FF. Early sexual initiation: the role of peer norms. *Pediatrics* 1998; 102:1185-1192.

^{xxxiii} *Ibid.*

^{xxxiv} National Coalition for the Homeless. *Homeless Youth NCH Fact Sheet #11*. May 1998.
<http://nch.ari.net/youth.html>.

^{xxxv} Ensign J, Santelli J. *Shelter-based homeless youth: health and access to care*. *Arch Pediatr Adolesc Med*. 1997 Aug;151:817-23.

^{xxxvi} Molnar BE, Shade SB, Kral AH, Watters JK. *Suicidal behavior and sexual/physical abuse among street youth*. *Child Abuse and Neglect*. 1998;22(3):213-21.

^{xxxvii} American Health Line. *National Journal's Daily Briefing*. Thursday, April 8, 1999.

^{xxxviii} Oliver C, Shackleton BW. *The indoor air we breathe: a public health problem of the '90s*. *Public Health Rep*. 1998;113:398-409.

^{xxxix} Wood RA. *The role of cockroach allergy and exposure to cockroach allergen in causing morbidity and inner-city children with asthma*. *Pediatrics* 1998;102(Suppl):455.

^{xl} Oliver C, Shackleton BW. *The indoor air we breathe: a public health problem of the '90s*. *Public Health Rep*. 1998;113:398-409.

^{xli} American Health Line. *National Journal's Daily Briefing*. Thursday, April 8, 1999.

^{xlii} American Health Line. *National Journal's Daily Briefing*. Thursday, April 8, 1999; Centers for Disease Control and Prevention. *Preventing lead poisoning in young children: a statement by the Centers for Disease Control and Prevention*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, 1991.

^{xliii} Centers for Disease Control and Prevention. February 21, 1997. "Update: blood lead levels—United States, 1991-1994."

^{xliv} Schoen EJ. *Childhood lead poisoning: definitions and priorities*. *Pediatrics*. 1993;91:504-505.

^{xlv} *Housing and Health: Getting it together*, Association of Metropolitan Authorities
1997: <http://www.vois.org.uk/healthhousing/html/healthimplications3.htm>

^{xlvi} Personal communication with Sister Catherine Kelly, St. Mary's Medical Center, April 6, 1999.

^{xlvii} Zuvekas A, Silver K, Scarpulla-Nolan L, Scarpulla R. *Identifying and selecting gaps in morbidity and mortality rates for low-income and minority populations*. Center for Health Services Research and Policy, The George Washington University Medical Center. Written for the Bureau of Primary Health Care.

^{xlviii} *Ibid.*

^{xliv} Comerci G. *Efforts by the American Academy of Pediatrics to prevent and reduce violence and its effects on children and adolescents*. *Bulletin of the New York Academy of Medicine*, Winter 1996; 73(2): 398-410.

¹ Kipke MD, Simon TR, Montgomery SB, Unger JB, Iversen EF. *Homeless youth and their exposure to and involvement in violence while living on the streets*. *J Adolescent Health*. 1997;20:360-367; Ensign J, Santelli J. *Shelter-based homeless youth: health and access to care*. *Arch Pediatr Adolesc Med*. 1997 Aug;151:817-23.

^{li} Ensign J, Santelli J. *Shelter-based homeless youth: health and access to care*. *Arch Pediatr Adolesc Med*. 1997 Aug;151:817-23.

-
- ^{lii} Molnar BE, Shade SB, Kral AH, Watters JK. Suicidal behavior and sexual/physical abuse among street youth. *Child Abuse and Neglect*. 1998;22(3):213-21.
- ^{liii} Browne A, and Bassulk SS. Intimate violence in the lives of homeless and poor housed women: prevalence and patterns in an ethnically diverse sample. *Amer J Orthopsychiatry*. 1997 April; 67(2):261-77.
- ^{liv} National Coalition for the Homeless. *Who is homeless? NCH Fact Sheet #3*. February 1999. <http://nch.ari.net/who.html>.
- ^{lv} Kalichman SC, Williams EA, Cherry C. Sexual coercion, domestic violence, and negotiating condom use among low-income African-American women. *Journal of Women's Health*, 1998; 7(3): 371-77.
- ^{lvi} Comerci G. Efforts by the American Academy of Pediatrics to prevent and reduce violence and its effects on children and adolescents. *Bulletin of the New York Academy of Medicine*, Winter 1996; 73(2): 398-410.
- ^{lvii} National Crime Victimization Survey. *U.S. Bureau of Justice Statistics: 1980-1994*.
- ^{lviii} Duran R, et al. The association between weapon carrying and the use of violence among adolescents living in and around public housing. *Journal of Adolescent Health*. 1995; 17: 376-380.
- ^{lix} Personal communication with Ronald Bianchi, St. Vincent Medical Center, April 9, 1999.
- ^{lx} Cheadle A, Pearson D, Wagner E, et. al. Relationship between socioeconomic status, health status, and lifestyle practices of American Indians: evidence from a plains reservation population. *Public Health reports*. 1994; 109: 405-413.
- ^{lxi} Bechtel GA, Shepherd MA, Rogers PW. Family, culture and health practices among migrant farmworkers. *J Community Health Nurs*. 1995;12(1):15-22.
- ^{lxii} Zaldivar RA. American lifestyle tied to immigrant health woes. *The Fort Worth Star-Telegram*. August 3, 1998.
- ^{lxiii} *Ibid*.
- ^{lxiv} Uba, L. Cultural barriers to health care for Southeast Asian refugees. *Public Health Reports*. 1992 Sept-Oct;107:544-48.
- ^{lxv} Cheng M. Keeping well in a new world/immigrant suicide/groups:city must address growing problem. *Newsday*, 16 December 1997, A03.
- ^{lxvi} Branigin W. Chilling effects seen from welfare reform: Caseloads drop sharper among immigrants. *Washington Post*. March 9, 1999; page A06.
- ^{lxvii} Fix M and Passel JS. Trends in non-citizens' and citizens' use of public benefits following welfare reform: 1994-97. Washington, DC: Urban Institute, March 1999; p. 10.
- ^{lxviii} National Coalition for the Homeless. *How many people experience homelessness? NCH Fact Sheet #2*. February 1999. <http://nch.ari.net/numbers.html>; *Who is homeless? NCH Fact Sheet #3*. February 1999. <http://nch.ari.net/who.html>.
- ^{lxix} National Coalition for the Homeless. *Health care and homelessness*. NCH Fact Sheet #8. October 1997. <http://nch.ari.net/health.html>.

