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Migration and Health

Latinos in the United States



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Forword

“Ever since borders were invented, people have crossed them, not only to visit other countries, but also to live and work in them. In doing so, they have nearly always run risks, driven by the determination to overcome adversity and improve their quality of life. Historically, migration has not only improved the well-being of individuals but also of humanity as a whole.”

(Kofi A. Annan, 2006)

The development of mankind has been intrinsically linked to migration. Population movements into new territory can be said to have been one of the engines of human history and perhaps even? the basis of our collective memory as human beings. Migration is a complex phenomenon. Although it does not in itself constitute a problem—the movement of populations is age-old—the circumstances in which it occurs may transform it into a highly complex one.

Unlike other living creatures that also migrate, The capacity to adapt to extremely varied climates and surroundings has been one of the keys to the progress of the human race ever since Homo sapiens began to migrate approximately 150,000 years ago. The possibility of migration serves as powerful motivation for exploration; nowadays we even explore the possibility of going beyond our own planet.

In this global era, mediated by technological progress and the growing ease of movement, international migration has achieved an unprecedented scope, driven primarily by social inequality. Currently, over 200 million people live outside their country of origin. In the Western Hemisphere, particularly in the north, the attraction exerted by the United States on several countries in the region has intensified migration, producing substantial changes in demographic trends and therefore the foreign policies of interdependent nations.

For some, however, migration is a strategy that goes beyond economic survival and is often linked to identity issues and rites of passage, as in the case of many teenagers who see migration as an opportunity to escape from local community control and enjoy new experiences.

Because of the current scope of migration in North and Central America and of current governmental approaches to managing such a diffuse process, international migration has become a problem in the places of origin, transit, and destination. Since migration is predominantly undocumented, the social cost is extremely high, particularly since young people stop playing a strategic role in the social and economic development of their communities.

The scope of the migratory phenomenon in the region has fueled xenophobic stereotypes and encouraged policies of exclusion, as well as jingoism. On the other hand, migrants are exposed to several types of human rights violations as well as violence and abuse.

Undocumented migration divides an ever-increasing number of families and it is extremely difficult, if not impossible, to measure this negative impact for future generations. Mothers and fathers, often with small children, leave and do not see their spouses or children for long periods of time leaving them dependent on the rest of their family for their care, upbringing, and emotional development.

Despite enormous efforts to control borders, the flow of undocumented people has increased, and so have the risks for migrants. This flow has become one of the axes of public debate and the struggle for power, particularly in relation to geopolitical security. Thus, in the long term, it is in no one's interest for illegality to be perceived as a synonym of migrants' identity. This is a temporary condition that could change if there is a political will and regulations that will allow it.

Migration and health are closely linked. Migrants' health forms part of their social, human, and productive capital and is an asset for the migrants themselves, their families and communities of origin and destination. The process of relocating to another country, with another culture, language, norms and customs different from one's own often entails exposure to risks and changes in behavior that affect individuals' psychological conditions and right to social protection. Migrants' health is therefore the joint responsibility of the countries of origin and destination, in this case, the United States. Taking care of it requires strategies and programs with a binational perspective.

It is in this spirit that the National Population Council (CONAPO) and the Health Initiative of the Americas, with the support of the Mexican Health and Foreign Affairs ministries?? and the University of California in Los Angeles, have produced this

report to help decision-makers design and implement policies aimed at improving migrants' health and quality of life.

The document comprises four chapters. The first describes the scope, trends, and characteristics of Latin American, and particularly Mexican, migration to the United States. Where the data are available, it also refers to the Latin American countries that take part in ISA, activities: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador. The second analyzes immigrants' health insurance coverage and level their level of access to the various types of medical security. The third describes their health service access and use. The last describes specific aspects of migrants' health, including the main illnesses affecting them. The document ends with a number of considerations, pointing out challenges and opportunities in the field of binational public policy.

As long as there are borders, there will be migrants. Migration cannot be stopped, even with the current control mechanisms that exact a high toll on everyone. In this respect, it is essential to rethink regional migratory dynamics and try to find mechanisms that will benefit all the parties involved. Migrants contribute enormously to the development of the receiving countries and therefore warrant special treatment that will enable them to lead a safe, pleasant, healthy, and decent life.

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Chapter I

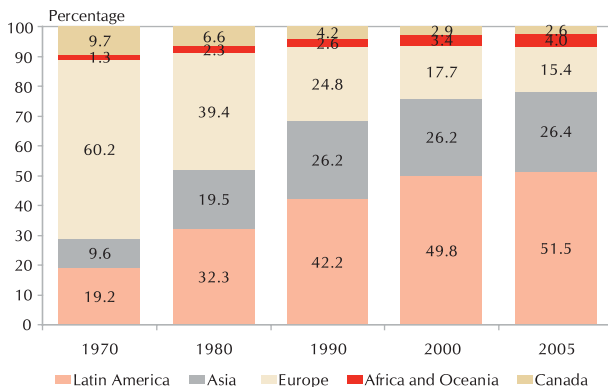
Characteristics of Mexican Migration to the United States

Trends and Scope

Mexicans: the largest immigrant minority in the United States

The history of the United States is indissolubly linked to immigration. However, the geographic origins of this immigration have changed over time. Today, Latin American and Caribbean countries with the greatest geographic proximity to the U.S. constitute the main source of migratory currents. This latest change in migration trends has had a strong effect on the ethnic make-up in the U.S. Whereas in 1970 over two-thirds of immigrants were of European or Canadian origin, now virtually half (52%) are from Latin America and the Caribbean (Figure 1). Mexico has continued to be the main sender of migrants to the United States.

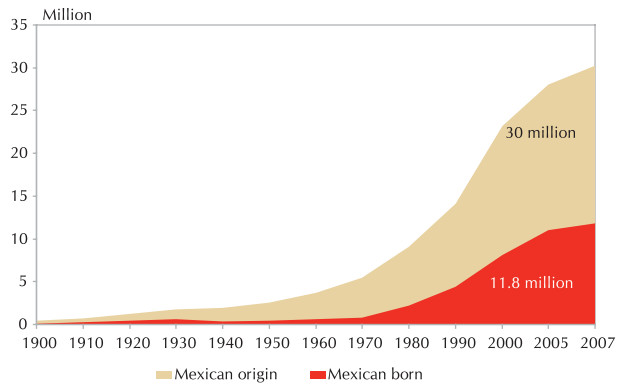
Figure 1. Distribution of Foreign Population Resident in United States by Region or Country of Birth, 1970-2005



Source: CONAPO estimates based on U. S. Census Bureau, 15-percent sample 1970, 5-percent sample 1980, 5-percent sample 1990, 5-percent sample 2000 and American Community Survey (ACS), 2005.

Over the last century the Mexican-born population resident in the United States registered an enormous increase. It is estimated that in 1900, there were approximately 100,000 Mexican-born people living in the United States. Their number progressively increased until 1970, when it reached nearly 800,000 (Figure 2).

Figure 2. Population of Mexican Origin Resident in United States, 1900-2007



Source: From 1900 to 1990: drawn up on the basis of Corona Vázquez Rodolfo, *Estimate of population of Mexican origin resident in United States*, El Colegio de la Frontera Norte, 1992. Figures for 2000, 2005 and 2007: CONAPO estimates based on U.S. Census Bureau, *Current Population Survey (CPS)*, March supplement, 2000, 2005 and 2007.

The 1970s saw the beginning of a new cycle of Mexican migration to the United States, characterized by a significant increase in intensity and scope (particularly of undocumented workers), a growing territorial extension of the phenomenon in both countries, a propensity towards a “more permanent” form of migration, and a diversification of migrants’ socio-demographic profile, among other aspects. By 1980, the number of Mexicans resident

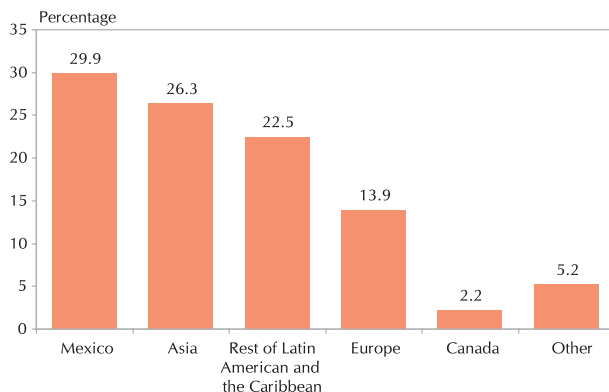
in the United States reached 2.2 million, and since then the figures have doubled every 10 years: 4.4 million by 1990 and 8.8 million by 2000. It is estimated that in 2007 the number was 11.8 million. Thus the Mexican population in the United States has increased by over a hundredfold over the past 105 years, although 95% of the increase (nearly 10 million) occurred from 1970 onwards.

If migrants' offspring are also taken into account, it is estimated that the population of Mexican origin in the United States increased by 5.4 million to 30.3 million between 1970 and 2007. Of these, 18.5 million were born in the United States (9.6 million second generation and 8.8 million third generation or more).

The 11.8 million Mexicans resident in the United States in 2007 accounted for 4% of the total U.S. population and approximately 30% of the immigrant population. These figures make Mexico the country with the highest number of emigrants resident in the United States, placing it above some of the world's major regions: Asia (26%), the rest of Latin America and the Caribbean (23%), and Europe (14%) (Figure 3).

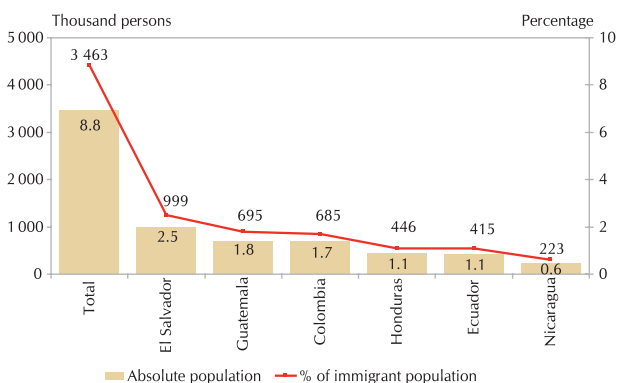
It is worth noting, because of their size, the importance of the immigrant populations from Guatemala, El Salvador, Honduras, Nicaragua, Colombia, and Ecuador resident in the United States. For analytical purposes, these have been included under the category of "Selected Latin American countries" (Figure 4).¹

Figure 3. Distribution of Foreign Population Resident in United States by Region or Country of Birth, 2007



Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007.

Figure 4. Population of Selected Latin American Countries Resident in United States, 2007



Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007.

¹ These countries were included in this report because of their formal participation in the activities in the Health Initiative of the Americas at the University of California, Berkeley. One of the main activities is the Binational Health Week which, thanks to the active participation of consular networks in the United States and the foreign affairs secretariats of these countries, will be held in over 42 U.S. states, including 300 cities.

The Mexican immigrant population resident in the United States is concentrated in working ages

In general, young adults are the main participants in migration, with the populations at the extreme ends of the age scale playing a minor role. In fact, there are striking differences between the age structures of the immigrant and the white U.S.-born population.

Immigrants' age composition is characterized by a broad segment in the intermediate ages of the life cycle. This is particularly evident in the Mexican immigrant population and that of the selected Latin American countries, whose 18-to-64 age group make up about 85% and 88% of their immigrant population, respectively (with the majority being concentrated between 18 and 44).

The low percentage of people older than 64 is closely linked to the relatively recent nature of permanent Latin American migration to the United States primarily by younger people. It is also related to the greater propensity of earlier, now older

migrants to return to their communities in their native lands once they have completed their working years in the U.S. (Figure 5).

Conversely, the white U.S.-born population has a profile in which just over three out of every five people (61%) are adults, while the population at either end of the age scale, both under 18 (26%) and 65 and over (13%), comprises the remaining two-fifths.

Mexican migration has helped reduce demographic ageing in the United States

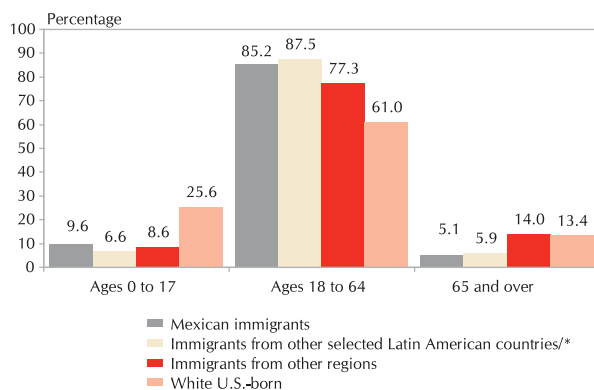
As a whole, the U.S. population has been getting older. This demographic aging partly reflects the deceleration in population growth. Although immigration alone cannot reverse this trend, Mexican immigrants and their offspring have made an undeniable contribution to the population growth of certain age groups in the country.

Indeed, as by far the largest national immigrant group, Mexicans and their offspring have decisively contributed to the increase in absolute numbers of people ages 0-17 and 18-64, slowing the demographic aging. Between 1997 and 2007, the number of children ages 0-17 in the United States increased by a mere 2.9 million, and the second generation of Mexicans accounted for 70% of this growth (in absolute terms, they contributed almost two million more people) (Figure 6).

Conversely, the population group called "other", which includes the US-born population, decreased by 584,000. If it had not been for Mexican migration, the country's total under-18 population would have declined over the past decade and the United States would be undergoing a rapid process of demographic aging.

At the same time, by increasing by over four million during the same period, Mexican-born immigrants accounted for a quarter of the growth registered in

Figure 5. Immigrant Population (from Mexico and Other Regions) and White US-born Population Resident in United States by Age Group, 2007



Notes: */ Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007.

