

**The Personal Responsibility and Work Opportunity Reconciliation Act of 1996:
Access and Utilization of Health Care Services among Children of Black
Foreign-born Mothers**

A Final Project

Submitted to

**College of Public Affairs
University of Baltimore
in partial fulfillment of the requirements for the degree of**

Doctor of Public Administration

By

Michelle Nichole Charlene Browne

**College of Public Affairs
University of Baltimore
Baltimore, Maryland
March, 2012**

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March, 2012**

DEDICATION

This paper is dedicated to the two women in my world who reared me, my grandmother, Martha Blake and my mother, Lucille Blake-Browne. When I was at least five years of age, my mother migrated from Trinidad to the United States (US) in search of a new life. During my mother's time away, Martha Blake, my grandmother, provided me with all that a small child could possibly desire; her enduring love for my emotional well-being and support for my education. Trinidad is one of the Islands in the Commonwealth Caribbean. In the US for over seven years, my mother worked illegally as a domestic servant until she was able to receive a green card signifying legal permanent residence in the US. With her green card in hand, she went on to become a Nurse's Aide. On August 4, 1976, along with my older sister, Shawne, I began a new life in the US.

From both women, early in my life's journey, I learned that I must put God and only God first in my world. I learned the power of perseverance and never giving up on one's dreams. I learned that with gracefulness, humility, kindness, having a positive self-image, an innate desire to acquire knowledge, utilizing knowledge acquired to encourage others, the good God of Israel will take care of me. For me, life has not an easy road, but, when a person set goals and places them in God's hands, Lucille asserted, he/she will achieve them in this world. Most importantly, I learned about being respectful to everyone regardless of one's life's status.

Like Oprah Winfrey, who once stated that our crowns have been purchased for us, we need to go and acquire them. My mother loved telling me that I must acquire the opportunities that God has uniquely positioned for me. Throughout my life's journey in the US, I could remember so much about my mother, her unbelievable trials, and her joys. But, above all, always, I would recall, as a middle school and a high school student, how each day, she sought assurance that my school assignments were completed in preparation for the next school day. As a young child, I was keenly aware that she did not comprehend all of my assignments, but, by checking over each question, in her mind, my home work was completed. This gesture illustrated her compassion for my education. When I encountered failed moments, she argued vehemently that my failures would lead to opportunities. I owe all that I am and anticipate to become to my mother who left this world on January 1st 2006.

ACKNOWLEDGEMENTS

Completing this degree was a labor of love, resiliency, perseverance and many tearful moments. So many personal and professional challenges surrounded my journey. But, I was blessed with my on-going faith in God, great family support, great friends, and the expert guidance and nurturing support of Dr. Alan Lyles, the chair of my dissertation committee.

Dr. Lyles, you have been coaching me on this topic since December 2006. From providing me the background on the Robert Andersen Health Care Belief Model that I utilized to complete the required Advance Research Course to the completion of this dissertation. Thanks for taking my countless telephone calls on my data analysis, my numerous e-mails on developed logistic regression tables, various health care topics, lunch meetings to ensure that my paper has a true Public Administration significance. But, most importantly, thanks for those emotional and encouraging talks on my adventures at work and ensuring that I maintain my positive self-image throughout this adventure. Sometimes, I became so frustrated, but, you continued to be an awesome encouraging soul. You were so correct in saying that having the tenacity to persevere is critical in the doctoral process. I know that I have a mentor and a friend for life.

Dr. Naylor thanks for teaching me throughout the completion of my doctoral courses. In each course that I completed, such as, Organizational Leadership and Implementation Theory, your encouraging notes at the end of each written papers provided me with the self-esteem boost that I needed to persevere in this academic

journey. Also, thanks for reminding me that I can determine the true significance of my dissertation to the field of public administration; “it is at your finger tips,” you stated.”

Dr. Spencer, always, I will remember these words, “what a good public health paper, try to make it more public administration and you will do fine.” Whenever, I doubted myself; I remembered your kind words on May 5, 2009. Also, thanks for telling me to take this subject to the next level of analysis. Do not investigate only young children, you stated, consider using the entire data base and consider other dependent variables.

Since July 2000, I have worked in the Health Resources and Services Administration, HIV/AIDS Bureau. To the people who I have encountered at HRSA, Sylvia Trent-Adams, Valerie Darden, Lois Eldred, Kim Evans, Gregory Fant, Marcia Gomez, Alice Litwinowicz, Fritz Marshall, Douglas Morgan, DaDera Moore, Sam Ndubuisi, Gail Cherry-Peppers, Sidney Petersen, Harold Phillips, Helen Rovito and Kelley Weld, my very special thanks to each of you for your genuine encouragement and support. To Celia Gabriel, you have been the most awesome friend that God has allowed in my world. Thanks for all of your emotional support throughout my challenges at work, for giving up your Sundays to assist me in this process and for taking so much of my telephone calls at nights. To my friends outside of work, there are so many of you to list, what can I say, but THANKS A MILLION!