-
- ^{lxx} National Coalition for the Homeless. Homeless youth NCH fact sheet #11. May 1998. <http://nch.ari.net/youth.html>.
- ^{lxxi} Weinreb L, Goldberg R, Bassuk E, Perloff J. Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics*. 1998;102(3):554-61.
- ^{lxxii} Personal communication with Sr. Mary Rose McGeady, Covenant House, March 29, 1999.
- ^{lxxiii} Zima BT, Wells KB, Bernadette B, Duan N. Mental health problems among homeless mothers: relationship to service use and child mental health problems. *Arch Gen Psychiatry*. 1996;53:332-37.
- ^{lxxiv} Dalaker, Joseph; Naifeh, Mary. Poverty in the United States: 1997. Current population reports, consumer income P60-201. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September, 1998.
- ^{lxxv} Malmgren JA, Martin ML, Nicola R. Health care access of poverty-level older adults in subsidized public housing. *Public Health Reports* 1996;111:260-263.
- ^{lxxvi} NACHC. Access to community health care: a national and state data book, 1998. Washington: DC, National Association of Community Health Centers. 1998.
- ^{lxxvii} Kutner NG, Ory MG, Baker DI, Schechtman KB, Hornbrook MC, Mulrow CD. Measuring the quality of life in health promotion intervention clinical trials. *Public Health Reports*; 107:530-9.
- ^{lxxviii} NACHC. Access to community health care: a national and state data book, 1998. Washington: DC, National Association of Community Health Centers. 1998, p. 9.
- ^{lxxix} Newacheck P, Strickland B, Shonkoff J. An epidemiological profile of children with special health care needs. *Pediatrics* July 1998;102(1): 117-121; Newacheck PW. Adolescents with special health care needs: prevalence, severity, and access to health services. *Pediatrics* 1989;84:872-81; Aday L. et al. health insurance and utilization of medical care for children with special health care needs. *Medical Care* 1993;31(11):1013-26; Heinzer Marjorie M. Health promotion during childhood chronic disease: a paradox facing society. *Holistic Nursing Practice* 1998;2(12); Fox H, McManus M, Almeida R, Lesser C. Medicaid managed care policies affecting children with disabilities: 1995 and 1996; measuring and improving the health status of the elderly, poor and disabled. *Health Care Financing Review* June 22, 1997; (18):48-66; and Newacheck PW. Adolescents with special health needs: prevalence, severity, and access to health services. *Pediatrics* 1989 Nov;84(5):872-81.
- ^{lxxx} Saunders E. Hypertension in African-Americans. *Circulation* 1991 Apr;83(4):1465-7.
- ^{lxxxi} Health United States 1993 Chartbook. NCHS Vital Statistics, USDHHS/PHS. Hyattsville:MD. May 1995.
- ^{lxxxii} Shulman NB, Hall WD. Renal vascular disease in African-Americans and other racial minorities. *Circulation* 1991 Apr;83(4):1477-79.
- ^{lxxxiii} Saunders E. Hypertension in African-Americans. *Circulation* 1991 Apr;83(4):1465-7.
- ^{lxxxiv} Becker LB, Han BH, Meyer PM, Wright FA, Rhodes KV, Smith DW, Barrett J. Racial differences in the incidence of cardiac arrest and subsequent survival. *New Eng J Med* 1993;329(9):600-06.
- ^{lxxxv} Schulman KA, Berlin JA, Harless W, Kerner JF, Sistrunk S, Gersh BJ, Dube R, Talehani CK, Burke JE, Williams S, Eisenberg JM, Escarce JJ. The effect of race and sex on physicians' recommendations for cardiac catheterization. *NEJM* 1999 Feb;340(8):618-26.

-
- ^{lxxxvi} Goldberg KC, Hartz AJ, Jacobsen SJ, Krakauer H, Rimm AA. Racial and community factors influencing coronary artery bypass graft surgery rates for all 1986 Medicare patients. *JAMA*. 1992 Mar 18;267(11):1473-6.
- ^{lxxxvii} Hypertension detection and follow-up program co-operative group: five-year findings of the hypertension detection and follow-up program: III. Reduction in stroke incidence among persons with high blood pressure. *JAMA* 1982;247:633-8.
- ^{lxxxviii} Preventing blindness from diabetic eye disease: Texas. *MMWR* 1990 Nov 16;39(45):812-9.
- ^{lxxxix} Miller BA, Ries LAG, Hankey BF, Kosary CL, Edwards BK, eds. *Cancer Statistics Review: 1973-1989*. Bethesda, MD: National Cancer Institute; 1992. NIH publication 92-2789.
- ^{xc} Black-White differences in cervical cancer mortality: United States, 1980-1987. *MMWR* 1990 Apr 20;39(15):245-8; Meyers WA. Cancer prevention effective for African-Americans. *Stat Bull* 1991 Apr-Jun:18-22.
- ^{xc1} Pap smear screening: behavioral risk factor surveillance system, 1988. *MMWR* 1989 Nov 17;38(45):777-79.
- ^{xcii} Trends in prostate cancer: United States, 1980-1988. *MMWR* 1992 June 12;41(23):401-5.
- ^{xciii} Alter MJ, Hadler SC, Margolis HS, Alexander WJ, Hu PY, Judson FN, Mares A, Miller JK, Moyer LA. The changing epidemiology of hepatitis B in the United States. Need for alternative vaccination strategies. *JAMA* 1990 Mar 2; 263(9):1218-22.
- ^{xciv} Bloch AB, Rieder HL, Kelly GD, Cauthen GM, Hayden CH, Snider DE. The epidemiology of tuberculosis in the United States. *Semin Respir Infect* 1989 Sep; 4(3):157-70.
- ^{xcv} Moran JS, Aral SO, Jenkins WC, Peterman TA, Alexander ER. The impact of sexually transmitted diseases on minority populations. *Public Health Rep* 1989 Nov-Dec;104(6):560-5.
- ^{xcvi} Selik RM, Castro KG, Pappaioanou M. Distribution of AIDS cases, by racial/ethnic group and exposure category, United States, June 1, 1981 – July 4, 1988. *MMWR* 37 (no.SS-3):1-10.
- ^{xcvii} Hinman AR. Disease prevention programs for racial and ethnic minorities. *Ann Epidemiol* 1993 Mar; 3(2):185-92.
- ^{xcviii} Sly RM. Mortality from asthma, 1979-1984. *J Allergy Clin Immunol* 1988 Nov; 82(5 Pt 1):705-17.
- ^{xcix} Evans R 3d. Epidemiology of asthma in childhood. *Pediatrician* 1991; 18(4):250-6.
- ^c Malveaux FJ, Houlihan D, Diamond EL. Characteristics of asthma mortality and morbidity in African-Americans. *J Asthma* 1993;30(6):431-7.
- ^{ci} Infant mortality: United States, 1991. *MMWR* 1993 Dec 10;42(48):926-30.
- ^{cii} Bureau of the Census, unpublished data, 1992.
- ^{ciii} Kleinman JC, Kessle SS. Racial differences in low birth weight: trends and risk factors. *New Eng J Med* 1987;317:749-53; Donadegan A, Rosenfeld LS, Southern EM. Infant mortality and socioeconomic status in a metropolitan community. *Pub Health Rep* 1965;0:1083-94; Bedger JE, Gelperin A, Jacobs EE. Socioeconomic characteristics in relation to maternal and child health. *Pub Health Rep* 1966;81:829-33.
- ^{civ} Foster HW Jr, Thomas DJ, Semanya KA, Thomas J. Low birthweight in African-Americans: does intergenerational well-being improve outcome? *J Natl Med Assoc* 1993; 85:516-20.