Figure 6. Absolute Growth of Population resident in the United State by Origin and Group 1997-2007

	Total	Mexican origin			Selected Latin American Countries ³	Other
		Mexican born	Second generation ¹	Third or more ²		
Absolute difference (1997-2007)	30 031 595	4 513 488	3 044 649	3 111 654	1 267 866	18 093 938
Ages 0 to 17	2 877 185	118 746	1 999 233	1 339 066	4 383	- 584 243
Ages 18 to 64	22 996 707	4 100 965	974 063	1 576 535	1 156 952	15 188 192
Ages 65 or over	4 157 703	293 776	71 354	196 053	106 531	3 489 989
Contribution to growth (1997-2007)	100.0	15.0	10.1	10.4	4.2	60.2
Ages 0 to 17	100.0	4.1	69.5	46.5	0.2	- 20.3
Ages 18 to 64	100.0	17.8	4.2	6.9	5.0	66.0
Ages 65 or over	100.0	7.1	1.7	4.7	2.6	83.9

Notes: 1/ Second generation in the United States: Population resident in the United States, not Mexican-born, with some parents born in Mexico.
 2/ Third generation or more in the United States: Population resident in the United States, not Mexican-born, with non Mexican-born parents but who declared they were of Mexican origin (Mexican-American, Chicano or Mexican).
 3/ Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 Source: CONAPO estimates, based on Bureau Census, *Current Population Survey*, March 1997 and 2007.

the 18-to-64 population. Given its high concentration of young adults, this segment has also helped slow the country’s population aging.

Territorial Extent of Mexican Immigration

The predominance of the Mexican population among the immigrant population occurs throughout virtually all U.S. territory

The growing intensity of Mexican immigration to the United States over the last few decades has made the presence of Mexicans more visible virtually throughout the U.S. Although California and Texas (40% and 19%, respectively) continue to have the greatest number of Mexicans, migratory flows reveal a gradual variation over time. In 1990 Mexicans were among the five largest groups of immigrants in 23 U.S. states; by 2005 they occupied this position in 43 states.

In some states, Mexicans account for an extremely high proportion of the immigrant population. This trend can be seen in Figure 7: by 2005, the Mexi-

can-born population accounts for at least 40% of the immigrant population in 13 states, that is, at least 40% *vis-à-vis* all the other immigrant subpopulations combined.

Migratory Status

Mexican immigrants’ migratory status has a negative effect on their integration into U.S. society

The high rate of undocumented workers in the migratory flow from Mexico and the relatively low rate at which they adopt U.S. citizenship constitute major obstacles to their integration into U.S. society, including restricting their access to medical insurance.

In 2006 there were an estimated 12 million undocumented immigrants in the United States. Fifty-six percent of this population —6.7 million people—were born in Mexico, a much higher percentage than that for migrants from other parts of the world (Figure 8). This, in turn, exacerbates the vulnerability and marginalization of this population.

Figure 7. Proportion of Mexicans in Relation to Total Immigrants, 1990 and 2005

1990

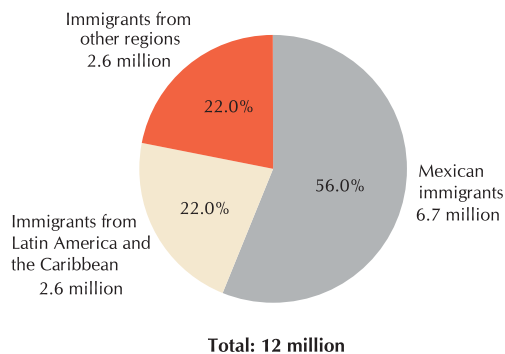


2005



Source: Estimates based on U. S. Census Bureau, *percent samples 1990* and *American Community Survey (ACS), 2005*.

Figure 8. Undocumented Immigrant Population (from Mexico and other regions) Resident in United States, 2006

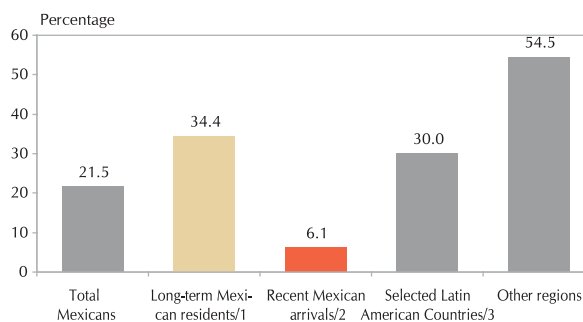


Source: Pew Hispanic Center tabulations of augmented March 2006 *Current Population Survey*, adjusted for omission.

U.S. citizenship constitutes a major determinant of economic and social rights and benefits. The data clearly show that Mexican-born immigrants have much lower naturalization rates than other groups of immigrants. Approximately one in every five Mexican-born immigrants has U.S. citizenship, a rate lower than that of immigrants from other Latin American countries (30%) and far less than half the rate for immigrants from other regions (55%). The extremely low rate of naturalization of recent Mexican arrivals (1996–2007) (6%) is particularly striking (Figure 9).

These discrepancies extend to the household level. In just 18% of Mexican households are all its members citizens (as opposed to 46% of households headed by other immigrants); in one out of every four Mexican households, none of the members holds citizenship. Most Mexican households (58%) contain some people with and some without citizenship. Thus some household members have different rights and privileges (meaning that they are exposed to different risks and forms of vulnerability). In most of these cases the “mix” is due to the fact that the householder is not a U.S. citizen while some of the offspring are, having been born in U.S. territory (Figure 10).

Figure 9. Immigrant Population (from Mexico and other regions) Resident in United States and Possessing Citizenship, 2007

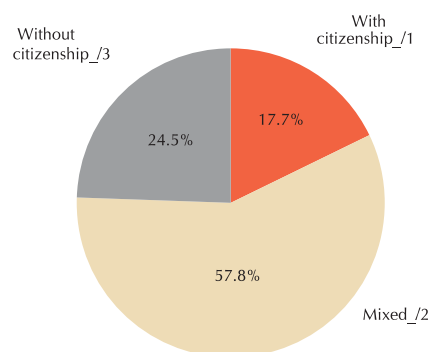


Notes: 1/ Long-term residents: Population that arrived before 1996. 2/ Recent arrivals: Entered between 1996 and 2007.

3/ Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

Source: Estimates based on Census Bureau, *Current Population Survey* (CPS), March 2007.

Figure 10. Households Headed by Immigrant Mexicans in the United States by Members’ Citizenship Status, 2007



Notes: 1/ All household members are U.S. citizens.

2/ At least one household member is a U.S. citizen and one is not.

3/ None of the household members are U.S. citizens.

Source: CONAPO estimates based on U.S. Census Bureau, *Current Population Survey* (CPS), March 2007.

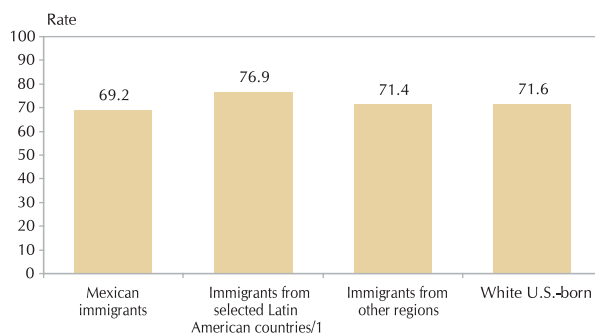
Employment and poverty

Mexican immigrants play a key role in the U.S. economy

Mexican immigration to the United States is largely determined by the sharp contrast in salary and employment conditions between the two countries. Once in the United States, Mexican migrants display a high rate of participation in economic activity, slightly lower than that of immigrants from selected other Latin American countries but higher than that of other immigrant groups and the white U.S.-born population.

Over two out of every three Mexican immigrants resident in the United States who are between 15 and 64 are economically active —7.6 million engage in some form of work (Figure 11). Furthermore, approximately 94% of the economically active Mexican-born population are employed, reflecting a widespread demand for Mexican labor on the U.S. labor market. This high participation rate is shared by immigrants from other Latin American countries, among whom 96% of the economically active population are employed.

Figure 11. Economic Participation Rate of Immigrant Population (from Mexico and other regions) and White U.S.-born Population Resident in United States, 2007



Note: 1/ Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
Source: Estimates based on Census Bureau, *Current Population Survey* (CPS), March 2007.

Mexicans tend to be concentrated in poorly-paid manual occupations

Mexican immigrants engage primarily in poorly paid, unskilled occupations. This distribution largely parallels the labor-market profile of immigrants from other Latin American countries, but it is very different to that of immigrants of other nationalities and the white U.S.-born population. The great number of undocumented Mexican workers and the low level of human capital (measured by years of education, language barriers, familiarity with U.S. culture) largely determine their over-representation at the base of the occupational pyramid (Figure 12).

Unskilled service occupations, manufacturing, and construction account for nearly 85% of recently arrived Mexican workers and 70% of long-term Mexican residents. These indicators contrast with those of both non-Latin American immigrants and the white U.S.-born population, who have greater access to executive, professional, and technical positions (41% and 39%, respectively). The markedly low rate of the Mexican-born in jobs at the top of the occupational scale (3.8%) is particularly noticeable among recent arrivals in the U.S. These figures clearly reflect the existence of a polarized labor market for immigrants, shaped largely by ethnic origin, where workers from Mexico and other Latin American countries contribute substantially to meeting the demand for unskilled labor, while immigrants from other regions primarily satisfy the need for skilled labor.

Nearly half the immigrants with low incomes are Mexican

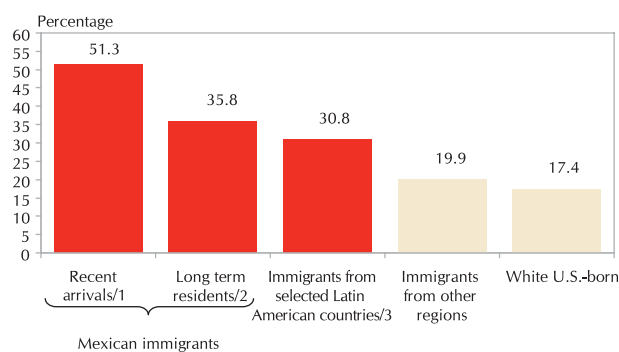
The high degree of socio-economic marginalization of the Mexican population in the U.S. and their concentration at the manual-labor end of the occupational distribution are correlated with an alarmingly large subpopulation with scant

Figure 12. Distribution of Employed Immigrant Population by Place of Birth and Type of Occupation Resident in United States, 2007

Occupation	Total Mexican immigrants	Recent arrivals from Mexico ¹	Mexican long-term residents ²	Immigrants from selected Latin American Countries ³	Immigrants from other regions	U.S.-born whites
Total population⁵	6,964,227	2,932,924	4,029,663	2,336,569	13,988,713	100,866,738
Total	100.0	100.0	100.0	100.0	100.0	100.0
Executives, Professionals y Technicians	7.4	3.8	10.1	12.3	40.8	38.8
Semi-skilled service workers	1.5	0.8	2.0	2.8	4.4	4.0
Sales, administrative assistance and office work	11.0	6.2	14.5	15.3	21.7	26.1
Poorly qualified service workers	25.1	25.6	24.7	27.2	14.4	9.9
Specialized workers ⁴	26.9	25.6	27.9	24.4	13.9	15.1
Construction workers	24.2	34.0	17.0	17.7	4.5	5.6
Farmers and farm workers	3.9	4.0	3.9	0.3	0.3	0.5

Notes: 1/ Recent arrivals: Population that entered the country between 1996 and 2007.
 2/ Long-term residents: Population that arrived before 1996.
 3/ Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 4/ Excludes construction workers.
 5/ Excludes armed forces personnel and those with an unspecified occupation.
 Source: CONAPO estimates, based on *Current Population Survey*, March 2007 supplement.

Figure 13. Immigrant Population (from Mexico and Other regions) and White U.S.-born Population Living in Poverty, 2007



Notes: 1/ Recent arrivals: Arrived between 1996 and 2007.
 2/ Long-term residents: Arrived before 1996.
 3/ Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 Source: CONAPO estimates, based on Census Bureau, *Current Population Survey* (CPS), March 2007.

resources. Nearly 43% Mexicans has a low income,² a rate that is 12 percentage points higher than that for immigrants from of other Latin American countries and more than double that of other immigrant groups and the white U.S.-born population. This situation is much more dramatic among Mexicans who are recent arrivals (51%) (Figure 13).

Data point to the existence of five million Mexicans in the United States with low incomes, representing 8% of the total population of this country in this condition. The over-representation of poverty among the Mexican population emerges more clearly if one considers only the universe of immigrants in the United States: nearly half of all immigrants in the most precarious economic conditions are Mexican-born.

² Defined as 150% below the US federal poverty line.

Chapter II

Coverage and Type of Health Insurance

The U.S. “social security” system is based mainly on the private sector; the state’s responsibility is restricted to the care of the most vulnerable groups, who have scant resources. In particular, the health care system is based on private Health Insurance acquired primarily through employment (whether one’s own or that of a relative); only a fifth of the country’s total insured population is covered by publicly provided insurance. In the first case, health security depends primarily on workers accepting the coverage offered by their employer, and on workers’ room for maneuver to negotiate job benefits through unions if they are members. In the second, access to public programs targeting people with few resources, such as *Medicaid*, for example, is contingent on meeting eligibility criteria, associated with income levels and certain circumstances, having special health conditions, and, in the case of immigrant populations, their migratory status and length of legal residence in the country (Figure 27).

This dual system has created one of the most unequal health provision systems in the developed world. In this context, the incorporation of migrant populations into health insurance schemes constitutes a key issue in the current debate on reform of the United States health care system. Immigrants’ level of access to different types of health insurance responds to and expresses the way their insertion into the receiving society is carried out. Consequently, the Latin American immigrant population’s deficient processes of integration are correlated by a major health vulnerability among this population in U.S. territory.