I am the youngest of five children of Albert and Lucille Blake-Browne of Trinidad and Tobago. I am a sister to Janice, Louis, Webster, and Shawne. In addition, I have five nieces and nine nephews. Being the youngest, I have become a great aunt to three great nieces and two great nephews. In all that I do, I am overwhelmed by the

support of my family. What could I ever accomplish without their adoration, kindness, love towards me, there prays, weekly check-in teleconferences and massive text messages? Webster, thanks for letting me know that Attila never gave up especially when the dream was ever so near.

Completion is a massive accomplishment not only for me but for my entire family. I have laid the foundation for the children in my family to continue to value their education, their internal power and not external forces, and their spirituality. But, most importantly, a foundation has been established for those children external to my family whose lives have touched my very own and for those children who I will encounter in the future, especially my very own.

To my good professional colleague, thanks for your honesty, your comments on my countless e-mails on medical homes for people with chronic diseases, Medicaid, poverty, race relations, and the future of the bio-medical, psychosocial and funding needs of organizations caring for people living with HIV/AIDS (PLWA). Truly, you fundamentally comprehend the holistic and expert care coordination requires for PLWA.

Most importantly, to my Godchildren, Hadassah, Matthew, and Michaela, thanks for your beautiful company, your comfort, for teaching me to listen, to play, to laugh, and believing that I am so funny☺. Truly, God has been merciful to me.

Michelle Nichole Charlene Browne, MSW, CSW, MPA

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LIST OF ACRONYMS

Acronyms	Definition
ACP	American Academy of Pediatrics
ADC	Aid to Dependent Children
ACA	Affordable Care Act of 2010
AD	Additional Demographics
AFDC	Aid to Families with Dependent Children
BMHS	Behavioral Model of Health Service Use
CB	Census Bureau
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicare Services
CPS	Current Population Survey
CV	Control Variable
DRA	Deficit Reduction Act of 2006
DV	Dependent Variable
EPSDT	Early and Periodic Screening, Diagnostic and Treatment Program
HBM	Health Belief Model
HI	Health Insurance
HCAU	Health Care Access and Utilization
HFS	Health and Functional Status
HP 2010	Healthy People 2010
HRSA	Health Resources and Services Administration
ID	Initial Demographics
IV	Independent Variable
MCHB	Maternal and Child Health Bureau
MH	Medical Home
NHLP	National Health Law Project
NSCH 2003-2004	National Survey of Children's Health
PRWORA	Personal Responsibility and Work Opportunities Reconciliation Act of 1996
SC	Sample child
SCHIP	State Children's Health Insurance Program
SCHIPRA	State Children's Health Insurance Program Re-authorization Act of 2009
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families

ABSTRACT

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996: Access and Utilization of Health Care Services among Children of Black Foreign-born Mothers

Michelle Nichole Charlene Browne

Objectives: This comparative retrospective study examined the health care access, health care status, and health service utilization of children from birth to seventeen years whose mothers self identified as native-born and foreign-born blacks from the National Survey of Children's Health (NSCH). In addition, it investigated whether the Medicaid provision for immigrants in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Public Law No. 104-193) was associated with differential utilization of dental, medical, and mental health services among children born to mothers who identified as blacks. Embedded within PRWORA is a stipulation asserting that to receive Medicaid, one must reside in the United States (US) continuously for a period of five years beginning in August 1996.

Design: This study utilized data from the NSCH, a nationally representative survey instrument having a sample size of 102, 353 children from zero to seventeen years. Children's caretakers were interviewed from January 2003 to July 2004. Of those, 11,535 children had mothers who self-identified as foreign-born. The sample population for this comparative research consisted of the 651 children whose mothers self identified as being Black foreign-born and 7,815 children whose mothers self identified as Black native-born. This investigation stratified the children from the NSCH into four categories: 0-3; 4-7; 8-11; and 12-17.

Main outcome measures: The theoretical framework that guided this investigation was

The original Behavioral Model of Health Service Use developed by Robert Andersen in 1968. The main clinical outcome measures were the provision of dental, mental health and medical services to children from birth to seventeen years of age.