-
- ^{cv} *Vaccination coverage of 2 year-old children: United States, 1991-1992. MMWR 1994 Jan 7; 42(51 &52):955-8.*
- ^{cvi} *Vaccination coverage of 2 year-old children: United States, 1993. MMWR 1994 Oct 7; 43(39):705-9.*
- ^{cvii} *Caplan DF, Weintraub JA. The oral health burden in the United States: a summary of recent epidemiologic studies. J Dent Educ 1993 Dec;57(12):853-62.*
- ^{cviii} *Bennefield, R. Health Insurance Coverage: 1997. Current population reports, consumer income P60-202. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September, 1998.*
- ^{cix} *Fronstin P. Sources of health insurance and characteristics of the uninsured: analysis of the March 1998 current population survey. EBRI Issue Brief. 1998 Dec;(204):3.*
- ^{cx} *Ibid, p. 21.*
- ^{cxii} *Ibid, p. 4.*
- ^{cxiii} *Ibid. p. 5.*
- ^{cxiiii} *Ibid.*
- ^{cxv} *Polednak A. Health insurance for low-income adults: the issue of Hispanics. Health Affairs, 17(3), 282-3.*
- ^{cxvi} *Fronstin P. Sources of health insurance and characteristics of the uninsured: analysis of the March 1998 current population survey. EBRI Issue Brief. 1998 Dec;(204):11,19.*
- ^{cxvii} *Ibid. pps.10,19.*
- ^{cxviii} *Ibid. p.4.*
- ^{cxix} *Long P, Liska D. State Facts: Health needs and Medicaid financing. the Kaiser commission on Medicaid and the uninsured. February 1998, pg. 13.*
- ^{cx} *Ibid.*
- ^{cxii} *Fronstin P. Sources of health insurance and characteristics of the uninsured: analysis of the March 1998 current population survey. EBRI Issue Brief. 1998 Dec;(204):4,5; Long P, Liska D. State Facts: Health needs and Medicaid financing. the Kaiser commission on Medicaid and the uninsured. February 1998..*
- ^{cxiii} *Long P, Liska D. State Facts: Health needs and Medicaid financing. the Kaiser commission on Medicaid and the uninsured. February 1998, pg. 9.*
- ^{cxiiii} *Kaiser Commission on the Future of Medicaid. Medicaid facts: the Medicaid program at a glance. December 1995.*
- ^{cxv} *Selden TM, Banthin JS, Cohen JW. Medicaid's problem children: eligible but not enrolled. Health Affairs. Health Affairs 1998 May-Jun; 17(3):192-200.*
- ^{cxvi} *Darnell, Julie; Rosenbaum, Sara; Nolan, Lea; Zuvekas, Ann; Budetti, Peter. Access to care among low-income, inner-city, minority populations: the impact of managed care on the urban minority poor and essential community providers. Prepared for the Commonwealth Fund. December, 1995.*
- ^{cxvii} *Schoen C, Lyons B, Rowland D, Davis K, Puleo E. Insurance matters for low-income adults: results from a five-state survey. Health Affairs 1997 Sep-Oct;16(5):163-71.*

-
- ^{cxxvi} Kiefe CI, Hyman DJ. Do public clinic systems provide health care access for the urban poor? A cross sectional survey. *J Community Health*, 1996 Feb;21(1):61-70.
- ^{cxxvii} Freeman HE, Corey CR. Insurance status and access to health services among poor persons. *Health Services Research* 1993 Dec;28(5):531-41.
- ^{cxxviii} Personal communication with Sr. Mary Rose McGeady, Covenant House, March 29, 1999.
- ^{cxxix} NACHC. *Access to community health care: a national and state data book*, 1998. Washington: DC, National Association of Community Health Centers. 1998.
- ^{cxxx} Cunningham PJ, Grossman JM, St. Peter RF, Lesser CS. Managed care and physicians' provision of charity care. *JAMA* 1999 Mar;281(12):1087-92.
- ^{cxxxi} NACHC. *Access to community health care: a national and state data book*, 1998. Washington: DC, National Association of Community Health Centers. 1998.
- ^{cxxxii} Public hospital data reflect members of the National Association of Public Hospitals and Health Systems only. NAPH. Findings from the 1996 NAPH Hospital Characteristics Survey. <http://www.naph.org/96char.html>.
- ^{cxxxiii} Bureau of National Affairs, Inc. Disease management introduced for uninsured, Medicaid populations: special report 1998 Nov 11;6(45):1844-45.
- ^{cxxxiv} Zuvekas A, Darnell J, Nolan L, Tumaylle C, Hudman J. Policy implications of survival strategies adopted by inner-city safety-net providers in an era of managed care. Prepared for the Commonwealth Fund. May 1998.
- ^{cxxxv} American Health Line. Charity care: UNLV wants freeloading customers to pay up. Friday, March 5, 1999.
- ^{cxxxvi} American Health Line. Indigent: University of South Alabama wants county to pay. Friday, April 2, 1999.
- ^{cxxxvii} Kalkines, Arky, Zall and Bernstein, LLP. *The health care safety net: preserving access to care for low-income New Yorkers: a report of the financially distressed and voluntary SLIPA hospitals*. January 1999.
- ^{cxxxviii} Bureau of National Affairs. States can use Section 1931 to steady number of beneficiaries dropping from rolls. 1998 Nov 23;6(46):1870-71.
- ^{cxxxix} Commonwealth of Massachusetts. Uncompensated Care. <http://commonwealth2.cam-colo.bbnplanet.com>.
- ^{cxl} New Jersey Health Reform Demonstration Fact Sheet. <http://www.hcfa.gov/Medicaid/njfact.htm>.
- ^{cxli} Hospitals and Health Networks. April 20, 1998.
- ^{cxlii} Health Resources and Services Administration. Community Health Center Program. <http://www.bphc.hrsa.dhhs.gov/chc/chc1.htm>.
- ^{cxliii} Health Resources and Services Administration. Maternal and Child Health Bureau fact sheet. <http://www.hrsa.gov/mchb/old/hotline2.htm>.
- ^{cxliv} Health Resources and Services Administration. Healthy Schools, Healthy Communities. <Http://158.72.83.221/hshc/hshcfact.htm>.
- ^{cxlv} Health Resources and Services Administration. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. <http://www.hrsa.gov/newsroom/factsheets/careact.htm>.

^{cxlvi} *Hospitals and Health Networks*. November 5, 1998.

^{cxlvii} *Hospitals and Health Network*. November 20, 1998.

^{cxlviii} *Hospitals and Health Networks*. September 5, 1999.

APPENDIX

DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM ENVIRONMENTAL ASSESSMENT

BIBLIOGRAPHY

Aday LA, Lee E, Spears B, Chung C, Youssef A, Bloom B. Health insurance and utilization of medical care for children with special health care needs. *Medical Care*. 1993;31(11):1013-1026.

Aduician. Oral health: an essential service for the homeless. *Journal of Public Health Dentistry*. 1995;55(1):8-9.

Alter M, Hadler S, Margolis H, Alexander W, Hu P, Judson F, Mares A, Miller J, Moyer L. The changing epidemiology of hepatitis B in the United States. Need for alternative vaccination strategies. *JAMA*. 1990; 263(9):1218-22.

American Health Line. *Charity care: UNLV wants freeloading customers to pay up*. 5 March 1999.

American Health Line. *Indigent: University of South Alabama wants county to pay*. 2 April 1999.