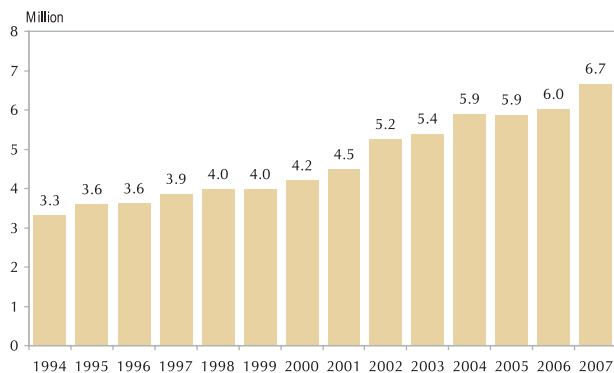
Health Insurance Coverage

Over half of all Mexican immigrants resident in the United States are not covered by any health system

Mexican immigrants face enormous obstacles in terms of access to health insurance systems. Parallel to the growth of Mexican migration, the volume of the uninsured Mexican population more than doubled over the past 13 years from 3.3 to 6.7 million people (Figure 14). Today 56% of the Mexican immigrant population lacks any kind of health coverage. The pattern of health insurance coverage of immigrants from other Latin American countries is slightly more favorable (50%), but also reflects their disadvantaged position in relation to other immigrant populations (19%) and the white U.S.-born population (12%) (Figure 15). These figures make it possible to identify sharp ethnic disparities in access to health insurance systems, and show Latinos to be clearly the most vulnerable population group.

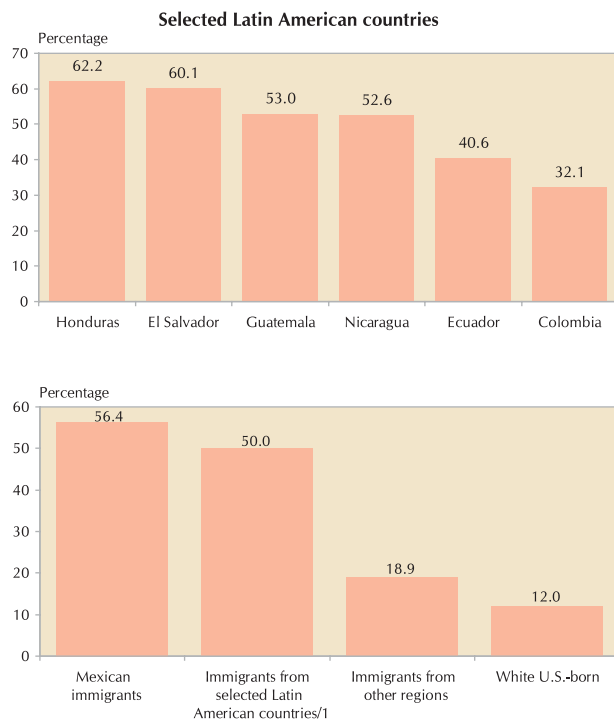
This situation is particularly dramatic among recent Mexican and other Latin American arrivals in the United States: those with fewer than 10 years of residence in the country have “vulnerability rates” (lack of health insurance) of approximately 70%, whereas those who have lived in the U.S. for over 10 years have vulnerability rates that are 20% to 30% lower (Figure 16). Thus, the length of stay greatly improves the chances of social integration as measured by health insurance coverage.

Figure 14. Mexican Population Resident in United States without Medical Insurance 1992-2007



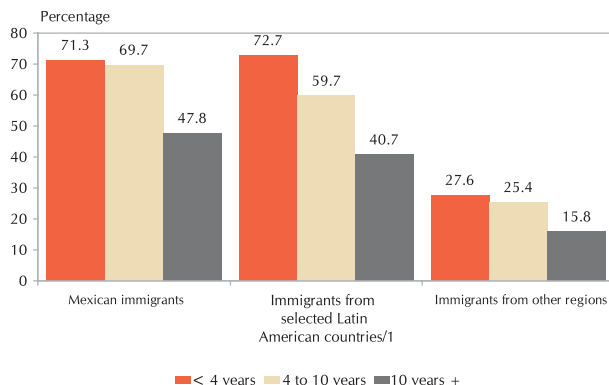
Source: CONAPO estimates, based on *Current Population Survey*, March 1994-2007 supplement.

Figure 15. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population without Medical Insurance in United States, 2007



Note: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
Source: CONAPO estimates, based on *Current Population Survey* (CPS), March 2007 supplement.

Figure 16. Immigrant Population (from Mexico and Other Regions) without Medical Insurance by Length of Stay in United States, 2007



Note: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

Source: CONAPO estimates, based on *Current Population Survey* (CPS), March 2007 supplement.

Nevertheless, the pattern of Mexicans' disadvantage *vis-à-vis* other populations continues over time. Despite considerable improvement in the number who over time obtain medical coverage, Mexicans resident longer remain characterized by higher levels of vulnerability than non-Hispanic immigrant populations who have spent fewer than four years in the country (28% lack health insurance). The degree of exclusion of the Mexican population from health services is particularly evident when one considers that although they account for only 4% of the country's population, they constitute 14% of the total uninsured population.

The Non-Naturalized Mexican Population with Low Incomes Displays the Lowest Rates of Health Insurance Coverage

Although the right to health has been universally acknowledged, recent years have seen the imposition of new legal obstacles in the U.S. that have particularly, and negatively, affected the Mexican immigrant population's ability to obtain health care coverage. Citizenship, for example, is a key factor in obtaining public health care coverage designed

for low-income families. Thus, immigrants without U.S. citizenship face several obstacles in their access to social benefits. Moreover, in order to be able to gain access to these programs, in most cases the law now requires immigrant populations to prove at least five years' legal residence in the U.S.

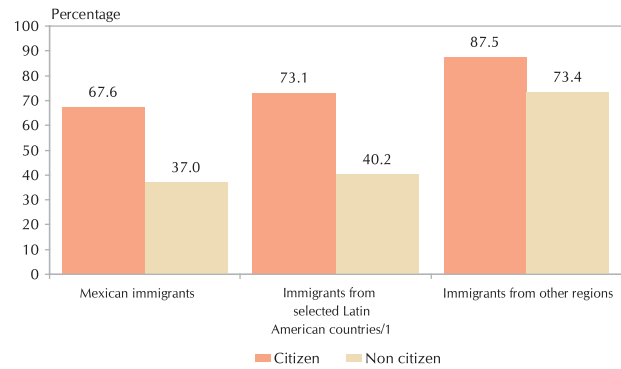
This policy change appears to be an attempt, in part, to dissuade migration. In this regard it has proved largely unsuccessful, since the incentive for migration to the United States is not possible access to social services but predominantly, the good prospect for work. These measures, however, have had the counterproductive effect of exacerbating inequalities regarding health, not only between the U.S.-born population and foreigners, but also between different ethnic groups.

The data clearly show how obtaining citizenship adds to the social integration of immigration populations, expressed in greater access to social and work rights and benefits, including health insurance: over two out of three naturalized Mexicans have health insurance (Figure 17). The situation of Mexicans who are not citizens, mainly comprising the undocumented population located on the lowest steps of the occupation pyramid, is very different; only 37% have health coverage.

Even with similar citizenship conditions, the Mexican-born population has lower coverage rates than other immigrant populations. This is probably closely linked to a pattern of labor-force participation that is characterized by engagement in occupations offering limited or no work benefits.

Immigrants from Mexico and other Latin American countries with scant resources are extremely vulnerable: two out of every three lack health insurance (Figure 18). It is hardly surprising that these immigrants (many of whom are undocumented and live in conditions marked by extremely limited resources) face severe financial hardship when they have to go to the hospital in the event of a serious illness or accident.

Figure 17. Immigrant Population (from Mexico and Other Regions) with Medical Insurance by Citizenship Status in United States, 2007



Note: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

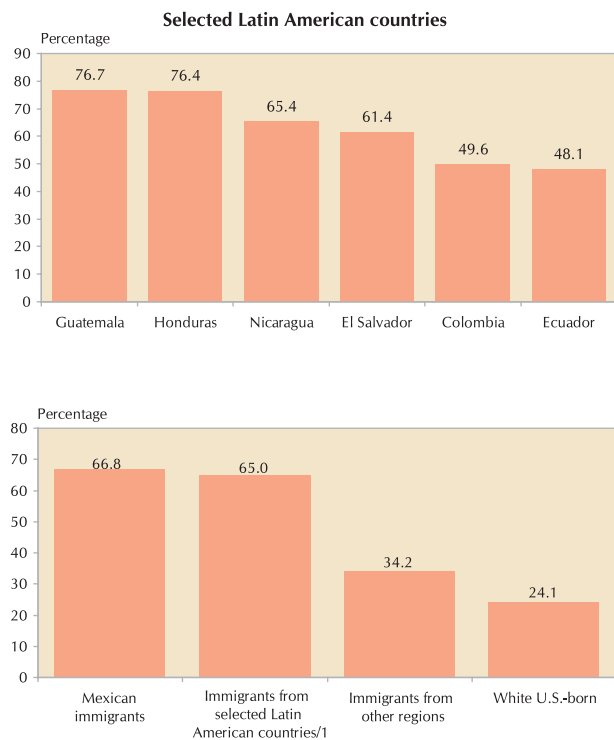
These stark figures indisputably demonstrate the exclusion of over half the Latin American population in general and the Mexican immigrant population in particular from the U.S. health system, as well as the over-representation of uninsured Latinos among the uninsured. Despite the size of this uninsured immigrant population, the primary burden of vulnerability still falls on the 47 million Americans without health insurance. The problem is mainly the result of a system that delegates much of the responsibility of providing health insurance to employers, who tend not to provide benefits for low-paid workers.

Health Insurance Coverage by Age Group

Both Mexican children and adults display high rates of lack of health insurance

An analysis of health care coverage by age group corroborates the disadvantaged situation of Mexican immigrants at various stages of the life cycle. With the exception of immigrants from other Latin American countries, who also display high

Figure 18. Low-income* Immigrant Population (from Mexico and Other Regions) without Health Coverage in United States, 2007

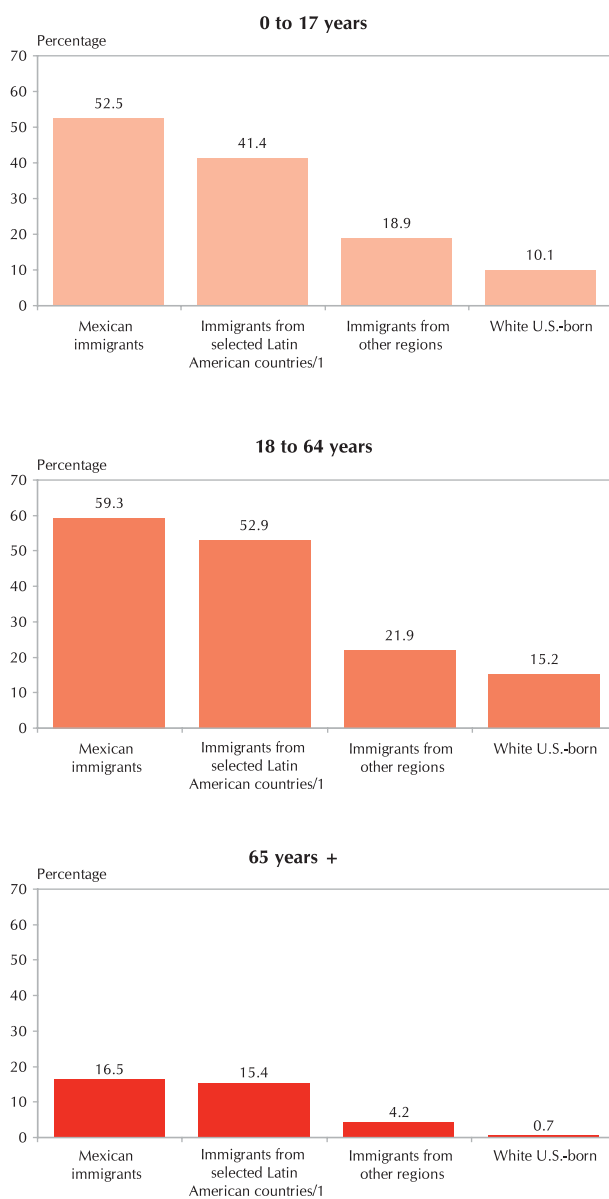


Notes: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 *Income below 150% of U.S. federal poverty line.
 Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

rates of lack of protection (albeit slightly more favorable), the extreme vulnerability of the Mexican-born population is obvious: over half of all Mexican children and adults lack health care coverage, while 16% of those over 65 lack coverage (Figure 19).

These figures are particularly serious if one looks at the actual numbers behind the percentages: approximately 600,000 Mexican-born children and youth, six million working-age adults, and over 100,000 senior citizens lack health coverage.