Results: Bivariate analyses disclosed that there were significant differences among the children born to mothers who identified as black foreign-born and mothers who self-identified as black native-born in various predisposing, enabling, and need variables. Statistical differences were reported in insurance type for all age cohorts except 4-7. Logistic regression models were developed to perform multivariate analyses on the odds ratio for the receipt of dental services, medical services, mental health services, and any one of these services (any service) and having Medicaid as a type of insurance. The analysis revealed that there were no statistically significant differences between the receipt of any service Odds Ratio (OR) =1.34; 95% confidence intervals (CI) =0.45-4.00); and dental service (OR =1.36; CI= 0.76-2.46) among the US population of black children. The OR for mental health service was 0.36; CI =0.15-0.89 revealing that children of black foreign-born were less likely to receive mental health services compared to children of black natives. There were no statistically significant differences in having Medicaid (OR =0.60; CI =0.35-1.05) as an insurance type among the US black population of children. Children with Medicaid were more likely to have medical services (OR=1.51; CI=1.07-2.15); and mental services (OR=2.27; CI=1.25-4.11) compared to uninsured children.

Public Administrative Significance: The purpose of the Medicaid Program is to address the health care needs of the poor. Since 1965, various federal and state administrations have utilized this significant public policy legislation to increase access

to health care for their constituents. This study highlighted the pivotal role that Medicaid continues to play in both accessing and the utilization of health services for the US population of black children. Public administrators implementing various programs should continue to advocate for the Medicaid program and increase societal education on the need to address mental health services among young children.

Conclusion: This analysis discovered that unlike research on the children born to Asian and Hispanic parents where low access and utilization of health care services were found; children born to black foreign-born mothers are assessing an array of services in the US health care system. Findings indicate the need for interventions to address disparities among the black sub-population of children in the receipt of mental health services. There remains a need to collect data specific to black sub-population groups at the federal, state, and local levels on health access and service utilization. Disparities among sub-populations identify a critical need to explore factors beyond commonly researched variables to ascertain the root causes of health outcomes.

Keywords: Black immigrants, social equity, personal responsibility and work opportunity reconciliation Act of 1996, dental, medical and mental health services

CHAPTER ONE

INTRODUCTION

**“There can be no keener revelation of a society than the way it treats its children.”
(Mandela 1995)**

There exists a paucity of literature on whether the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (Public Law No. 104-193) is associated with health care access and health service utilization to the children born to black foreign-born mothers. Growing evidences in the field of children’s health have reported that Asian and Latino children of foreign-born parents are less likely than their native born counterparts to have a regular source of care to receive age appropriate health services (Flores et al; 1998); are less likely to have had a recent physician visit (Ku and Matani, 2001); are more likely to delay seeking care (Weathers, 2008); are more likely to report poorer health outcomes (Yu et al. 2004); and are more likely to report being uninsured (Ku, 2007). Researchers have attributed these disparities to the Medicaid provision embedded in the PRWORA signed into law under President William Clinton’s administration. The provision in question limits access to Medicaid to legal permanent immigrants not residing in the United States (US) for five years beginning in 1996 (Capps et al. 2004; O’Connor 2004; Goldman and Smith 2005).

For that reason, the public administration and policy question which is of critical significance to this comparative retrospective study is ascertaining whether the Medicaid provision in PRWORA for immigrants is associated with differential health care access, health care status, and health care service utilization of dental services, of medical services and mental health services to children whose mothers identified as black foreign-born from the National Survey of Children’s Health (NSCH). In comparison to the

children of immigrants, such as, Asians, Latinos, and Whites, the children of black foreign-born women are small in numbers. Most of these parents are from the Commonwealth Caribbean and such countries are small by global standards (Marshall 1987:16). Although numerically small, “poverty and the dynamics of race in the US combine to make some of these children especially vulnerable to negative outcomes” (Landale et al. 2011:44).

This study is of significance to the field of public administration because of critical social theory (Box 2005:21), cultural competency (Bailey 2005:177), and social equity theoretical frameworks (Frederickson 2010). Limited utilization of preventative age appropriate health care services for the children of immigrants will potentially lead to costly medical expenditures in the future in states in which these children are residents. The guiding principles of the field of public administration are administrative efficiency, individual rights, social equity and political responsibility. Public administrators working with local, state and federal representatives can develop unique services to address this on-going challenge of health care inequities faced by all children of immigrants who are overwhelmingly minority children. The promotion of ethical organizations, demonstrating professional integrity, and by ascertaining variables associated for differences in health utilization among children at the macro-level will benefit the entire US society.

Chapter Outline

This chapter is outlined as follows: (1) the problem statement; (2) the public administration significance; (3) literature on immigrant children’s health utilization; (4) limitation of current literature; (5) the critical role of mothers in health access and

utilization; (6) the theoretical framework and its applicability to the study; and (7) the remaining dissertation chapters.