American Health Line. *National Journal's Daily Briefing*. 8 April 1999.

Anderson C, Murphy J. Will elderly seasonal nomads need health services? *Public Health Reports*. 1996;111:55-56.

Anderson R, Giachello A, Aday L. Access of Hispanics to health care and cuts in services: a state-of-the-art overview. *Public Health Reports*. 1986;101:238-252.

Aruffo J, Coverdale J, Vallbon C. AIDS knowledge in low-income and minority populations. *Public Health Reports*. 1991;106:115-119.

Audrulis, D. Access to care is the centerpiece in the elimination of socioeconomic disparities in health. *American College of Physicians-American Society of Internal Medicine*. 1998;129(5):412-416.

Averhoff F, Brink E, Pollard B, Resha K, Bryan G, Vaillancourt M. Adolescent immunization: focus on implementation; special report: focus on adolescent immunization. *Journal of School Health*. 1997;67(7):starting on pg. 304.

Badgercare steps toward health care for everyone. *Wisconsin State Journal*. 21 December 1997;2B.

Bassuk E, Weinreb L, Buckner J, et al. The characteristics and needs of sheltered homeless and low-income housed mothers. *JAMA*. 1996;276(8):640-646.

Bassuk E, Weinreb L, Dawson R, Perloff J, Buckner J. Determinants of behavior in homeless and low-income housed preschool children. *Pediatrics*. 1996;100:92-100.

Bates-Rudd R. Medical systems unite to aid the uninsured: \$5 million grant will buy voices of Detroit to efficiently serve area. *The Detroit News*. 23 December 1998;D8e.

Baxter, M. Solid citizens' pursuit of health care quality also provides benefits to communities. *Employee Benefit News*. 1 September 1998.

Beardstown's health care needs being assessed. *The State Journal-Register*. 9 April 1998;10.

Bechtel G, Shepherd M, Rogers P. Family, culture and health practices among migrant farmworkers. *J Community Health Nurs*. 1995;12(1):15-22.

Becker LB, Han BH, Meyer PM, Wright FA, Rhodes KV, Smith DW, Barrett J. Racial differences in the incidence of cardiac arrest and subsequent survival. *New Eng J Med*. 1993;329(9):600-06.

Bedger JE, Gelperin A, Jacobs EE. Socioeconomic characteristics in relation to maternal and child health. *Public Health Reports*. 1966;8:829-33.

Beitz JM. Sexual health promotion in adolescents and young adults: primary prevention strategies. *Holistic Nursing Practice*. 1998;2(12):27.

Bennefield R. Health Insurance Coverage: 1997. Current Population Reports, Consumer Income P60-202. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September 1998.

Bigelow B, Arndt M, Middleton M. Corporate political strategy: incorporating the management of public policy issues into hospital strategy. *Health Care Management Review*. 1997;22(3):53-63.

Black-White differences in cervical cancer mortality: United States, 1980-1987. *MMWR* 20 Apr 1990;39(15):245-8.

Bloch AB, Rieder HL, Kelly GD, Cauthen GM, Hayden CH, Snider DE. The epidemiology of tuberculosis in the United States. *Semin Respir Infect*. 1989;4(3):157-70.

Blustein J, Hanson K, Shea S. Preventable hospitalizations status. *Health Affairs*. March/April 1998;177-189.

Branigin W. Chilling effects seen from welfare reform: caseloads drop sharper among immigrants. *Washington Post*. 9 March 1999;A06.

Brewster D. Families pay a high price for a legislature's inaction. *Seattle Times*. 2 April 1998.

Browne A, and Bassulk S. Intimate violence in the lives of homeless and poor housed women: prevalence and patterns in an ethnically diverse sample. *Amer J Orthopsychiatry*. April 1997; 67(2):261-277.

Bulger RJ. The broadening scope of health care; the quest for mercy: the forgotten ingredient in health care reform, part 3. *The Western Journal of Medicine*. 1998;1(168):54.

Bureau of the Census, unpublished data, 1992.

Bureau of National Affairs. States can use Section 1931 to reduce the number of beneficiaries dropping from rolls. 23 Nov 1998;6(46):1870-71.

Bureau of National Affairs. Disease management introduced for uninsured, Medicaid populations: special report 11. Nov 1998;6(45):1844-45.

Busen N, Bettina B. A collaborative model for community-based health care screening of homeless adolescents. *Journal of Professional Nursing*. 1997;13(5):316-324.

Caloptima in Success Spotlight. *Los Angeles Times*. 6 December 1998;10.

Caplan DF, Weintraub JA. The oral health burden in the United States: a summary of recent epidemiologic studies. *J Dent Educ*. 1993 Dec;57(12):853-62.

Carleton G. Uninsured are underserved; health forum seeks solutions, produces mostly

questions. *Capital Times*. 1998.

Catholic charities USA and major Catholic health care organizations collaborate to improve children's health. *Washington Dateline*. 26 September 1997.

Center for Health Services Research and Policy, The George Washington University. Mental health: study finds Medicaid managed care weakness. *The National Journal Group*. 20 April 1998;209-10.

Centers for Disease Control and Prevention. *Chronic disease in minority populations: African-Americans, American Indians and Alaska Natives, Asians and Pacific Islanders, Hispanic Americans 1994*. Atlanta: Centers for Disease Control and Prevention; 1992, p2-6.

Centers for Disease Control and Prevention. *Preventing lead poisoning in young children: A statement by the Centers for Disease Control and Prevention*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service; 1991.

Centers for Disease Control and Prevention. "Update: Blood Lead Levels—United States, 1991-1994." 21 February 1997.

Cheadle A, Pearson D, Wagner E, Psaty B, Diehr P, Koepsell T. Relationship between socioeconomic status, health status, and lifestyle practices of American Indians: Evidence from a plains reservation population. *Public Health Reports*. 1994;109:405-413.

Chen E. Near retirees in a health gap; losing insurance at rapid rate. *The Los Angeles Times*. 1 June 1997;A01.

Cheng M. Keeping well in a new world/immigrant suicide/groups: city must address growing problem. *Newsday*. 16 December 1997;A03.

Clabby C. Speaking out for health care for those most in need. *The News and Observer*. 4 May 1997;B1.

Comerci G. Efforts by the American Academy of Pediatrics to prevent and reduce violence and its effects on children and adolescents. *Bulletin of the New York Academy of Medicine*. Winter 1996;73(2):398-410.

Commonwealth of Massachusetts. Uncompensated Care. <http://commonwealth2.cam-colo.bbnplanet.com>.

Cunningham PJ, Grossman JM, St. Peter RF, Lesser CS. Managed care and physicians' provision of charity care. *JAMA*. 1999;281(12):1087-92.

Dalaker J, Naifeh M. Poverty in the United States: 1997. Current Population Reports, Consumer Income P60-201. U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. September 1998.

Dalton R. Changes in health care urged; panel calls for shake-up in area system, targets poor. *The San Diego Union-Tribune*. 12 Feb 1998. Section: Local; Ed. B-1; pg. 1,4,5,6,7,8; Ed. B-5; pg. 2,3.