Figure 19. Immigrant Population (from Mexico and Other Regions) and White U.S.-Born Population without Health Coverage by Age Groups in United States, 2007

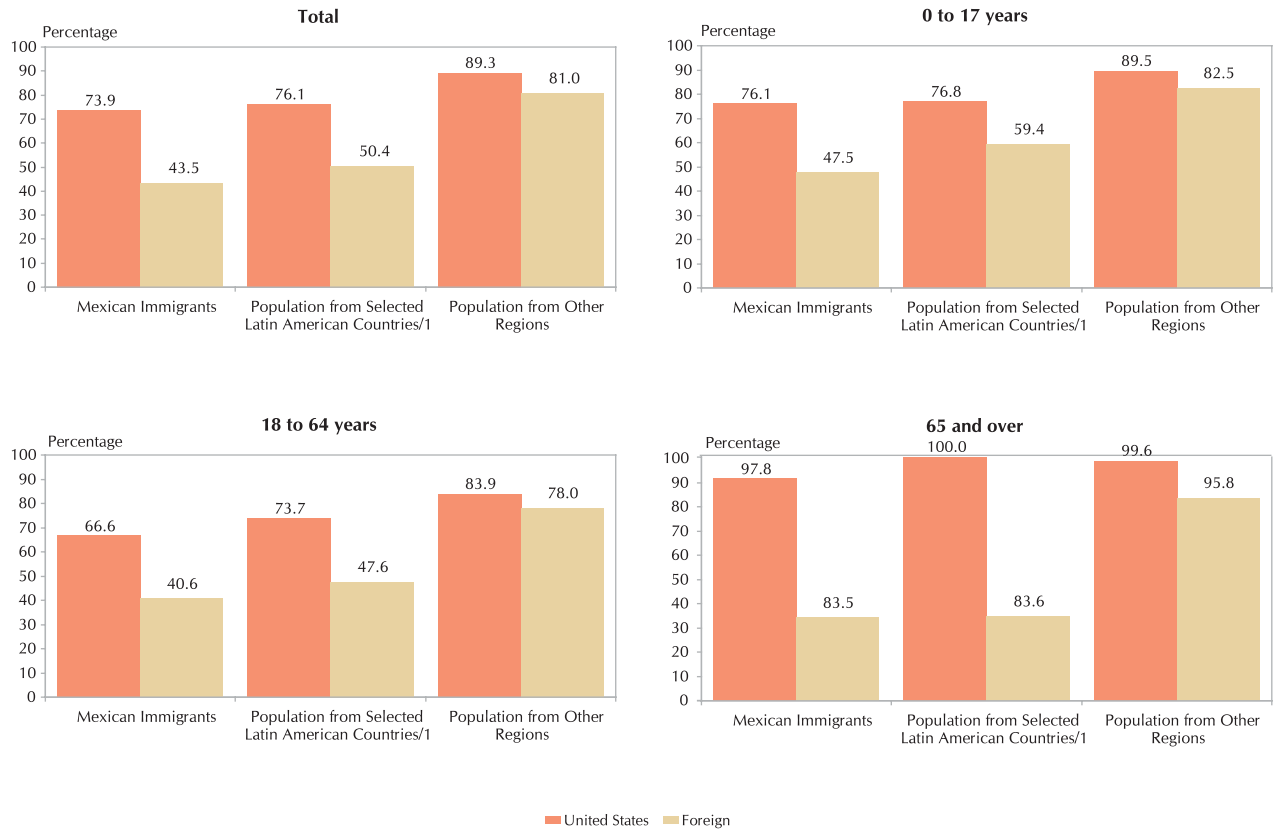


Note: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

Health insurance among the population of Mexican origin varies according to the country of birth; naturally, those born in the U.S. and those who are naturalized citizens have higher health coverage rates. Despite this, in all the age groups in the population of Mexican origin born in the United States the coverage levels are lower than for those of other

populations also born in the country (Figure 20). It is important to note the delicate situation of many Mexican families: a sharp inequality exists between the children, some of whom hold citizenship by virtue of having been born in the U.S. and therefore eligible for medical insurance, while others are ineligible, by virtue of having been born in Mexico.

Figure 20. Population with Health Coverage by Origin*, Place of Birth and Age Group Resident in United States, 2007



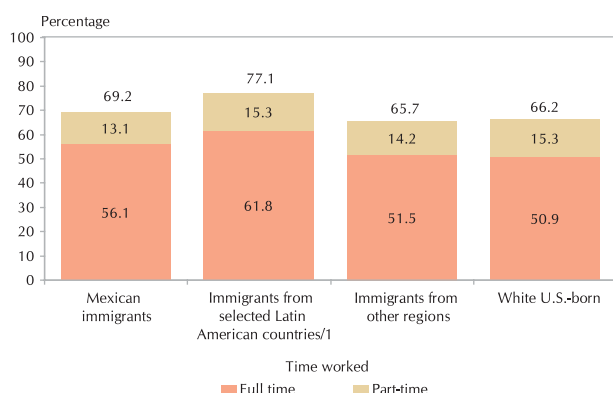
Notes: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 *Origin determined by parents' birthplace.
 Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

Types of Health Insurance

The vast majority of the uninsured Latin American adult population participate in the U.S. labor market

The limited health coverage of Mexican immigrants and other Latin Americans resident in the United States cannot be explained by low labor participation rates. More than two out of every three adults from Mexico and other countries in the region who lack health coverage participate in the U.S. labor market, usually on a full-time basis (Figure 21).

Figure 21. Employed Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population without Health Coverage by Work Shift in United States, 2007



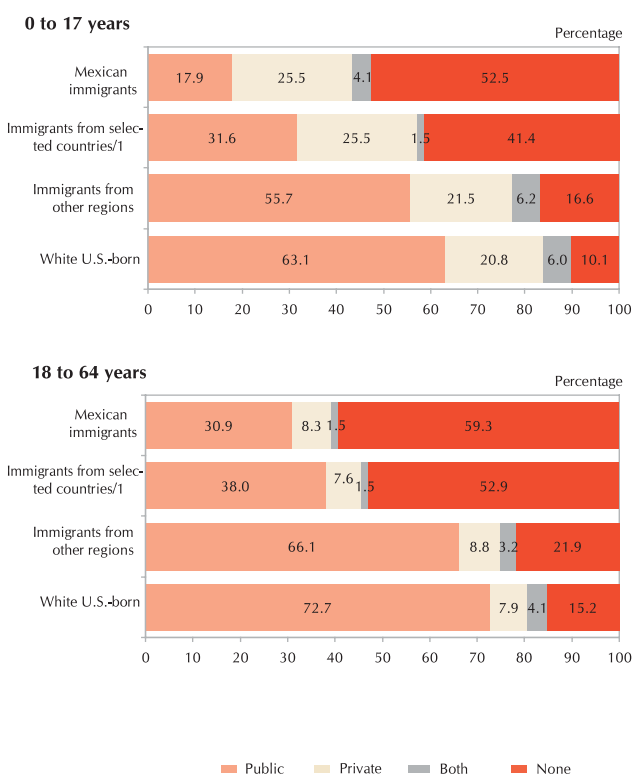
Note: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

Since Mexican and other Latin American immigrants are less likely to acquire medical insurance through their employer than other immigrant groups and native-born whites, because of the high cost of private insurance and their limited access to public health programs, they have high rates of lack of protection.

Only 18% of Mexican-origin children and youth and 31% of adults of the same origin have private medical insurance (Figure 22), obtained primarily through employment. Compared with the rates for immigrants from other Latin American countries and particularly those of immigrants from other regions (56% and 66%, respectively) and native-born whites, (63% and 73%, respectively), these rates are extraordinarily low.

Figure 22. Immigrant Population (from Mexico and Other Regions) and White U.S.-Born Population by Age Group and Type of Medical Coverage in United States, 2007



Note: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

The concentration of Latin Americans in jobs entailing certain risks exacerbates their vulnerability given their lack of health insurance

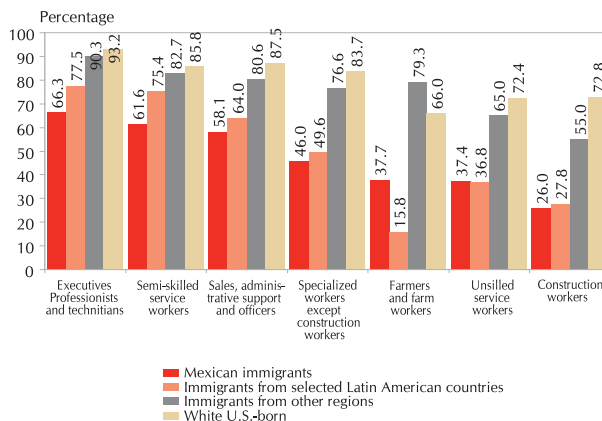
The possibility of obtaining health insurance through employment varies according to the type of occupation: workers employed in less skilled activities are harmed at a higher rate than those higher up on the occupational scale.

The low level of educational attainment and undocumented status characterizing a significant portion of Latin American workers contributes to their overrepresentation in low-paid activities, while relieving employers of the obligation to provide them with any kind of benefit.

Occupations in the construction industry, agriculture, and less skilled jobs—in which a high number of Latin immigrant workers are concentrated—are by far those with the highest rates of lack health insurance. Only 26% of Mexicans working in construction and 38% of those working in agriculture are insured, despite the fact that there is a high prevalence of work accidents in these sectors (Figure 23). Alarming, nearly half the victims of fatal work accidents among immigrant populations in the United States are of Mexican origin (Figure 24).

At the other extreme, professional and technical occupations are characterized by high levels of health insurance coverage, although the disadvantage among Mexican immigrants (66%) persists in relation to other populations (78%, 90%, and 93% among other Latin Americans, other immigrants and native-born whites, respectively). This suggests that the possibility of negotiating work benefits is determined, among other factors, by stereotypes about “Mexican labor,” which tends to be less highly valued than that of other population groups, particularly whites.

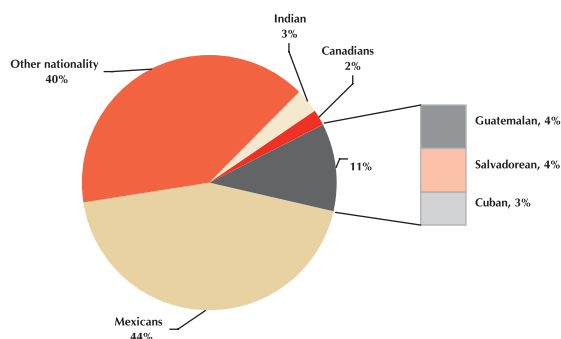
Figure 23. Immigrant Population (from Mexico and Other Regions) with Medical Insurance by Type of Occupation in United States, 2007



Note: */Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.
 Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

Figure 24. Work Risks among Immigrant Population in United States

Work-Related Fatal Injuries Suffered by Foreign Workers in the United States by Nationality of Origin, 2006



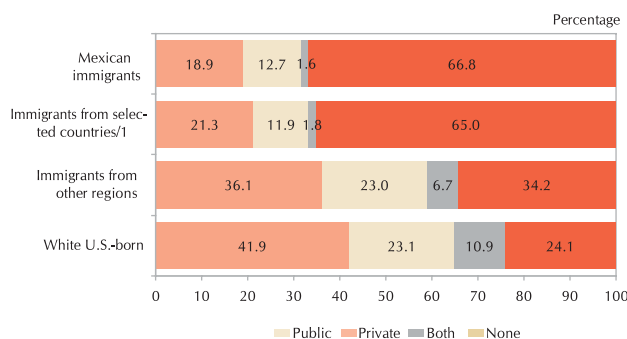
Source: U.S. Bureau of Labor Statistics, U.S. Department of Labor, 2007.

Lack of health insurance especially affects the Mexican population with the lowest income

Half the Mexican population resident in the United States with no health insurance is found in the low-income category. This population, however, has extremely limited access to federal programs dedicated to the health of the most disadvantaged populations: just one of five meet the eligibility criteria for public health insurance while 67% have no health insurance (Figure 25). This situation is shared by immigrants from other Latin American countries, which corroborates the socioeconomic disadvantages of the Latino population in the U.S.

U.S.-born population: 56% and 63% lack health insurance, while the figures corresponding to migrants of other nationalities and the white U.S.-born population are 28% and 18% respectively (Figure 26). Public health programs such as *Medicaid* and *Children’s Health Insurance Program (CHIP)* are crucial to guaranteeing the protection of children with scant resources. However, due to their migratory status (or that of their parents), Mexican-origin children and youth are characterized by having less access to public health programs (32% overall: 29% insured by a public program, 3% by private insurance) in comparison with immigrants from other regions and the white U.S.-born population.

Figure 25. Immigrant Population (from Mexico and Other Regions) and Low-Income* White U.S.-Born Population by Type of Medical Coverage in United States, 2007



Notes: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

* Income below 150% of US federal poverty line.

Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

It is also worth noting the extremely alarming condition that nearly one out of every four Mexican-born senior citizens living in poverty in the United States lacks any kind of health insurance. These Mexican-born senior citizens face numerous obstacles in gaining access to public health programs: only two out of every three have this type of coverage. The health status of this population —migrant, elderly, with scant resources— is extremely vulnerable since they are unable to obtain medical care services.

The pattern of unequal health insurance among younger Mexican and other Latin American immigrants who have scant resources is similar to that observed in other age segments of these two immigrant populations. Children and youth of Latino origin are at a severe disadvantage in relation to the comparable segments of the immigrant population from other countries, and above all, the white

Figure 26. Immigrant Population (from Mexico and Other Regions) and Low-Income* White U.S.-Born Population by Age Group and Type of Medical Coverage in United States, 2007



Notes: 1/Includes: Guatemala, El Salvador, Honduras, Nicaragua, Colombia and Ecuador.

* Income below 150% of U.S. federal poverty line.

Source: CONAPO estimates, based on Census Bureau, *Current Population Survey (CPS)*, March 2007 supplement.