SECTION II--PROBLEM STATEMENT

Immigrant Children, Health Care Access and Utilization

International migration has resulted in a large number of foreign-born women residing in the US. Given this increase, births to foreign-born women accounted for one in five births in the US in 2002 (Schmidley 2002). Children born to immigrants are the fastest growing population groups in the US (Hernandez 2004; Shields et al. 2004). Children of immigrant are defined as those children who are foreign born or who have at least one foreign-born parent (Ku 2007; Capps et al. 2003). Sometimes, they are called children in mixed status household; defined in the literature, as American born children whose parents are either undocumented or documented (Capps and Fortuny 2006).

Access to health care services increases the use of ambulatory care, enhances the chances of receiving needed health care, prevents unnecessary hospitalizations, and improves health status (Forrest and Starfield 1998). From an early age, all children regardless of insurance coverage type are entitled to age appropriate services. Health insurance coverage, whether public or private, is a key factor in making health care accessible.

According to Strickland et al. (2011), in the general population of America's children, one in five uninsured children does not have a regular source of health care. Consequently without a medical home, children are 30 percent more likely to fall behind on well-child care and 80 percent more likely to never receive routine health care services. Uninsured children are 70 percent more likely than children with insurance to

have failed to receive needed medical care for common but serious conditions such as asthma, which when left untreated may lead to even more serious health problems (Janicke 2001).

There is a preponderance of academic literature on health service accessibility and health service utilization of children born to Asian and Latino immigrants (Flores et al; 1998; Flores et al 2006; Flores and Tomany-Korman 2008; Ku 2007; Ku and Matani 2001; Yu et al. 2004; Weathers et al. 2008). On the other hand, there exists a paucity of literature on the children born to women who self-identify as black foreign-born. Studies developed to ascertain the health and well-being of children of foreigners have reported that they have a tendency not to have public or private health insurance compared to native citizens (Ku 2007; Burgos et al. 2005; Capps et al. 2004; Huang et al. 2006; Ku & Matani 2001); tend to utilize emergency rooms for an array of medical services (Ku & Matani 2001; Carrasquillo et al. 2000; Evans 1995:310); have low levels of preventative services and health status is reported as fair to poor by caregivers (Derose et al. 2009). Seeking health care is challenging for the children of foreigners due to their parents difficulties in navigating health resources in the US (Flores et al. 2006); policies created in the US to reduce public health insurance eligibility to immigrants (Kaushal and Kaestner 2004; Kullgren 2003; Burgos et al. 2005; Berk et al. 2000) and health care literacy (Capps 2006). Why do these challenges persist for children being reared by foreign-born parents?

In 1993, John Kingdon wrote “*Agenda, Alternatives, and Public Policies,*” highlighting a framework to comprehend the policy-making process at the federal level of government. Kingdon argued that problems are more likely to be placed on the decision

agenda when three separate process streams which are problems, policies, and politics are joined. The first stream is the process for choosing and defining problems. The second stream, the policy stream is called the primeval soup to highlight ideas floating around and recombining; some ideas remain viable and some do not survive. The third process is the political stream, and it is shaped by factors, such as, the public mood (Kingdon 1993). Kingdon explained that along with the three streams, there are various windows of opportunities converging to create various policies and developed policies do have unintended consequences.

It has been argued by various immigration scholars that the anti-immigration language in PRWORA materialized because of the impressions of Native Americans. Natives were under the impression that a large number of immigrants came to the US especially from Asia, Latin America and the West Indies ill-prepared or unwilling to work upon the passage and signage of the Immigrant and Naturalization Act of 1965 (P.L. 89-236) (Borjas 2003). It has been postulated that these immigrants expected public assistance and other governmental benefits with the goal of being dependent on the government and hard working tax payers for their livelihood (Borjas 2001). Hence PRWORA was legislated and authorized in 1996 to address this perception by Native Americans.

Since the implementation of PRWORA, various academic researchers have reported various unintended consequences of this policy. The creators of PRWORA did not envision the impact of welfare reform on the children of immigrants, many of whom are born in the US and are entitled to resources developed for the US native population. It is well documented that only three percent of the children of immigrants were born in a

foreign country and the remainder are US citizens. It has been argued that the access to and the receipt of health care services have been reduced for the children of immigrants especially Asians and Latinos. Immigrants are even less likely to use Medicaid when their families are eligible for this benefit (Pati and Danagoulian 2008).

In a landmark study on the impact of PRWORA completed by the Kaiser Family Foundation (KFF), researchers reported that even when states developed unique outreach and educational initiatives to educate immigrant parents on the health care services available to their children, immigrant children born to Latino parents did not avail themselves to receive services for their children (Guendelman et al. 2005). Compelling rationales for this behavior were fear of deportation and limited knowledge by immigrants that states, such as, Washington State, can continue one's eligibility for Medicaid with state resources and not federal funding. Upon the authorization of PRWORA, states were provided with the option of providing health and other social services to legal immigrants with state only resources (Borjas 2003).