Darnell J, Rosenbaum S, Nolan L, Zuvekas A, Budetti P. Access to care among low-income, inner-city, minority populations: the impact of managed care on the urban minority poor and essential community providers. Prepared for the Commonwealth Fund. December 1995.

De la Barra X. Poverty: the main cause of ill health in urban children. *Health Education & Behavior*. 1998;25(1):46-59.

Denker, A. University of Miami/Jackson Memorial Medical Center restructuring its health care system for the 21st century. *Nursing Administration Quarterly*. 1998;3(22):8-55.

Diwan S, Berger C, Manns E. Composition of the home care service package: predictors of type, volume, and mix of services provided to poor and frail older people. *Gerontologist*. 1997;37(2):169-181.

Donadebian A, Rosenfeld LS, Southern EM. Infant mortality and socioeconomic status in a metropolitan community. *Public Health Rep*. 1965;0:1083-1094.

Donovan J. A question of community: at not-for-profit hospitals health is a local affair; differences between for- and not-for-profit hospitals; healthcare. *Fund Raising Management*. 1997;28(8):starting on pg. 32.

Duffy RW. The gap in the safety net; candid comments in the challenges of how to ensure health care; uninsured poor. *St. Louis Post-Dispatch*. 11 May 1997;01B.

Dukarm C, Holl J, McAnarney E. Violence among children and adolescents and the role of the pediatrician. *Bulletin of the New York Academy of Medicine*. Summer 1995;5-15.

Durant R, Getts A, Cadenhead C, Woods E. The association between weapon carrying and the use of violence among adolescents living in and around public housing. *Journal of Adolescent Health*. 1995;17:376-380.

Durant R, Pendergrast R, Seymore C. Sexual behavior among Hispanic female adolescents in the United States. *Pediatrics*. 1990;85:1051-1058.

Edds M. *Health Care; Fixing What Ails Uninsured Virginians*. Norfolk, VA: The Virginia-Pilot, Landmark Communications, Inc; 1998.

El-Bassel N, Schilling R. Drug use and sexual behavior of indigent African American men. *Public Health Reports*. 1991;106:586-590.

Ensign J, Santelli J. Shelter-based homeless youth: health and access to care. *Arch Pediatr Adolesc Med*. 1997;151:817-823.

Escobedo L, Zhu B, Giovino G, Eriksen M. Educational attainment and racial differences in cigarette smoking. *J Natl Cancer Inst*. 1995;87:1552-1553.

Esposito L. Home health case management rural caregiving. *Home Healthcare Nurse*. 1994;3(12):38-43.

Evans R 3d. Epidemiology of asthma in childhood. *Pediatrician*. 1991;18(4):250-6.

Fessenden, F. The health divide/difference of life and death for blacks, medical care and state of health trail whites, developing a health profile. *Newsday*. 29 November 1998;A04

Fix M, Passel JS. *Trends in non-citizens' and citizens' use of public benefits following welfare reform: 1994-97*. Washington, DC: Urban Institute, March 1999;10.

Food Research and Action Center:

http://www.frac.org/html/hunger_in_the_US/health.html

Foster H Jr, Thomas D, Semanya K, Thomas J. Low birthweight in African-Americans: does intergenerational well-being improve outcome? *J Natl Med Assoc*. 1993;85:516-20.

Fox H, McManus M, Almeida R, Lesser C. Medicaid managed care policies affecting children with disabilities: 1995 and 1996; measuring and improving the health status of the elderly, poor and disabled. *Health Care Financing Review*. June 1997;4(18):48-66.

Freeman H, Corey C. Insurance status and access to health services among poor persons. *Health Services Research*. 1993;28(5):531-541.

Friedman L, Savage G. Can ethical management and managed care coexist? *Health Care Management Review*. 1998;23(2): starting on pg. 56.

Fronstin P. Sources of health insurance and characteristics of the uninsured: analysis of the March 1998 current population survey. EBRI Issue Brief. 1998 Dec;(204).

Gelberg L, Doblin B, Leake B. Ambulatory health services provided to low-income and homeless adult patients in a major community health center. *J Gen Intern Med*. 1996;11:156-162.

Gennaro S, York R, Dunphy P. Vulnerable infants: kinship care and health. *Pediatric Nursing*. 1998;2(24):119.

Gillis M, Singer J. Breaking through the barriers: healthcare for the homeless. *JONA*. 1997;27(6):30-34.

Gold M. Making Medicaid managed care research relevant. *Health Services Research*. 1999;33(6):1639-1649.

Gold, M. Beyond coverage and supply: measuring access to healthcare in today's market; the concept of access and managed care. *Health Services Research*. 1998;3(33):625.

Goldberg K, Hartz A, Jacobsen S, Krakauer H, Rimm A. Racial and community factors influencing coronary artery bypass graft surgery rates for all 1986 Medicare patients. *JAMA*. 1992 Mar 18;267(11):1473-6.

Grogan C. The Medicaid managed care policy consensus for welfare recipients: a reflection of traditional welfare concerns. *Journal of Health Politics, Policy and Law*. 1997;22(3):815-838.

Hardy J, Shapiro S, Mellits D, Skinner E, Astone N, Ensminger M, LaVeist T, Baumgardner R, Starfield B. Self-sufficiency at ages 27 to 33 years: factors present between birth and 18 years that predict educational attainment among children born to inner-city families. *Pediatrics*. 1998;99:80-87.

Health United States 1993 Chartbook. NCHS Vital Statistics, USDHHS/PHS. Hyattsville: MD. May 1995.

Health Resources and Services Administration. Community health center program. <http://www.bphc.hrsa.dhhs.gov/chc/chc1.htm>.

Health Resources and Services Administration. Maternal and Child Health Bureau fact sheet. <http://www.hrsa.gov/mchb/old/hotline2.htm>.

Health Resources and Services Administration. Healthy schools, healthy communities. <Http://158.72.83.221/hshc/hshcfact.htm>.

Health Resources and Services Administration. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. <http://www.hrsa.gov/newsroom/factsheets/careact.htm>.

Hearing of the Senate Finance Committee. *Children Access to Health Care*. Washington, DC: Federal News Service; 30 April 1997.

Heart Information Network. *Link found between fetal nutrition and the long-term risk of developing heart disease*. <http://www.heartinfo.org/fetalut.htm>

Heinzer M. Health promotion during childhood chronic disease; a paradox facing society. *Holistic Nursing Practice*. 1998;2(12):starting on pg. 8.

Hemingway H, Nicholson A, Roberts R, Marmot M. The impact of socioeconomic status on health functioning as assessed by the SF-36 questionnaire: the Whitehall II study. *American Journal of Public Health*. 1997; 87(9):1484-1490.

Heneghan A, Malakoff M. Availability of school health services for young children. *Journal of School Health*. 1997;67(8):starting on pg. 327.

Higgins A. Maine's kids need better health coverage: commission seeks Medicaid expansion. *Bangor Daily News*. 22 January 1998.

Hillenmeyer K. Project access vies for semifinalist title for national award. *Asheville Citizen-Times*. 20 July 1998;B1.

Hinman A. Disease prevention programs for racial and ethnic minorities. *Ann Epidemiol*. 1993;3(2):185-92.