Figure 27. Main US Government Health Programs

Program	Basic definition	Number of schemes under this name	Main eligibility criteria	Main eligibility criteria	Expanded Groups	Coverage/Basic Parts of Program Compulsory/ no premium	Optional / without premium
MEDICAID	The program provides medical benefits for low-income groups who lack medical insurance or do not have appropriate medical insurance. MEDICAID is a federal and/or state program, administered by each state, which sets its own rules of eligibility, services and coverage, within federal guidelines.	51 programs, one for each U.S. state, including the District of Columbia, in addition to the programs in US territories ¹ , all with different names.	Mainly as a function of income level, in addition to any of the following assumptions: 1- Low-income families with dependent children or minors who receive financial assistance through Social Security; 2- Children under 6 in low-income families; 3- Expectant mothers in low-income families; 4- Persons who due to age, blindness or disability, meet the eligibility requirements. The immigrant population also requires US citizenship and/or permanent legal residence of a minimum of 5 continuous years in the country.	Federal / State ² / Local ² .	Includes other populational groups ³ , which vary by state in the US.	Certain services must be covered by each state, in order to receive federal funds. 1- Hospital services for in-patients 2- Hospital services for out-patients 3- Antenatal care 4- Immunization for children 5- General medical services 6- Basic nursing services 7- Clinical laboratory and radiodiagnostic services 8- Diagnosis and treatment evaluations 9- Pediatric and family services by health experts 10- Durable medical equipment and medical care in the homes of eligible persons 11- Emergency transport, including ambulance services 12- Services in welfare home	There are additional optional services in the program and each state decides which services it wishes to include in its coverage. 1- Rural health clinics 2- Preventive diagnostic evaluations 3- Rehabilitation services 4- Emergency dental care and teeth 5- Terminally ill patient care 6- Hospital care for patients admitted for mental diseases 7- Medications with medical prescription (in and out patients)
State Children's Health Program (SCHIP)⁴	The program provides health benefits for certain children that meet the eligibility criteria. SCHIP is a federal and/or state program, administered by each state, which set their own rules of eligibility, services and coverage, within federal guidelines.	51 programs, one for each U.S. state, including the District of Columbia, plus the programs in U.S. territories ¹ , all with different names.	Mainly as a function of income level, in addition to any of the following assumptions: 1- Amedim most US states at children under the age of 19; 2- Despite the flexibility of U.S. states in setting income level to be eligible for the program, most of them cover children and/ teenagers in families on or below 200% of the federal poverty line 5 (FPL); 3- Uninsured children and/or minors of families whose incomes are too high to be eligible for MEDICAID but too low to be able to afford private medical services. The immigrant population also requires U.S. citizenship and/or permanent legal residence of a minimum of 5 continuous years	Federal when the SCHIP program is an extension of MEDICAID. State when the SCHIP program is independent of MEDICAID or the two are provided simultaneously.	Does not Include:	Certain services must be covered by each state, in order to receive federal funds. 1- General visits to the doctor 2- Immunizations 3- Hospitalizations and expenses derived from the latter. 4- Laboratory and radiodiagnostic services 5- Emergency medical visits 6- Certain prescribed medication 7- Dental treatment 8- Eye care 9- Durable medical equipment	There are additional optional services in the program and each state decides which services it wishes to include in its coverage.

Figure 27. Main US Government Health Programs

Program	Basic definition	Number of schemes under this name	Main eligibility criteria	Main eligibility criteria	Expanded Groups	Coverage/Basic Parts of Program Compulsory/ no premium	Optional / without premium
MEDICARE	MEDICARE is a federal health insurance program, only available for certain individuals who meet the eligibility criteria established by federal guidelines for their administration, services and coverage.	51 programs, one for each U.S. state, including the District of Columbia, plus programs from U.S. territories ¹ , all called "MEDICARE."	Mainly as a function of income level, in addition to any of the following assumptions: 1-. Persons ages 65 or over (automatic in Part 1); 2-. Certain persons under 65 with some form of disability; 3-. Individuals in terminal phase of renal conditions (permanent disorder requiring dialysis or kidney transplant). The immigrant population also requires U.S. citizenship and/or permanent legal residence of a minimum of 5 continuous years in the country.	Federal.	Does not Include:	<p>Part A—Hospital or Internment Insurance— 1-. Stays in hospitals or other authorized places 2-. Hospital services and supplies received during hospital stay 3-. Certain limited, reasonable forms of home health care 4-. Hospice care including: Care of persons at terminal stage for symptom control and pain relief, etc.</p>	<p>Part B—Medical Insurance— 1-. Medical care during hospitalization (fees) 2-. Outpatient medical care at hospital 3-. Laboratory and radiodiagnostic services 4-. Durable medical equipment (wheelchairs, oxygen tanks, walking frames, etc.) 5-. Specialized medical service. 6-. Partial psychiatric hospitalization 7-. Ambulance service 8-. Certain preventive diagnostic evaluations 9-. Certain services and types of care not covered by Part A</p> <p>Part C—MEDICARE Advantage. Provides coverage of Parts A and B of program and additional benefits not covered by these parts, in a private plan regardless of whether or not the person uses the medical services.</p> <p>Part D—Prescribed medication 1-. Prescribed medication and other essential supplies such as: syringes, needles, pads with alcohol, gauze, etc.</p>

Notes: 1/ US territories include: The Virgin Islands, Puerto Rico and islands in the Pacific (except Hawaii).

2/ State and local participation is voluntary.

3/ Includes other population groups in a broader sense, including: infants up to 1 year and expectant mothers not covered under certain rules regarding income level or rent set by each state; teenagers under the age of 21 according to more liberal criteria regarding families' income level and rent, certain disabled persons that work, among other groups.

4/ Information corresponds to SCHIP program financed with federal funds.

5/ According to the federal poverty line, determined by the US Health and Human Services Department.

6/ There is a private plan offered by insurance companies that supplements the original MEDICARE plan, called MEDIGAP which provides all the benefits of the original MEDICARE and accessory services, in addition to covering others, health care costs (deductible, co-insurance and other expenses in Parts A and B).

7/ The range of coverage in the various programs corresponds to federal norms and rules for coverages, which may vary from state to state or according to the coverage plan to which the beneficiary (ies) are entitled are entitled.

Source: Drawn up by CONAPO, on the basis of data from the US Health and Human Services Department.

Chapter III

Health Care Service Use and Health Insurance

Where social services are concerned, the United States is split mainly along ethnic and racial lines. Unequal access to health care services in the United States reflects social integration processes that differ largely according to these categories, together with their migratory status. In this respect, the Latino immigrant population as a whole is more vulnerable and unprotected than other groups. The relatively low level of integration of this population, particularly the Mexican population, into the larger society is correlated with fewer possibilities of visiting health care providers on a regular basis, which in turn negatively affects their health.

Health care insurance is the main means to obtaining periodic medical care services, in that it provides financial access to a broad range of preventive, diagnostic and treatment services. The lack of health insurance—a condition shared by a large segment of the low-income population—constitutes the main inhibitor of regular medical supervision.

Medical insurance does not usually cover the full cost of these services; part of the consultancy and prescription fees is directly absorbed by the patient through joint payments. These may be relatively high, particularly for the low-income population. Although people, by being covered by private or public insurance, nominally enjoy medical security, socio-economic disparities between groups lead to different health care practices—more services for some, fewer for others. There may be other disparities besides financial restrictions for low-income immigrant populations—cultural, linguistic, and legal barriers—that inhibit or prevent access to medical care.

Access to Health Services and Medical Insurance

Nearly half the Mexican population resident in the United States reports having no place to receive regular medical care

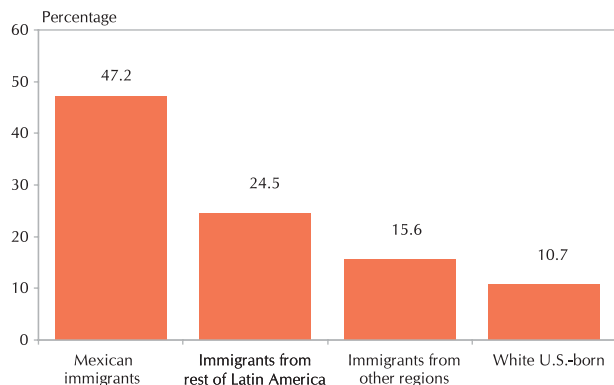
Staying in good health requires having a place or person to go to for regular health care. In this regard, there are sharp disparities between population groups, with Mexicans being in the relatively most disadvantaged position: nearly half do not have a regular source of medical care, contrasted with a quarter of the other Latin American immigrants,³ 16% of non-Latino immigrants, and 11% of the white U.S.-born population (Figure 28).

Mexicans' disadvantaged status cuts through all age groups, although it is important to note that the lack of regular medical care has different implications according to a person's stage in the life cycle.

The lack of health insurance coverage undercuts regular use of health care services, whether for the prevention, diagnosis, or treatment of illness. As noted at the outset, the weak link between a population and health service providers has a negative effect on their health status.

³ Unlike the previous chapters, which analyzed the status of a set of selected countries (Guatemala, El Salvador, Honduras, Nicaragua, Colombia, and Ecuador), in this chapter and the next the category called "rest of Latin America" refers to all Latin American countries except Mexico. The way this information has been handled is due to restrictions on the sources that prevent a significant statistical analysis differentiated by country.

Figure 28. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population with No Place for Regular Medical Care in United States, 2006



Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

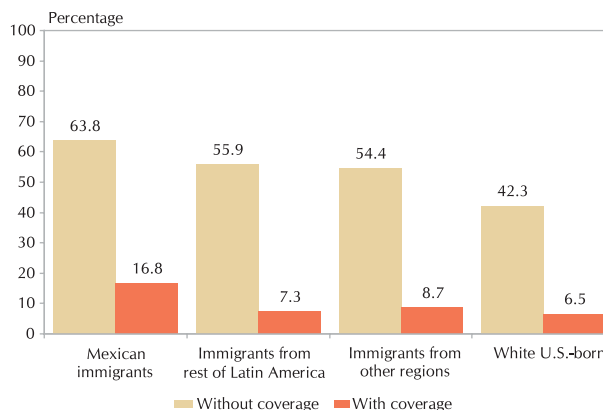
As we noted in Chapter II, the lack of health insurance mainly affects the most disadvantaged groups. People without health insurance are less likely to have a regular doctor. This is the case for 64% of the Mexican-born population, compared with other immigrant groups (approximately 55%) and the white U.S.-born population (42%) (Figure 29). The extremely low rate of regular medical service use among uninsured Mexican immigrants is probably not only linked to greater difficulty affording the cost but also to the fear associated with their lack of documents and to linguistic and cultural barriers.

Type of Medical Care Service

Mexican immigrants are less likely to be seen by private physicians

The quality of medical care received is closely linked to the type of source of medical care. Those attended by private physicians are more likely to receive better care than those that visit public health clinics or centers, since they establish more stable relationships with their doctors, from whom they receive more personalized treatment. The type of

Figure 29. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population with No Place for Regular Medical Care in United States by Medical Security Coverage, 2006

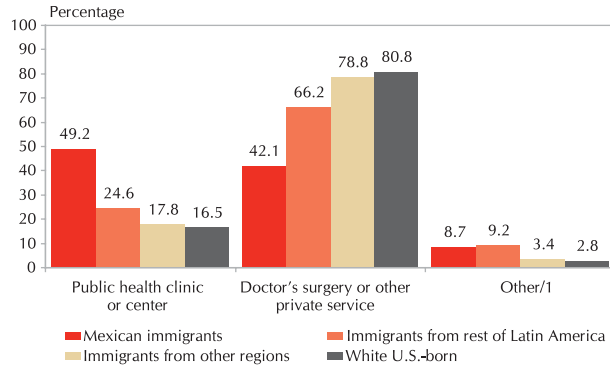


Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

health service used naturally reflects the prevailing socio-economic disparities between population groups. Almost a majority of Mexicans with a regular source of health care rely on public centers or clinics (49%). The proportion regularly receiving private medical care (42%) is significantly lower than that of other Latinos (66%), immigrants from other regions (79%), and the white U.S.-born population (Figure 30). These figures reflect social inequalities in the health care system, whereby the most disadvantaged groups often receive less personalized and less specialized medical supervision.

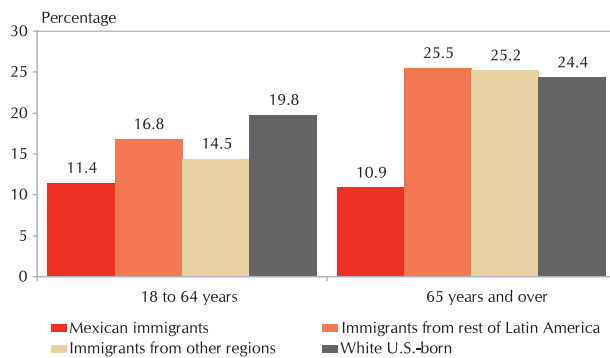
A common myth is that immigrant populations without either medical insurance or a regular source of medical care are more likely to use emergency services. The low rate of use of these units by Mexican-born immigrants (11%) in relation to other populations belies this, even though their occupations make them more exposed to work accidents, some of which are fatal (Figures 31 and 24).

Figure 30. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population by Source of Medical Care in United States, 2006



Note: 1/Other emergency unit, outpatient department of hospital and other places.
 Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Figure 31. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population Ages 18 and Over that Uses Emergency Hospital Units in United States, 2006



Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

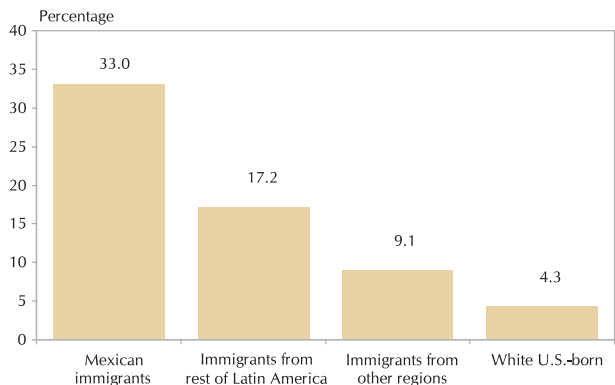
Children and Teenagers

Preventive and primary medical care

One in three Mexican children and teenagers does not have a place to go to for regular medical care

Childhood and adolescence are stages in the life cycle that require continuous, integral medical supervision. A third of Mexican-born children and teenagers have nowhere to receive regular medical care, which prevents the consistent monitoring of their physical and intellectual development and state of health. The greater vulnerability of this group is particularly noticeable: it is nearly double the rate of other Latin American immigrants, more than triple that of immigrants from other regions, and nearly 30 percentage points higher than that of white U.S.-born children and teenagers (Figure 32).