Should public servants working in states in which immigrant families have migrated in search of new opportunities be concerned that immigrant children have reduce access to age appropriate services? There is a growing body of literature on health disparities among adult minorities (Lieu et al. 1993; Tucker 2002). The US is one of the most industrialized countries in the world. Yet, gross disparities persist in health care outcomes among America's adult minority population (Kawachi and Kennedy 1999). The 2002 Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic and Disparities in Healthcare*, extensively documented health care disparities in the US by race and ethnicity (Smedley et al. 2002).

The adult minority population continues to experience high prevalence of Asthma, Cancer, Diabetes, HIV/AIDS, Obesity and other debilitating chronic diseases. Like the adult minority population, minority children tend to experience preventable diseases at a higher rate than their white counterparts (Tucker 2002). Minorities, the emerging majority, will comprise the US labor force and will provide the tax base to deliver US social and public service programs. Given that their health status tends to be poor and that their numbers are increasing, the elimination of racial disparities in health continues to be one of the US national concerns and should begin early in one's life.

Without timely access to critical preventative services, states with immigrants could potentially incur increase expenditures for the provision of health care. When health care needs are not met, the nation potentially bears the burden of the lack of insurance as untreated health problems grows thereby leading to costly hospitalization and the need for specialty care services (Valdez et al. 1993). The children of immigrants are in need of access to health care services tailored to their unique needs. By addressing the health access, health status, and health care service utilization, the US can potentially avoid costly future health care expenditures and low productivity among its rising immigrant populations. For the US to survive, it is critical that our society addresses the needs of the immigrant population; its children who are citizens and permanent residents of the US (Evans 1995:310).

SECTION III---PUBLIC ADMINISTRATION SIGNIFICANCE

There are many significant policy problems facing public administrators in the US. For example, children in need of an effective education system, citizens in need of an affordable health care system, families in need of housing, children in need of safe living

environments and children in the foster care system in need of various bio-medical and bio-psychosocial services. The Medicaid provision placed in PRWORA in 1996 limiting access to Medicaid for legal permanent resident immigrants is another policy dilemma for public administrators. The provision is fundamentally problematic because children born to these immigrant parents are fearful to navigate the health care system leading children to go without age appropriate services.

Throughout the history of public administration, scholars in this field have emphasized the role of public administrators. In the *Preface to Public Administration*, Richard J. Stillman II (1991) highlighted Louis Brownlow's views on the role of the public administrator in the classic Brownlow Report. According to Brownlow,

“The task of the public administrator above all else is to concern himself with human relations, with human values, with those deeper than economic, social and spiritual needs of human beings whose government in its administrative branch he represents....He will not merely represent one government agency or be a legal or technical specialist but rather be a center of social cooperation and able to command and utilize broad knowledge, deep understanding, and human sympathy in a synthesis of social wisdom.”

The Brownlow report highlights the humanistic side of public administrators in addressing the needs of those less fortunate. Along with the humanistic approach to leadership and program implementation, public administrators must possess the skills to plan, organize, staff, direct, coordinate, organize, report and budget (POSDCORB). These concepts created by Luther Gulick in 1937 continue to be the cornerstone of the work of public servants working both domestically and internationally addressing the welfare of the community.

In 2009, the CPS reported that 52 million individuals were without access to health insurance coverage. Of that number, it has been documented that one third are

known to be immigrants with variation in their citizenship status. Immigrants face many challenges and barriers to services in their new environment but the decision to seek health care in the US is sometimes daunting for themselves and their children. Like the adult population, uninsured children are at a disadvantaged without health care insurance and without access to health care services.

Scholars on public administration have emphasized that this field values administrative efficiency (Woodrow 2004:28), protecting individual rights, addressing social equity (Frederickson 2010:42) and political responsiveness (Goodnow 2004:37). The research on the state of health care accessibility and utilization for children of immigrants should concern public administrators. It is a matter of critical importance because administrators need to develop specific strategic plans to address the needs of community residents. At a minimum plans should consist of infrastructure capacity, recruiting strategies to hire culturally trained staff, reporting systems to gain information on the type of services received; and annual budget projections to address community needs. If children of immigrants are not accessing health care resources, public servants should address this growing phenomenon and work with regulatory bodies to repeal provision(s) of the legislation that increases inequities among America's children. In their book entitled, *Unmasking Administrative Evil*, Adams and Balfour stated that:

“Public administration must also, and primarily, be informed by a historical consciousness that is aware of the fearsome potential for evil on the part of the state and its agents, and by a societal role and identity infused not only with personal and professional ethics but also with a social and political consciousness- a public ethics-that can recognize the masks of administrative evil and refuse to act as its accomplice.” (Adams and Balfour 1998:40)

Individuals working in the field of public administration are recognized as change agents. It is the responsibility of trained civil servants to implement the programs developed at all

levels of the government for the nation's citizens. The predicament facing the US is the complexity of its health care system and its impact on not only native born citizens, but the ever growing population of immigrants. The pursuit of the public good by enhancing civil society and social justice is the ultimate goal of the field of public administration. In their capacity as public servants, they can reach out to policy developers and provide statements on various strengths and weaknesses of programs implemented. Access to health care services for children of immigrants benefits not only immigrant families, but the overall US workforce of the future (Mullan 2005).