Hispanic doctors meet with White House officials. U.S. Newswire. 27 March 1997;70-1. (Contact: E. Rios, National Hispanic Med Assoc, 202-215-4297.)

Hood J. Pediatric politics; Clinton creates a kiddie care crisis. *Reson Foundation*. 1997;2(29).

Housing and Health: Getting it Together, Association of Metropolitan Authorities 1997: <<http://www.vois.org.uk/healthhousing/html/healthimplications3.htm>>

Hospitals and Health Networks. 20 April 1998.

Hospitals and Health Networks. 5 September 1998.

Hospitals and Health Networks. 5 November 1998.

Hospitals and Health Networks. 20 November 1998.

Hulse C. Retirees caught in health care gap. *The Ledger*. 25 May 1997;6.

Hypertension detection and follow-up program co-operative group: five-year findings of the hypertension detection and follow-up program: III. Reduction in stroke incidence among persons with high blood pressure. *JAMA*. 1982;247:633-8.

Infant mortality: United States, 1991. *MMWR* 1993 Dec 10;42(48):926-30.

Jean C, Robillard, K, Tumiel L, et al. Predictors of first-contact care in a poor urban community. *Family Medicine*. 1995;27:170-5.

Kaiser Commission on the Future of Medicaid. *Medicaid Facts: The Medicaid program at a glance*. December 1995.

Kalichman S, Williams E, Cherry C. Sexual coercion, domestic violence, and negotiating condom use among low-income African American women. *Journal of Women's Health*. 1998;7(3):371-377.

Kalkines, Arky, Zall and Bernstein, LLP. The health care safety net: preserving access to care for low-income New Yorkers: a report of the financially distressed and voluntary SLIPA hospitals. January 1999.

Kaplan A. Elgin group works toward health care for uninsured. *Chicago Daily Herald*. 7 June 1998;1.

Kasper J. Asking about access: challenges for surveys in a changing healthcare environment; what can we realistically expect from surveys? Constraints of data and methods. *Healthcare Services Research*. 1998;3(33):715.

Katz M, Hsu L, Lingo M, Woelffer G, Schwarcz S. Impact of socioeconomic status on survival with AIDS. *American Journal of Epidemiology*. 1998;148(3):282-290.

Keepnews D. Welfare reform and health care. *American Journal of Nursing*. 1998;98(3):55-56.

Kelly E. Nutrition among homeless children. *Public Health Rep*. 1998;113:287.

Key Facts from Surgeon General's Report; Minorities and Smoking. Action on Smoking and Health (www.ash.org). 27 April 1998.

Kiefe C, Hyman D. Do public clinic systems provide health care access for the urban poor? A cross-sectional survey. *Journal of Community Health*. 1996;21(1):61-70.

Kim R. NY: high-risk city/ 1 out of 4 lacks health coverage. *Newsday*. 12 February 1998;AO3.

Kinsman S, Romer D, Furstenberg F, Schwarz D. Early sexual initiation: the role of peer norms. *Pediatrics*. 1998;102:1185-1192.

Kipke M, Montgomery S, Simon T, Iverson E. Substance abuse disorders among runaway and homeless youth. *Substance Use and Misuse*. 1997;32(7&8):969-986.

Kipke M, Simon T, Montgomery S, Unger J, Iversen E. Homeless youth and their exposure to and involvement in violence while living in the streets. *Journal of Adolescent Health*. 1997;20:360-367.

Klag M, Whelton P, Randall B, Neaton J, et al. End state renal disease in African-American and white men. *JAMA*. 1997;277(16):1293-1298.

Kleinman J, Kessle S. Racial differences in low birth weight: trends and risk factors. *New Eng J Med*. 1987;317:749-53.

Kliegman R. Perpetual poverty: child health and the underclass. *Pediatrics*. 1992;89:710-713.

Klien J, et al. Adolescents and access to health care. *Bulletin of the New York Academy of Medicine*. Winter 1993;70(3):219-235.

Koppelman J, Lear J. The new child health insurance expansions: how will school-based health centers fit in? *Journal of School Health*. 1998;8(10): starting on pg. 441.

Kronebusch K. Medicaid and the politics of groups: recipients, providers, and policy making. *Journal of Health Politics, Policy and Law*. 1997;3(22):849-78.

Kutner N, Ory M, Baker D, Schechtman K, Hornbrook M, Mulrow C. Measuring the quality of the life of the elderly in health promotion intervention clinical trials. *Public Health Reports*. 1992;107:530-539.

Lack of preventive health care caused by poor coverage, ignorance, study says. *The Bureau of National Affairs, Inc*. 23 Sept 1996.

Leiser K. Late budget hurts 'little guy' providing services to poor, handicapped. *Copley News Service*. 1 August 1997.

Linehan T. Who Cares? (Contact: The Children's Society, 0171-837-4299.)

Long P, Liska D. *State facts: health needs and Medicaid financing*. The Kaiser Commission on Medicaid and the Uninsured. February 1998;9.

Lundeen SP. An alternative paradigm for promoting health in communities: the Lundeen community nursing center model. *Family and Community Health*. 1999;21(4):pg. 15.

MacPherson P. As Medicaid managed care changes the need for--and nature of--emergency departments, will the poor and needy be left behind? *Hospitals*. 1996;70(14):60-62,64.

Malmgren J, Martin M, Nicola R. Health care access of poverty-level older adults in subsidized public housing. *Public Health Reports*. 1996;111:260-263.

Malveaux F, Houlihan D, Diamond E. Characteristics of asthma mortality and morbidity in African-Americans. *J Asthma*. 1993;30(6):431-7.

Mason J. Who Cares? (Contact: National Children's Bureau, 0171-843-6095.)

McBride T. Uninsured spells of the poor: prevalence and duration; innovations in fee-for-service financing and delivery. *Health Care Financing Review*. 1997;19(1):starting on pg. 145.

McDonough P, Duncan G, Williams D, House J. Income dynamics and adult mortality in the United States, 1972 through 1989. *American Journal of Public Health*. 1997:1476-1483.

Measuring and improving the health status of the elderly, poor and disabled. *Health Care Financing Review*. 22 June 1997;(18):48-66.

Medicare Study: race and income affect services. *American Health Line*. 13 September 1996;5(115).

Meyer, H. Home care goes corporate; home care services industry trends; includes related articles on the five hospital homebound elderly program in Chicago, IL, and home care facts. *Hospitals & Health Networks*. 1997;10(71):20.

Meyers W. Cancer prevention effective for African-Americans. *Stat Bull* Apr-Jun 1991;18-22.

Miller B, Ries L, Hankey B, Kosary C, Edwards B, eds. *Cancer Statistics Review: 1973-1989*.

Bethesda, MD: National Cancer Institute; 1992. NIH publication 92-2789.

Miller R. Healthcare organizational change: implications for access to care and its measurement. *Health Services Research*. 1998;33(3):starting on pg. 653.

Molnar B, Shade S, Kral A, Booth R, Watters J. Suicidal behavior and sexual/physical abuse among street youth. *Child Abuse & Neglect*. 1998;22(3):213-222.

Montgomery L. Racial gap found in medical ethics debate. *The Cincinnati Enquirer*. 9 March 1997;A24.