Figure 32. Under-18 Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population with No Place for Regular Medical Care in United States, 2006



Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Nearly half of all Mexican children and teenagers fail to meet the minimum standard for regular medical check-ups

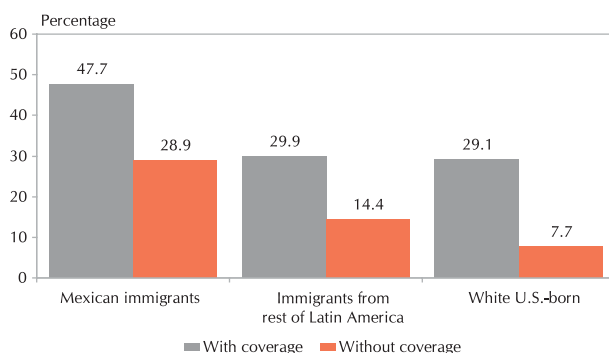
The regularity with which children and teenagers use medical services provides a significant indicator of their health care. The American Academy of Pediatrics emphasizes the importance of these groups' having continuous care within a context of integral health care. This organization recommends that children over the age of two years pay at least one visit to the doctor a year to prevent health problems.⁴ Those that meet this requirement are assumed to benefit from regular preventive practices that have a favorable effect on their physical and intellectual health (immunizations, growth checks, etc.) as well as their lifelong health status.

Nearly half the Mexican children (over two) and teenagers living in the United States fail to meet the minimum standards for the regularity of medical check-ups. As a consequence, they are more exposed to the risk of failing to cope with illness at an early stage or of experiencing development problems that in the long term may affect their physical and academic development, making them extremely vulnerable to health-related problems.

The lack of health insurance coverage is reflected in a greater failure to meet these standards among all the populations analyzed, but it is particularly evident for the Mexican immigrant population: 48% had either not visited a doctor or visited one after the scheduled date (Figure 33). At the same time, in comparison to other populations, the low proportion of insured Mexican children and teenagers who received timely check-ups suggests that the financial limitations on being able to cover their portion of medical expenses are a determining factor.

It is worth pointing out the extremely alarming situation of all those who have never seen a physician since coming to the United States. This situation affects 78,000 Mexican children and teenagers living in the United States, the majority of whom (68%) lack medical insurance.

Figure 33. Immigrant (from Mexico and Other Regions) and White U.S.-born Population Ages 2 to 17 in United States that Did Not See a Doctor in the Last Year by Medical Security Coverage, 2006



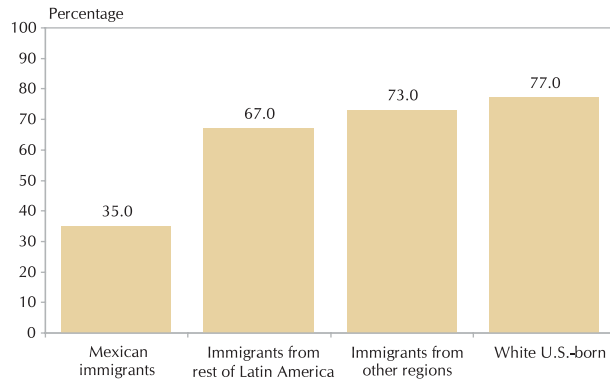
Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Mexican children and teenagers pay very few visits to the dentist

Routine dental check-ups constitute a significant indicator of a population's preventive and palliative health actions. Available data show that, compared with other groups, Mexican children and teenagers are unlikely to go to the dentist, thereby hampering the early prevention, diagnosis, and treatment of dental disease. Only 35% of Mexicans in this age group visit dentists more than once a year, nearly half the proportion for Latinos (67%), immigrants from other regions (73%), and the white U.S.-born population (77%) (Figure 34). Once again, having health insurance has a positive effect on the frequency of visits to the dentist.

⁴ The American Academy of Pediatrics recommends a higher number of visits for children under the age of 24 months.

Figure 34. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population Ages 2 to 17 in United States that Saw a Dentist in the Last Year in the United States, 2006



Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Working-Age Adults and Senior Citizens

Preventive and primary medical care

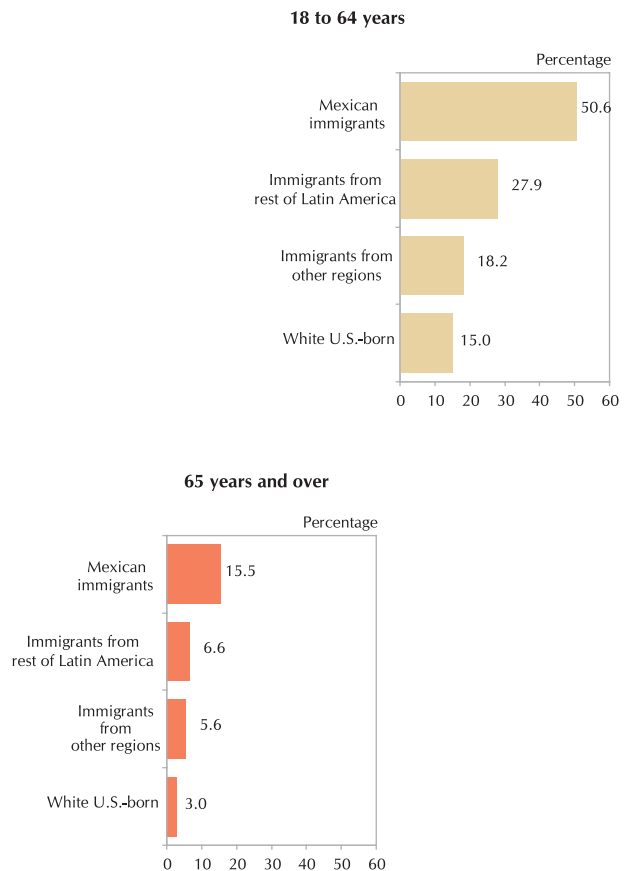
Mexican working-age adults and senior citizens are less likely to have regular medical care

In comparison with other population groups within the same age range, Mexican working-age immigrants are far less likely to have a regular source of medical care in the United States, reflecting the existence of sharp disparities in the opportunities to benefit from continuous, consistent check-ups. Half do not have a regular place to go to receive health care, while the proportions for other Latin American immigrants, immigrants from other regions, and the white U.S.-born population are 28%, 18%, and 15%, respectively (Figure 35).

The same comparison for senior citizens corroborates Mexicans' relative disadvantage: 16% do not have a regular place for health care, versus 6% of all other immigrants and 3% of the white U.S.-born population (Figure 35).

Although Mexican senior citizens are more likely to have a regular source of medical care than working-age adults in the same population, this group is at a stage of life at which health status deteriorates more quickly and chronic-degenerative diseases develop. Consequently, problems associated with the lack of continuous, consistent medical care increase when the population ages.

Figure 35. Under-18 Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population with No Place for Regular Medical Care in United



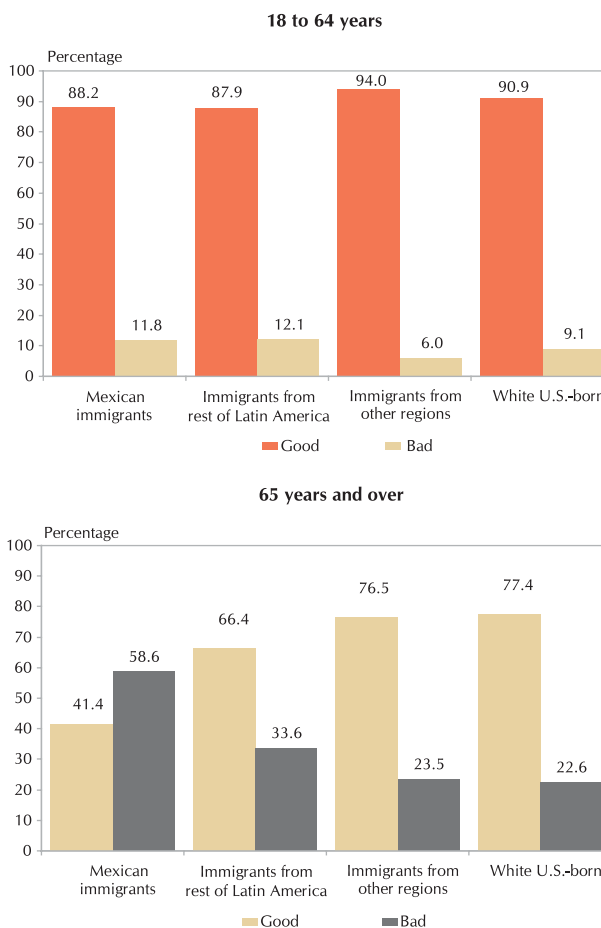
Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Unlike the working-age adult population, most of the Mexican senior citizen population regards itself as having health problems

In the United States, the regularity with which adults seek medical services is closely linked to their perception of the state of their health. One would expect visits to the doctor to be more frequent when a person notices that he has health problems and less frequent when a person regards his state of health as being good or excellent. This study considers that spacing medical consultations less than six months apart constitutes a minimum for those reporting an average or poor state of health. Conversely, the minimum standard for those who regard themselves as having good or excellent health is a visit to the doctor every two years⁵ for the adult population, and every year in the case of senior citizens.

No significant differences were found between the various populations regarding adults' perception of their state of health: only about one in 10 reported having average or bad health. There were, however, differences among the older population: almost 60% of Mexican senior citizens (corresponding to just over 5% of the total number of Mexicans in the country) believed they had health problems, compared with 34% of Latin American immigrants and over a fifth of immigrants from other regions and the white U.S.-born population that evaluated themselves in this way (Figure 36).

Figure 36. Employed Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population by Health Perception, 2006



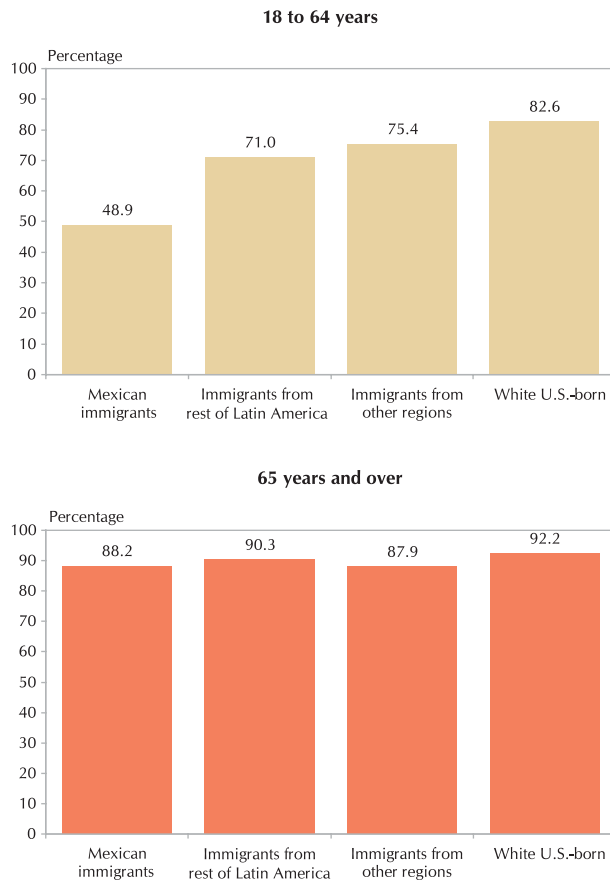
Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Uninsured Mexican adults with health problems are less likely to receive timely medical care

Mexican working-age adults who regard their state of health as average or poor are much less likely than comparable adults in other population groups to consult a doctor within a short space of time: fewer than half pay a visit to the doctor within six months of making this evaluation of their health status, which is much lower than the figure for other immigrant populations and the white U.S.-born population (Figure 37).

⁵ This criterion is based on the recommendations of the American Medical Association and other related associations.

Figure 37. Employed Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population who Perceived their Health as Average or Poor and Visited the Doctor over the Past Six Months in United States, 2006

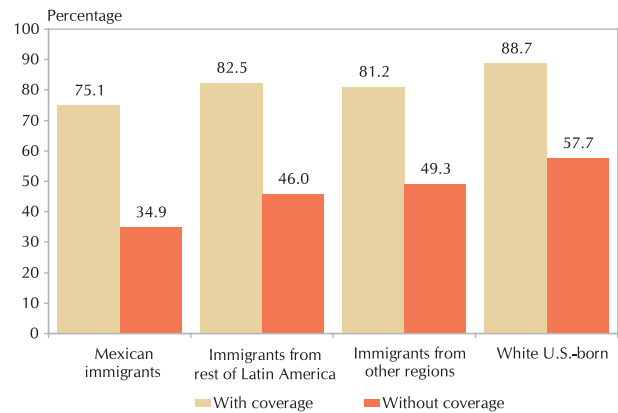


Source: CONAPO estimates, based on *National Health Interview Survey* (NHIS), 2006.

Across the analyzed working-age populations, having medical insurance encourages those covered to act on their sense of impaired health and make a doctor’s appointment earlier than those who have no coverage (Figure 38). The statistics also suggest that U.S.-born Mexicans, particularly the uninsured among them, are less likely to see a doctor in a timely manner as defined. Over 75% of the insured Mexican 18-to-64 population that regarded itself as having average or poor health visited a doctor within six months of their self-evaluation, while the percentage for the uninsured

among this population of the same origin is just 35%. These figures reconfirm the greater vulnerability of the Mexican-born population.

Figure 38. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population ages 18 to 64 who Perceived their Health as Average or Poor and Visited the Doctor over the Past Six Months in United States, 2006



Source: CONAPO estimates, based on *National Health Interview Survey* (NHIS), 2006.