SECTION IV---INVESTIGATIONS ADDRESSING IMMIGRANT CHILDREN

Reducing racial and ethnic disparities in children's health, improving access to health care, and increasing the number of lives for all Americans are critical goals of Healthy People 2010 (HP) (Stevens and Shi 2002:574). HP is a federal initiative that emerged in 1980 and is updated every 10 years. Examples of topics focusing on pediatric and adolescent health services are access to quality health care services, educational and community based programs, maternal, infant and child health, mental health and mental disorders, overweight, oral health, physical activity and fitness and vision hearing impairment. This investigation is concern with access and utilization of dental, of medical, and of mental health services to children of immigrants.

In addressing the needs of immigrant children, various research studies have investigated the needs of the Latino child specifically Mexican children (Flores et al. 1998; Flores et al. 2002; Flores et al. 2006; Flores and Tomany-Korman 2008; Burgos et al. 2005). In addition to studies looking at the Latino community, studies investigating the health access, health status, and health utilization among the Asian sub population

groups of children are emerging (Yu et al. 2004; Yu et al. 2005). The following are examples of academic articles highlighting some of the challenges facing Asian and Latino children of immigrants.

In 1998, Flores et al. conducted a study to investigate access barriers to health care for Latino children. The study concluded that language was the single greatest barrier to getting health care for children. The remaining factors of significance were a long wait at the physician's office, lack of medical insurance, and difficulties paying medical bills and transportation.

Using data from the Third National Health and Nutrition Examination Survey (NHANES III), Burgos et al. (2005) looked at differences among Mexican American children who were first, second, and third generation, non-Hispanic Black and non-Hispanic White children comparing health status and health care needs. The study concluded that all three groups of children lacked private insurance, lacked a usual source of care, and did not see a physician in the last year.

In 2006, Flores et al. identified the risk factors and consequences of being an uninsured Latino child. The quantitative study revealed that although parents of uninsured Latino children were less likely to be unemployed, and were married; Latino children were more likely to live in households with both parents, but were significantly less likely than non Latino children to have private insurance, and were uninsured. In addition, the parents of Latino children tended to have Limited English Proficiency (LEP) needs, not to be citizens, to be undocumented and lived in the US for less than 10 years.

Using the Sample Child Data Set of the National Interview Survey, in 2004, the health access, and utilization characteristics of U.S. Chinese, Asian Indian, Filipino, other

Asian/Pacific Islander (API), and non-Hispanic white children were investigated. Yu et al. 2004 investigation revealed that Asian American children had a lower prevalence of congenial diseases and chronic conditions compared with non-Hispanic whites. Chinese, American Indians, and other API children were more likely to be without health insurance as compared to whites. All children in the sample were more likely to be without a usual place for health care.

SECTION V---LIMITATION OF CURRENT LITERATURE

The black immigrant population groups are heterogeneous drawing from the Commonwealth Caribbean and countries in the Africa continent (Nopper 2008). Compared to all other US major racial groups, blacks have the highest rates of morbidity and mortality for all diseases, highest disability rates, shortest life spans, least access to health care, and startlingly low rates of the use of modern technology in their treatment (Read and Emerson 2005:181). Currently, little is known on the provision of dental, mental health, medical services, substance abuse and the provision of various social services to this sub-population group of residences in the US. Today, studies are emerging looking at the adult black immigrant population groups (Read and Emerson 2005).

Having socio-economic and religious identity differences, as a group, the black-foreign-born community is relatively poor, and lack resources to illicit the receipt of health services for themselves and their children. Stress arising from immigration and the process of adapting to a new culture may sometimes exacerbate symptoms and undermine the capacity for successful adjustment in the community (Bhugra 2001). Looking at the utilization of psychiatry services among Africans and Caribbean

immigrants residing in London, research demonstrates that low utilization of support services is linked to the worsening of mental health outcomes (Bhui 2003).