Moran J, Aral S, Jenkins W, Peterman T, Alexander E. The impact of sexually transmitted diseases on minority populations. *Public Health Rep*. 1989;104:560-565.

Morrison Clark. Project serves the poor, uninsured, considered most ambitious in the state. *Ashville Citizen-Times*. 8 June 1997.

Mueller K, Patil K, Boilesen E. The role of uninsurance and race in healthcare utilization by rural minorities. *Health Services Research*. 1998;33(3): 597.

NACHC. *Access to Community Health Care: A National and State Data Book, 1998*. Washington: DC, National Association of Community Health Centers. 1998.

Nadel M. Child welfare-early experiences implementing a managed care approach. GAO Reports, RPT-Number: GAO/HEHS-99-8: 21 October 1998.

Nagy S, Adcock A, Nagy C. A comparison of risky health behaviors of sexually active, sexually abused, and abstaining adolescents. *Pediatrics*. 1994;93:570-575.

National Association of Public Hospitals and Health Systems. NAPH. Findings from the 1996 NAPH Hospital Characteristics Survey. <http://www.naph.org/96char.html>.

National Coalition for the Homeless. *Health Care and Homelessness. NCH Fact Sheet #8*. October 1997. <http://nch.ari.net/health.html>

National Coalition for the Homeless. *How Many People Experience Homelessness? NCH Fact Sheet #2*. February 1999. <http://nch.ari.net/numbers.html>

National Coalition for the Homeless. *Homeless Youth. NCH Fact Sheet #11*. May 1998. <http://nch.ari.net/youth.html>.

National Coalition for the Homeless. *Who is Homeless? NCH Fact Sheet #3*. February 1999. <http://nch.ari.net/who.html>.

National Crime Victimization Survey. U.S. Bureau of Justice Statistics: 1980-1994.

National Diabetes Information Clearinghouse. *Diabetes in African Americans*. <http://www.niddk.nih.gov/health/diabetes/pubs/afam/afam.htm#3>

National Journal's Daily Briefing. 8 April 1999.

National Symposium on Multicultural Mental Health research to be held on October 30-31 in Boston, MA; Top researchers reveal learnings about the mental health of communities of color. 1997 PR Newswire Association, Inc.

Neus E. Are kids getting the mental health care they need? *Gannett News Service.* 23 August 1997.

New studies suggest 4 million children with no insurance are eligible for Medicaid. *The Bureau of National Affairs, Inc.* 1998.

Newacheck P, Halfon N, Hughes D, Brindis C. Evaluating community efforts to decategorize and integrate financing of children's health services. *The Milbank Quarterly.* 1998;76(2):starting on pg. 157.

Newacheck P, Strickland B, Shonkoff J. An epidemiological profile of children with special health care needs. *Pediatrics.* 1998;102(1):117-121

Newacheck P. Adolescents with special health needs: prevalence, severity, and access to health services. *Pediatrics.* 1989;84:872-881.

New Jersey Health Reform Demonstration Fact Sheet.
<http://www.hcfa.gov/medicaid/njfact.htm>.

Nichols L. What price is health care quality? health care costs. *USA Today* (Magazine). January 1999;127(2644):starting on pg. 50.

Nyamathi A, Bennett C, Leake B. Coronary artery disease in blacks; scientific contribution. *Public Health Reports.* 1995;110:600-606.

Nyamathi AM, Lewis C, Leake B, et. al. Barriers to condom use and needle cleaning among impoverished minority female injection drug users and partners of injection drug users. *Public Health Reports.* 1995;110:166-172.

Nyamathi AM, Bennett C, Leake B. Predictors of maintained high-risk behaviors among impoverished women. *Public Health Report.* 1995;110:600-606.

Oliver C, Shackleton BW. The indoor air we breathe: a public health problem of the '90s. *Public Health Rep.* 1998;113:398-409.

Ordog G, et al. Gunshot wounds seen at a county hospital before and after a riot and gang truce. *The Journal of Trauma, Injury, Infection and Critical Care.* 1995;38(3):417-419.

Palmore E. Health care needs of the rural elderly. *International Journal of Aging and Human Development*. 1983-84;18(1):39-45.

Pap smear screening: behavioral risk factor surveillance system, 1988. *MMWR* 17 Nov 1989;38(45):777-79.

Pear R. Researchers link income inequality to higher mortality rates. *New York Times*. 19 April 1996.

Peters R. The negative effect of the clinical model of "health": implications for health care policy. *Journal of Health Care Finance*. 1998;25(1):starting on pg. 78.

Personal communication with Dr. Ronald Bianchi, St. Vincent Medical Center, 9 April 1999.

Personal communication with Sr. Catherine Kelly, St. Mary's Medical Center, 6 April 1999.

Personal communication with Sr. Mary Rose McGeady, Covenant House, 29 March 1999.

Platts-Mills A. Asthma and indoor exposure to allergens. *The New England Journal of Medicine*. 1997;336(19):1383-1384.

Polednak A. Health insurance for low income adults: the issue of Hispanics. *Health Affairs*. 1998;17(3):282-3.

President Clinton and Vice President Gore working on behalf of African Americans. *M2 Press Wire*. 10 November 1998.

Presler B. Care coordination for children with special care needs. *Orthopedic Nursing*. 1998;2(17):S45.

Preventing blindness from diabetic eye disease: Texas. *MMWR* 16 Nov 1990;39(45):812-9.

Proenca J. Community orientation in health services organizations: the concept and its implementation. *Health Care Management Review*. 1998;23(2):starting on pg. 28.

Real risk from McDonald's diet. *The Herald (Glasgow)*. 1 April 1999;pg. 12.

Reinhart U. Wanted: a clearly articulated social ethic for American health care. *JAMA*. 1997;278(17):1446-1447.

-
- Rew L, Resnick M, Blum R. An exploration of help-seeking behaviors in female Hispanic adolescents. *Family and Community Health*. 1997;20(3): 1.
- Rhoades E. American Indians and Alaska Natives—overview of the population. *Public Health Reports*. 1996;111:49-50.
- Rosenthal D, Moore S, Buzwell S. Homeless youths: sexual and drug related behavior, sexual beliefs and HIV/AIDS risk. *Aids Care*. 1994;6(1):83-94.
- Rosentreich D, Eggleston P, Kattan M, et al. The role of cockroach allergy and exposure to cockroach allergen in causing morbidity among inner-city children with asthma. *New England Journal of Medicine*. 1997; 336(19):1356-1363.
- Salomon A. Welfare reform and the real lives of poor women: introduction. *American Journal of Orthopsychiatry*. 1996;66(4):486-489.
- Santelli J, Vernon M, et al. Managed care, school health programs, and adolescent health services: opportunities for health promotion. *Journal of School Health*. 1998;68(10):starting on pg. 434.
- Saunders E. Hypertension in African-Americans. *Circulation*. 1991;83(4):1465-7.
- Scheideberg D. Improved prenatal outcomes with prenatal case management. *Journal of Nurse Care Quality*. 1997;12(1):36-45.
- Schoen C, Lyons B, Rowland D, Davis K, Pulco E. Insurance matters for low income adults results from a five state survey. *Health Affairs*. 1997;16(5):163-171.
- Schoen EJ. Childhood lead poisoning: definitions and priorities. *Pediatrics*. 1993;91:504-505.
- Schulman K, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *The New England Journal of Medicine*. 1999;340(8):618-626.
- Schuster M, Wood D, Mazel R. Utilization of well-child care services for African-American infants in a low-income community: results of a randomized, controlled case management/home visitation intervention. *Pediatrics*. 1998;101:999-1005.
- Sedrel E. Health care needs boost, Cuomo says. *Albuquerque Journal*. 27 August 1998.
- Selden T, Banthin J, Cohen J. Medicaid's problem children: eligible but not enrolled. *Health Aff*. 1998;17(3)192-200.