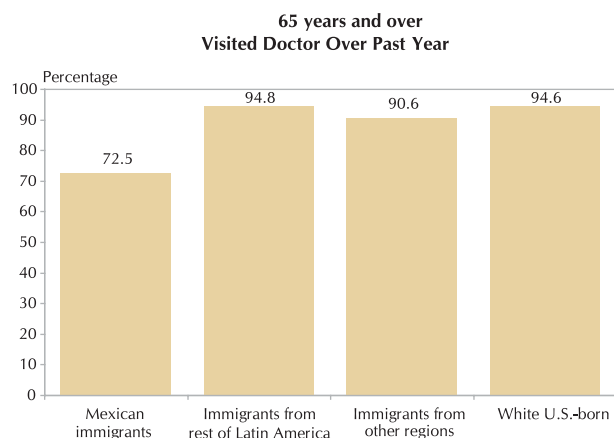
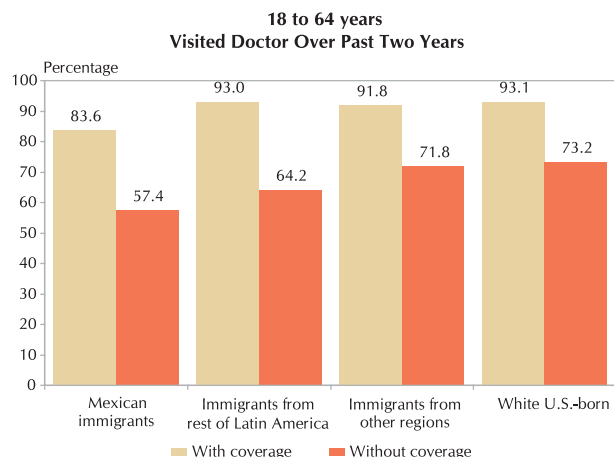
Mexicans who regard themselves as having good health pay fewer visits to the doctor

Among adults who regard themselves as having good health, Mexicans, particularly those lacking medical insurance, constitute the group that pays the fewest visits to the doctor within two years (84% among the insured and 57% among the uninsured) (Figure 39).

Among those who consider themselves to be in good health, Mexican seniors are also less likely to go in for medical check-ups within the recommended period of time: only 73% receive medical care within a period of less than a year, in contrast to over 90% for each of the comparison groups.

Conversely, there is a significant proportion of Mexican working-age adults who report being in good health but who have not had their check-ups

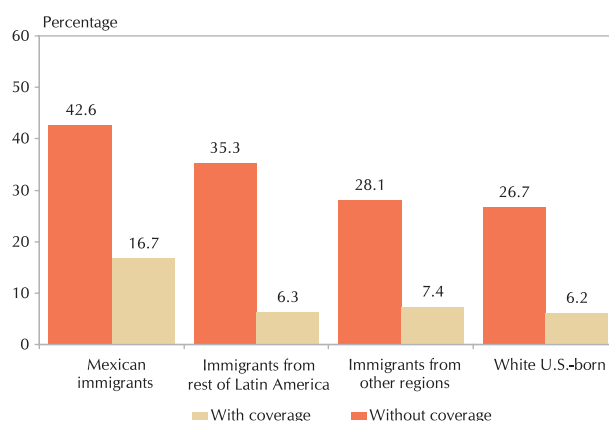
Figure 39. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population that Regards Itself as Being in Good Health, 2006



Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

during the recommended period of time (17% of those with medical insurance and 43% of those without) (Figure 40). The same is true of 28% of the Mexican senior citizen population. This translates into greater exposure to risk through failure to prevent the early stages of cardiovascular disease, diabetes, cancer, and other types of diseases that have a high prevalence among Mexicans.

Figure 40. Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population ages 18 to 64 that Regarded Itself as Being in Good Health and Did Not Visit the Doctor over Past Two Years, 2006



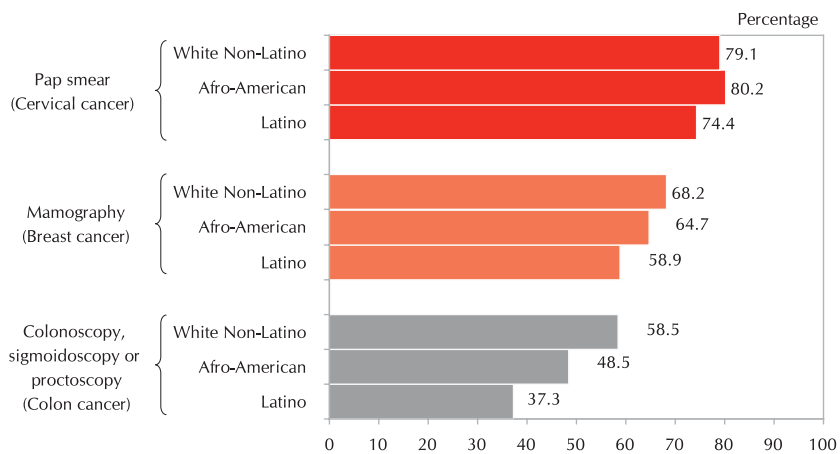
Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Cancer screening tests

Latinos have less frequent cancer screening tests

The disparities in access to health care described earlier are also reflected in the scale and nature of actions undertaken to prevent the occurrence of cancer. The Latino population in the United States is less likely to have early cancer screening tests done (Figure 41) relative to the comparison populations. As noted, these epidemiological differences between groups result from and express other forms of social inequality in the United States.

Figure 41. Early Cancer Screening Tests, 2005



Note: Men and women ages 50 and over who have never reported having a colonoscopy, sigmoidoscopy or proctoscopy or have had a fecal blood examination over the past 2 years. Women ages 40 and over who had a mammography within the past two years. Women ages 18 and over who had a pap smear within the last three years.

Source: Drawn up by CONAPO, based on the *National Healthcare Disparities Report, 2007*.

Chapter IV

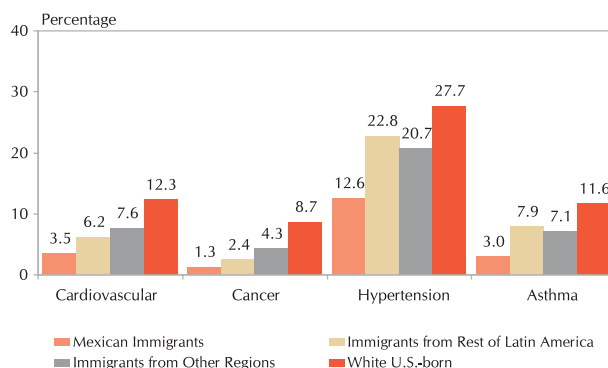
Illness

Prevalence of illness

Mexican immigrants have more positive health indicators than other populations

The statistics available on a broad range of illnesses suggest that Latin American immigrants to the United States, particularly Mexicans, are in better health than other population groups.

Figure 42. Diseases of Immigrant Population (from Mexico and Other Regions) and White U.S.-born Population Ages 18 and Over in United States, 2006



Source: CONAPO estimates, based on National Health Interview Survey (NHIS), 2006

For example, the data on cardiovascular disease and cancer —two leading causes of death among Latinos in the United States— as well as hypertension and asthma, reflect a lower prevalence of these diseases among Mexican immigrants than other Latin American immigrants, immigrants from other regions, and the white U.S.-born population (Figures 42 and 43).

The Mexican-born population’s good health relative to that of other groups, if one judges solely according to the statistics, is somewhat paradoxical, and to a degree misleading, for several reasons. In other words, the prevalence may be higher than the statistics suggest. Generally speaking, on their arrival in the United States, immigrant populations have better health indicators than the local population. A generally accepted explanation is that the migratory process is demanding and self-selective by nature, and that those that migrate are likely to be fitter in the first place. Over time, however, immigrants tend to acquire a culture of unhealthy habits, characteristic of the society they have entered, which in turn has a negative effect on their health.

The appearance of a paradox is heightened when one considers that there is also a close relationship between socio-economic level, medical security, and state of health (see Chapter II). Given their low income levels and limited health coverage, one would expect Mexican immigrants in the United States to have poorer health than they do, particularly those that have spent a long time in the country. This, together with the lower frequency

Figure 43: Main Causes of Death by Ethnic Group. United States, 2005

Rank	Total	Latino	White Non-Latino	Afro-American Non-Latino	Asian/Pacific	Native American
1	Heart disease	Heart disease	Heart disease	Heart disease	Cancer	Heart disease
2	Cancer	Cancer	Cancer	Cancer	Heart disease	Cancer
3	Cerebro-vascular diseases	Accidents	Cerebro-vascular diseases	Cerebro-vascular diseases	Cerebro-vascular diseases	Accidents
4	Chronic lower respiratory diseases	Cerebro-vascular diseases	Chronic lower respiratory diseases	Accidents	Accidents	Diabetes
5	Accidents	Diabetes	Accidents	Diabetes	Diabetes	Cerebro-vascular diseases

Source: Drawn up by CONAPO, on the basis of CDC/NCHS, *National Vital Statistics System*, 2008

and lack of timeliness with which Mexicans receive medical care (see Chapter III), suggests that the prevalence of illness among this population has been underestimated.

Further support for an underestimation of illness in this population may also come from the effects of return migration. Some of the effects of failing to take proper care of one’s health in the United States might be observed in Mexican territory once older migrants return to their communities of origin. If that is the case, illnesses among the Mexican-born immigrant population in the U.S. would be in a sense “masked”—recorded in and reflected by Mexican rather than U.S. epidemiological statistics.

Lastly, one should recall that given the enormous vulnerability of Mexican immigrants in the United States, other actors are playing the role of health providers, thereby helping fill the gap left by the U.S. health system. These include community clinics, health promoters and churches that foster health care among the Latino population, including those whose migratory status makes them ineligible for public programs designed to target the most vulnerable groups. Foremost among these

is the Health Initiative of the Americas,⁶ which has implemented various strategies to improve migrants’ quality of life in the United States, including the mobilization of networks to provide health services, train resources and develop research projects to increase knowledge of the Latino population’s health status. The Mexican government has also promoted a number of binational initiatives and implemented a series of programs designed to meet the health needs of the Mexican-born population in the United States.⁷

Despite their good “state of health,” empirical evidence exists to show that Latin American immigrants, particularly Mexicans, experience a high prevalence of certain chronic and infectious diseases—such as diabetes, HIV/AIDS, and tuberculosis—that require lifelong care. The effective management of these diseases requires continuous, integral medical care.

⁶ School of Public Health, University of California, Berkeley.

⁷ Key examples include the Binational Health Week and the Health Window Program.

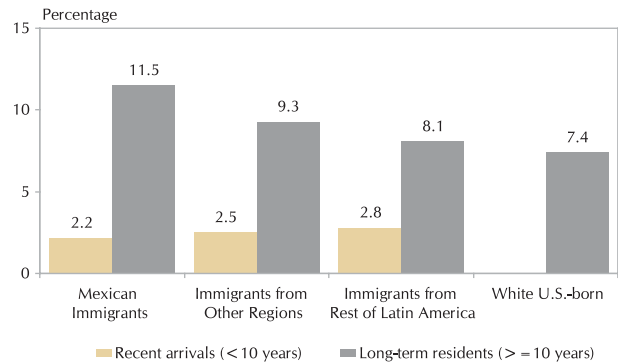
Diabetes

Although U.S. data on national coverage provide extremely limited information on certain chronic and infectious diseases that mainly affect certain immigrant groups, it is possible to undertake a comparative analysis of the prevalence of diabetes between different populations. The prevalence of diabetes is particularly high among Mexican immigrants who are long-term residents in the United States (12%), even higher than among the U.S.-born population (over 7%). At the same time, only 2% of recent Mexican arrivals (i.e., within the last 10 years) report suffering from this disease, which is lower than the figure for other immigrants with a similar period of residence in the country (Figure 44). This suggests that poor eating habits acquired in the United States, combined with the lack of routine medical check-ups, have triggered the development of diabetes among this population.

Diabetes is an extremely serious disease, requiring lifelong management. Without proper treatment and control, diabetes sufferers are likely to develop severe complications such as blindness, leg amputations, and cardiac and kidney disease. In fact, this is the fifth leading cause of death among Latinos in the United States (Figure 43). That is why continuous monitoring of the evolution of this disease is crucial to preventing these complications. The number of A1c hemoglobin analyses, sight tests, and other clinical studies carried out among diabetic Latinos in the U.S. is alarmingly low⁸ (Figure 45).

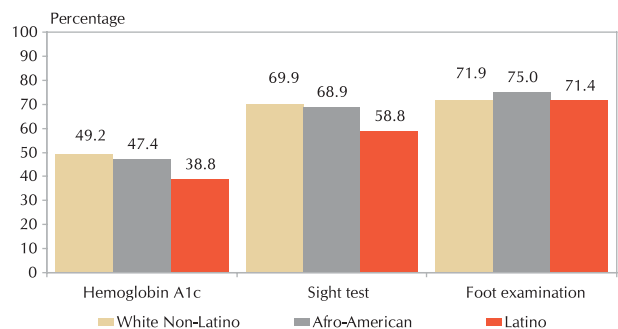
⁸ Due to the shortage of information on illnesses that affect Mexican and Latin American immigrants –populations analyzed in the previous chapters– in this chapter, it was decided to include information on the Latino population resident in the United States which, strictly speaking, includes both Latin American immigrants and the population of this origin born in the U.S.

Figure 44. Diabetic Population Aged 18 and Over in United States, 2006



Source: CONAPO estimates, based on *National Health Interview Survey (NHIS)*, 2006.

Figure 45. Recommended Tests for Diabetic Population in United States, 2004



Source: Drawn up by CONAPO, based on the *National Healthcare Disparities Report*, 2007.

Given their lower rates of medical supervision, it is hardly surprising that Latinos in the United States, together with Afro-Americans, have the highest admission rates to hospitals due to serious complications derived from uncontrolled diabetes (Figure 46). The sharp disparity in diabetes-related leg amputation rates between minority groups such as

Latinos and the white U.S.-born population clearly reflects the lack of effective diabetes monitoring (Figure 47).