In the US, in 1970, the black foreign-born population was 1.3 percent of the US population. In 1980, the group elevated to 7.8 percent (Miranda et al. 2005). Today, the black foreign-born population is over 10 percent of the US black population (US Census 2010). Although, the growth of the black foreign-born group is relatively less in percentages and absolute numbers than the Asian and the Hispanic groups, the growth of this population group is attributed to the rise in its foreign born population (Scopilliti and Iceland 2006). This investigation is unique because it stratifies the sample population of children ages 0-17 years into four categories and focuses specifically on the children born to Black foreign-born mothers. Unlike previous studies in which black children have been compared to white children, this investigation compares the children of black natives to the children of black foreign-born mothers.

SECTION VI---PURPOSES AND GOALS OF THE STUDY

This quasi-experimental investigation examines whether the Medicaid provision for immigrants in the PRWORA was associated with differential utilization of dental, medical and mental health services among children 8-11 and 12-17 years born to black foreign-born mothers. In addition, it also: (1) describes the socio-demographic characteristics of children with a black foreign-born mother as compared to children with a black native-born mother; (2) compares health care status among children with a black foreign-born mother as compared to children with a black native-born mother; (3) compares health care access among children with a black foreign-born mother as compared to children with a black native-born mother; and (4) compares the utilization of

dental, medical and mental health services among children with a black foreign-born mother as compared to children with a black native-born mother.

This section explains why mothers and not fathers were selected as an essential variable of interest for this investigation. There is a growing body of literature looking at parental nativity and their children's access to health care services (Weathers et al. 2008). Child health status as measured by presence/absence of a medical diagnosis or parent-ratings of child health is the single greatest determinant of pediatric health care access (Janicke et al. 2001). Pediatric health practice emphasizes the behavioral, emotional, and intellectual development, as well as physical well-being of children (Guyer et al. 2000).

The characteristics of the child are but a few of the variables to be examined because pediatric care is initiated by the caregiver (Moran and O'Hara 2006:171). The female caretaker of the child was the focus of this investigation because mothers' appear to serve as primary decision-makers with regard to their children's health (Minkovitz et al. 2002; D'Souza-Vazirani et al. 2005; Melnyk et al. 2007). When maternal and paternal use of health care is examined separately as potential determinants of pediatric health care use, maternal use is twice as influential as paternal use (Minkovitz et al. 2005; Riley et al. 1993; Wolfe 1980).

Weathers et al. (2008) have argued that the immigrant mother plays an important role in whether the child goes for medical care and where the medical care is received. It is well documented that minority children of immigrants are more likely to lack a usual source of medical care (Flores and Tomany-Korman 2008; Flores et al. 2002; Brown et al. 1999; Flores et al. 1998). Given the significant role of the mother in the life of their

children, mothers must be educated on the benefits of accessing age appropriate health care services for their children.

This study utilizes data from the NSCH that is designed and directed by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau and conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics. The NSCH has a sample size of 102, 353 children between the age groups from zero to seventeen whose caretakers were interviewed from January 2003 to July 2004. The NSCH provides variables on child health established by the American Academy of Pediatrics (AAP); The Centers for Medicaid and Medicare Services (CMS) and other organizations addressing the well-being of children in the US.

The mission of the AAP is to advocate for optimal physical, mental, and social health and well-being for all infants, children, adolescents and young adults. CMS has administrative authority over all 50 states and US territories and watches over both the Medicaid and the State Children's Health Insurance Programs (SCHIP) that are vital to the provision of bio-medical and psychosocial services to children.

Specific Medicaid benefits for children were established in 1967, with the creation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT is a comprehensive package providing periodic evaluations of health and developmental history, as well as vision, hearing, and dental screening services to children (State Medicaid Manual 1980). States are to inform the families of these children of the availability of EPSDT services, their benefits, and where and how to obtain them. All children who are enrolled in Medicaid and SCHIP must receive medical services in accordance with the regulations developed by the CMS.

SECTION VII---THEORETICAL FRAMEWORK OVERVIEW

The Behavioral Model of Health Service Use

The theoretical framework, the Behavioral Model of Health Service Use, first developed by Robert Andersen in 1968 guided this study. This framework is also known as the Socio-Behavioral Model (Suci 2006; Broyles et al. 2000) and the Health Belief Model (HBM). The early root of this theory was first developed in the 1950s and known as a psychological model that attempts to explain and predict health behaviors. HBM was developed by a group of social psychologists at the US Public Health Services in an attempt to understand the widespread failure of people to accept disease preventatives or screening tests for the early detection of asymptomatic disease (Janz and Becker 1984:2). The theory argues that a person's willingness to change his/her behavior is due to four dimensions:

- (1) Perceived Susceptibility: People will not change their behaviors unless they are at risk.
- (2) Perceived Severity: The probability that a person will change his/her health behavior to avoid a consequence depends on how serious he or she considers the consequence to be.
- (3) Perceived Benefit: It is difficult to convince people to change a behavior if there isn't something in it for them.
- (4) Perceived Barriers. One of the major reasons an individual does not change their health behaviors is that they think that doing so is going to be difficult. It is not only a physical difficult but a social difficulty as well. (Rosenstock 1974).