Selik RM, Castro KG, Pappaioanou M. Distribution of AIDS cases, by racial/ethnic group and exposure category, United States, June 1, 1981 – July 4, 1988. *MMWR* 37 (no.SS-3):1-10.

Shulman NB, Hall WD. Renal vascular disease in African-Americans and other racial minorities. *Circulation*. 1991;83(4):1477-79.

Slegers J, et al. Mental health problems among homeless adolescents. *ACTA Psychiatrica*. 1998;97:253-259.

Sly RM. Mortality from asthma, 1979-1984. *J Allergy Clin Immunol*. 1988;82(5 Pt 1):705-17.

Starfield B, Cassady C, Nanda J, Forrest C, Berk R. Consumer experience and provider perceptions of the quality of primary care: implications for managed care. *Journal of Family Practice*. 1998;3(46):216.

Strayer M, Kuthy R, Caswell R, Moeschberger M. Predictors of dental use for low-income, urban elderly persons upon removal of financial barriers. *The Gerontologist*. 1997;37(1):110-116.

Substance Abuse and Mental Health Statistics Source Book 1998. Office of Applied Studies. Department of Health and Human Services.

Substance Abuse and Mental Health Agency. Prevalence of substance use among racial and ethnic subgroups in the United States:
[Http://www.samhsa.gov/oas/nhsda/ethn/etn/etn%20Fallb%2005.htm](http://www.samhsa.gov/oas/nhsda/ethn/etn/etn%20Fallb%2005.htm).

Summerfield D. If children's lives are precious, which children? *Lancet*. 1998;351(9120):1955.

Taras H, Nader P, Swiger H, Fontanesi J. The school health innovative programs: integrating school health and managed care in San Diego, CA. *Journal of School Health*. 1998;1(68):88-95.

Tenner A, Trevithick L, Wagner V, Burch R. Seattle youth care's prevention, intervention, and education program: a model of care for HIV-positive, homeless, and at-risk youth. *Journal of Adolescent Health*. 1998;23S:96-106.

The Clinton Administration's initiative to improve health care access for uninsured workers. *FDCH Federal Department and Agency Documents*. 11 February 1999.

The Uninsured: New York Times looks at demographics. *American Health Line, National Journal's Daily Briefing*. 26 February 1999.

Through an innovative grantmaking initiative, Chicago area funders encourage healthcare services for at-risk individuals. *PR Newswire*. 17 February 1999.

Trager E. The health care gap between the affluent and the poor. *The Boston Globe*. 21 October 1998.

Trends in prostate cancer: United States, 1980-1988. *MMWR* 12 June 1992;41(23):401-5.

Uba, L. Cultural barriers to health care for Southeast Asian refugees. *Public Health Reports*. 1992;107:544-48.

Unger J, et al. Homeless youths and young adults in Los Angeles: prevalence of mental health problems and the relationship between mental health and substance abuse disorders. *American Journal of Community Psychology*. 1997;25(3):371-392.

US Department of Health and Human Services. *AHCPR Survey Finds 17 Percent of Civilian Population Uninsured. MEPS Highlights: The Uninsured in America*. Md: US Dept of Health and Human Services, Public Health Service, 1996. AHCPR publication 97-280025.

Vaccination coverage of 2 year-old children: United States, 1991-1992. *MMWR* 7 Jan 1994; 42(51 & 52):955-8.

Vaccination coverage of 2 year-old children: United States, 1993. *MMWR* 7 Oct 1994; 43(39):705-9.

Villarosa L. Tailoring a healthy message to blacks. Tuesday Late Edition-Final, *The New York Times*. 18 August 1998.

Vladeck B. Primary care: the urban hospital's role. *Henry Ford Hospital Medical Journal*. 1990;38(2 & 3):130-132.

Voelker R. Federal program nourishes poor elderly. *Journal of the American Medical Association*. 1997;278(16):1301.

Voices for Illinois children new study uncovers uninsured children in every Illinois county. *PR Newswire*. 11 November 1997.

Voluntary Organizations Internet Server. Health implications of poor housing. www.vois.org.uk.

Vostanis P, Grattan E, Cumella S. Mental health problems of homeless children and families: longitudinal study. *BMJ*. 1998;316:899-902.

Weinreb L, Goldberg R, Bassuk E, Perloff J. Determinants of health and service use patterns in homeless and low-income housed children. *Pediatrics*. 1998;102(3):554-561.

Weinreb L, Goldberg R, Perloff J. Health characteristics and medical service use patterns of sheltered homeless and low-income housed mothers. *J Gen Intern Med*. 1998;13:389-397.

Wiecha J, Dwyer J, Dunn-Strohecker M. Nutrition and health services needs among the homeless. *Public Health Reports*. 1992;89:710-713.

Williams, J. Health care to low income residents. *The Indianapolis Star*. 30 August 1998; 04.

Winett LB. Constructing violence as a public health problem. *Public Health Reports*. 1998;113(6):498.

Wood RA. The role of cockroach allergy and exposure to cockroach allergen in causing morbidity and inner-city children with asthma. *Pediatrics* 1998;102(Suppl):455.

Woods E, Samples C, et al. Boston Happens Program: a model of health care for HIV-positive, homeless, and at-risk youth. *Journal of Adolescent Health*. 1998;23S:37-48.

Yorke, L. Joint Center Forum to focus on impact of Medicaid reform on African Americans. *U.S. Newswire*. 13 November 1997.

Zaldivar RA. American lifestyle tied to immigrant health woes. AM Edition, *The Fort Worth Star-Telegram*. 3 August 1998;A.

Zaldivar, R. Racial changes push health care Issues forward. *The Times-Picayune*. 2 August 1998, A8.

Zima B, Bussing R, Forness S, Benjamin B. Sheltered homeless children: their eligibility and unmet need for special education evaluations. *American Journal of Public Health*. 1997;87(2):236-240.

Zima B, Wells K, Bernadette B, Duan N. Mental health problems among homeless mothers: relationship to service use and child mental health problems. *Arch Gen Psychiatry*. 1996;53:332-337.

Zuvekas A, Darnell J, Nolan L, Tumaylle C, Hudman J. Policy implications of survival strategies adopted by inner-city safety-net providers in an era of managed care. Center

for Health Services Research and Policy, The George Washington University Medical Center. Written for the Commonwealth Fund. May 1998.

Zuvekas A, Silver K, Scarpulla-Nolan L, Scarpulla R. Identifying and selecting gaps in morbidity and mortality rates for low-income and minority populations. Center for Health Services Research and Policy, The George Washington University Medical Center. Written for the Bureau of Primary Health Care. April 1995.