Accidents

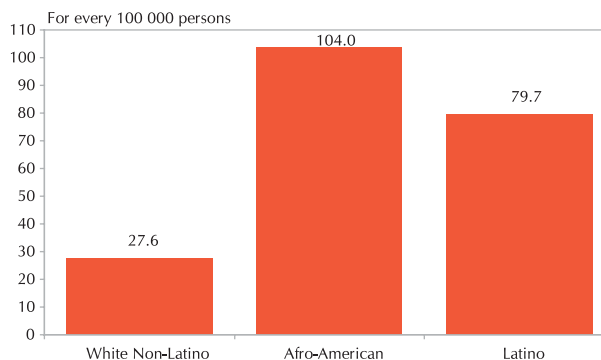
Mexican immigrants are more likely to suffer fatal work accidents

Accidents constitute the third leading cause of death among the Latino population in the United States; many of these accidents occur in the workplace. This is partly due to the fact that Latin Americans and Mexicans—who constitute the largest immigrant contingent in the country—are more exposed to negligence in workplace safety, particularly in the case of undocumented immigrants.

This is borne out by the available data on workplace accidents involving immigrants: nearly half the victims are of Mexican origin, while 11% are from Central America and 6% from South America (Figure 48).

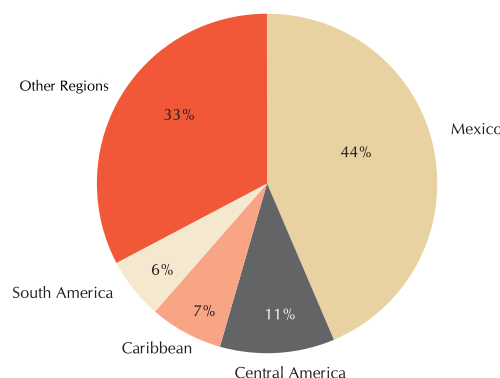
This reflects the increasing vulnerability and lack of work safety among the Latino population in the United States, expressed in the steady increase in work-related deaths. The number of deaths among this population has doubled over the past 15 years, totaling 908 in 2007 (Figure 49). Nearly two-thirds involved the foreign-born population. This bucks the national trend: the 5488 deaths reported in 2007⁹ reflect a 13% decline in the number of deaths reported in 1992 (6217) (Figure 49). These figures are even more alarming when one considers that the group of Latinos (both foreign- and U.S.-born) that died from a work-related accident in 2007 accounted for 17% of the national total, while the 607 Latin American immigrant workers that died in the workplace accounted for 11%.

Figure 47. Admission Rate to Hospitals for Leg Amputations due to Complications Derived from Uncontrolled Diabetes, 2004



Source: Drawn up by CONAPO, based on the *National Healthcare Disparities Report*, 2007.

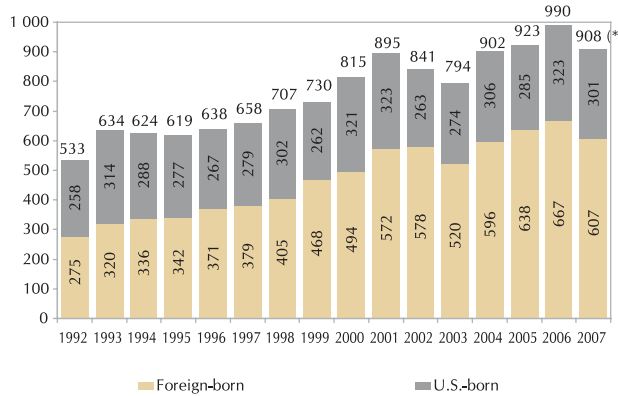
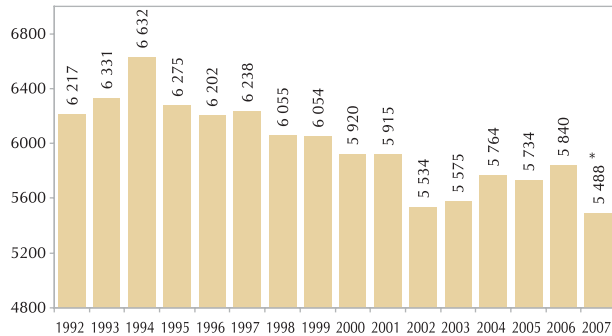
Figure 48. Distribution of Work-related Deaths of Foreign-born Population Resident in United States by Region or Country of Birth, 2007



Source: U.S. Bureau of Labor Statistics, U.S. Department of Labor, 2008.

⁹ Preliminary data.

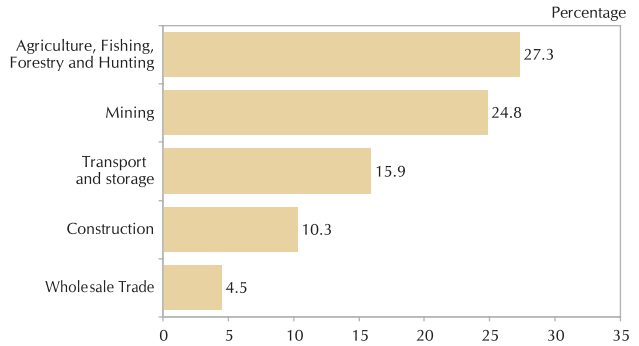
Figure 49. Number of Fatal Accidents among Workers in United States, 1992-2007



*/Preliminary data
Source: Drawn up by CONAPO, based on the *National Healthcare Disparities Report*, 2007.

The high prevalence of fatal work accidents among the Latino population in the United States is closely linked to their unfavorable work conditions and their concentration in the worst-paid sectors of the labor market, which tend to be high-risk and offer workers less in terms of social protection and work safety. These include certain jobs in the agricultural, mining, transport, and construction sectors, in which fatal accidents occur at a higher rate (Figure 50).

Figure 50. Number of Fatal Occupational Accidents by Sector of Activity, United States, 2007



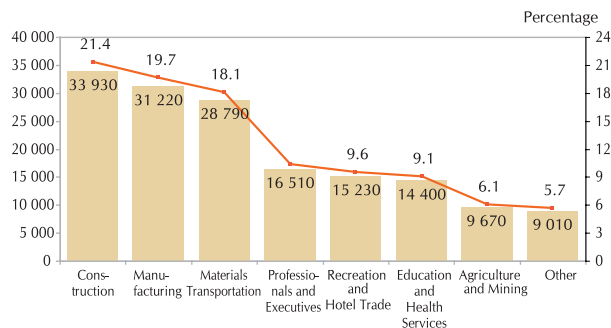
Source: U.S. Bureau of Labor Statistics, U.S. Department of Labor, 2008.

Many Latinos engaged in farm and construction work are victims of non-fatal work-related accidents and diseases

Nearly 60% of work-related injuries and illnesses affecting the Latino population in the United States occur in just three low-wage sectors: construction (21%), manufacturing (20%), and materials transportation (18%) (Figure 51). Since these sectors employ a large number of Mexican immigrants, one can safely assume that a significant proportion of victims are also Mexican-born.

This does not lessen the fact that a disproportionately large percentage of the Latino labor force have suffered work-related injuries or illness in the agriculture and mining (37%) and construction sectors (22%) in relation to the total number of victims in these sectors nationwide (Figure 52).

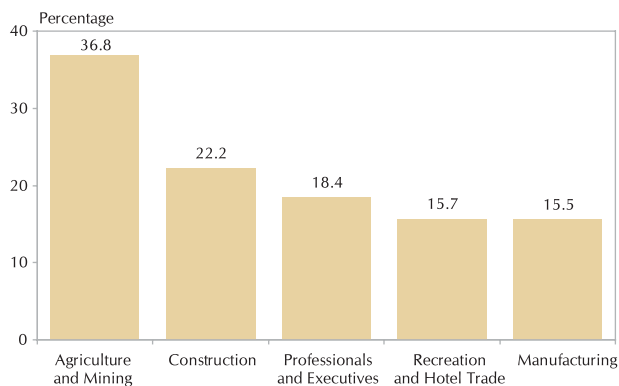
Figure 51. Occupational Injuries and Illness of Latino Population Forcing Them to Miss Work, 2006



Source: Drawn up by CONAPO, based on Bureau of Labor Statistics, U.S. Department of Labor, *Survey of Occupational Injuries and Illnesses* in cooperation with participating state agencies.

The risk of work-related accidents is much higher among Latino immigrants. Moreover, many lack health insurance, which in turn makes it more difficult for them to obtain health care (Chapters II and III). At the same time, they are ineligible for disability benefits. Undocumented Latino immigrants who have accidents, most of whom are Mexican, experience gross negligence on the part of their employers and are forced to pay for the consequences of these accidents with their own, limited resources. The current health care system, which delegates the responsibility for work benefits to employees and fails to enforce compliance with labor laws, jeopardizes a universally acknowledged human right: the right to protection in the workplace.

Figure 52. Percentage of Latinos with Occupational Injuries and Illnesses of Total of Each Sector of Activity in United States, 2004



Source: Drawn up by CONAPO, based on Bureau of Labor Statistics, U.S. Department of Labor, *Survey of Occupational Injuries and Illnesses* in cooperation with participating state agencies.

Chapter V

Final Considerations

The extraordinary increase in Latin American immigration to the United States in recent decades has had a profound impact on the demographic profile of U.S. society, with Latinos becoming the country's largest ethnic minority.

This change in the face of the United States has elicited considerable concern in society. One of the thorniest issues has been the largely undocumented nature of Latin American immigration in general and Mexican immigration in particular. This is largely the result of a migratory policy that fails to recognize the real need for Latin American workers in the U.S. economy, particularly in activities at the base of the occupational pyramid. In response to pressure from public opinion and certain political sectors to the possible costs associated with mass migration from Latin America, mainly Mexico, the United States has opted for a policy that attempts to dissuade migratory flows by law and force, which has had unexpected, unwanted consequences: these measures have failed to stem the flow of undocumented migration and a sizable Latino community has developed in the country, albeit with high rates of marginalization.

Unequal access to health services in the United States reflects social integration processes that differ according to ethnic group or race and migratory status. According to the statistical information in this report, the limited socio-economic integration of the Latino population in the United States correlates with the exclusion of a large sector of the population from the health system. Mexican immigrants, by far the largest foreign group in the country, but with a sizable undocumented sector, low rates of citizenship and poor integration into the work force, constitute the most marginalized population group among immigrants and are therefore

least likely to have health coverage. This situation contrasts with the high levels of health coverage of immigrants from other regions and the white U.S.-born population.

This is the result of a social security system that delegates much of the responsibility for health provision to the private sector, while the state's responsibility is based on a series of public programs targeting the poorest, most vulnerable groups that meet certain eligibility criteria. The lack of health insurance coverage among the Latino population in the U.S., particularly the Mexican immigrant population, is linked to their predominance in unskilled, poorly paid jobs, which do not usually enjoy employee benefits. The least protected group comprises undocumented workers, who are relegated to jobs that are not highly valued economically in which they have very little scope for negotiating employment benefits. The acute vulnerability of Mexican workers in agriculture and construction is particularly alarming, since only a small proportion have medical insurance, despite the high rate of often fatal accidents in these sectors.

Public programs targeting low-income families could offset the effects of a system that leaves health provision up to employers. Immigrant populations, however, particularly the Mexican population, face severe obstacles in gaining access to these programs, since the social security law requires either citizenship or proof of legal residence in the country for a minimum of five years. To a certain extent, these measures attempt to serve as form of migratory control, since they are based on the misguided assumption that migration to the United States is largely fueled by the search for social benefits. Although these regulations have obviously failed to dissuade immigrants who are mainly attracted by

work opportunities, they have exacerbated the already unequal access to health, not only between different ethnic groups, but also within each group and, even more dramatically, within families with mixed migratory status.

Given the lack of health insurance coverage of a large number of immigrants from Mexico and other Latin American countries -provided either by their employers or public programs- and the unaffordability of individual health insurance, these groups are likely to experience acute financial crises in the event of illness or serious accidents, or admission to hospital. Given this scenario, these migrants obviously tend to postpone seeking treatment for an illness or an accident for as long as possible.

Lack of health insurance coverage constitutes the main inhibitor of regular access to U-S. health services. Good health – a universally acknowledged right- is therefore undercut by the difficulty of obtaining timely preventive services, diagnoses or treatment for illness. More than any other group, immigrants with low income levels experience enormous difficulty in receiving proper health care at the various stages of the life cycle. Particularly problematic is the lack of regular medical check-ups for a large number of Mexican children and teenagers, which increases the risk of failing to obtain timely treatment for possible illnesses or problems of physical and intellectual development. Even more alarming is the case of the nearly 80,000 Mexican children and adolescents who have not paid a single visit to a physician during their time in the United States. The long-term consequences could be severe. The exclusion of migrant children and adolescents from basic health programs makes

this sector of the population extremely vulnerable, as well as compromising their future development and health.

Lastly, the paradox regarding Latin American immigrants' health indicators, which are apparently more favorable than those of other populations, can be partly explained by the fact that this population's illnesses are likely to be under-registered, due to their lower use of health services. At the same time, some of the effects of neglecting one's health in the United States might be felt in their own countries, once older migrants return to their communities of origin. Nevertheless, there is empirical evidence of the high prevalence of certain chronic diseases among the Latino population as in the case of diabetes, often not properly monitored during their stay in the United States, which leads to future catastrophic complications.

These elements highlight the need for the U.S. government to develop initiatives that will enable it to deal with the health crisis affecting the Latino population, particularly immigrants of that origin. The health system currently in place both reflects and reproduces the country's social inequality which, as mentioned earlier, has a strong ethnic component. The debate in the United States on the reform of the health system must include the issue of health insurance coverage of the most disadvantaged minority groups, including Latino immigrants. Government is not representative if it excludes a growing part of the population from its universe. Expanding health insurance coverage for these groups is therefore crucial to narrowing the gaps in health care.

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