Perceived susceptibility to disease and perceived seriousness to disease is known as the individual perceptions. The modifying factors are demographic variables, which are not limited to age, sex, race, ethnicity and other socio-psychological variables. The perceived benefits and perceived barriers are the likelihood that an action will occur on the path of the individual (Rosenstock et al. 1988:177).

In summary, the health belief model stipulates that a person's health-related behavior depends on the person's perception of four critical areas: the severity of a potential illness, the person's susceptibility to that illness, the benefit of taking a preventive action, the barriers to taking that action and self efficacy (Chen 2007:7). In creating the Behavioral Model of Health Care Use, Robert Andersen (1995) borrowed concepts from the HBM.

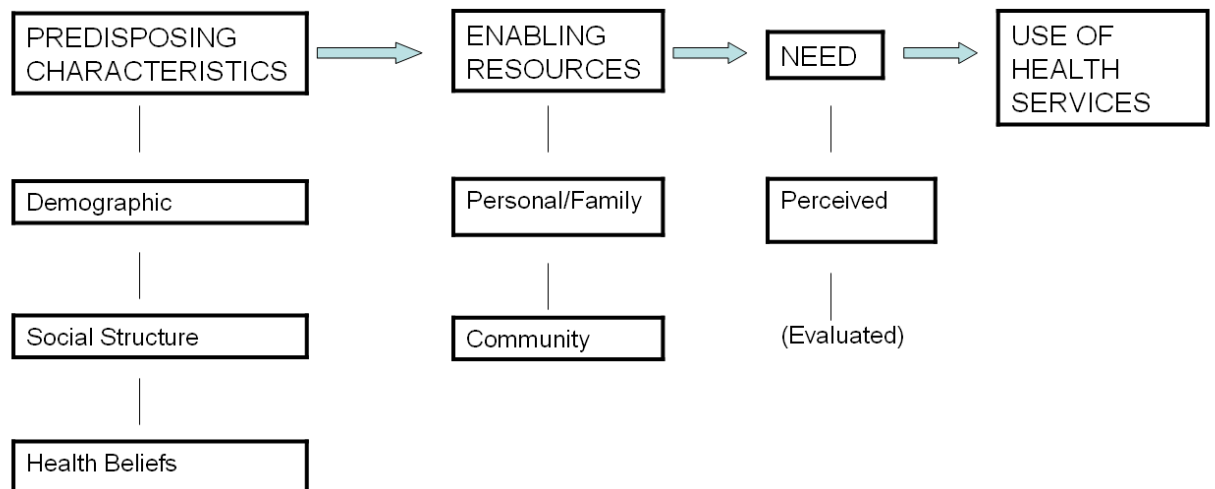
The purpose of the BMHS is to understand health service delivery, utilization, and health-related outcomes. The model was first developed to assist in the understanding of why families use health services; to define and measure equitable access to health care; and to assist in developing policies to promote equitable access (Andersen 1995). The framework suggests that the poor and the uninsured, not only experience a poorer health status, and are at greater risk than other members of society, but, also are least able to finance the use of primary care (Broyles et al. 2000:454).

The framework argues that an individual's access to, and the use of health care services, is considered a function of three characteristics that are the predisposing, enabling and need factors (Anderson and Newman 1973; Aday and Andersen 1974; Aday et al. 1980; Andersen 1995). Predisposing factors are the socio-cultural characteristics of individuals that exist prior to their illness. Examples are the social structures, health beliefs and the individual's demographic. Predisposing variables are acculturation, age, gender, educational attainment, marital status, family size, nativity, and race. Enabling factors consist of those factors that facilitate or impede the use of health services. Examples are personal and family income, health insurance coverage, language, availability of providers, ease of making an appointment and community resources

(Derose et al. 2009). The need factor refers to the actual illness or perceived need for a given health service. Examples are immunizations, chronic health conditions, and gender related preventive needs.

Since the early development of the Andersen Model, it has undergone various iterations and is utilized by various researchers to investigate health care access at the individual, provider and the structural levels of the health care system. The model has been expanded to include social, economic, structural, public policy environments and other characteristics relevant for vulnerable populations. Although new variables have been added to the original framework, given its robustness looking at associations and relationships, the framework continues to be used by academic researchers. Figure 1, is an illustration of the initial behavioral model of health care access developed in the 1968 which is drawn upon in this current investigation.

Figure 1--The Initial Behavioral Model



Source: Andersen, RM. (1995)

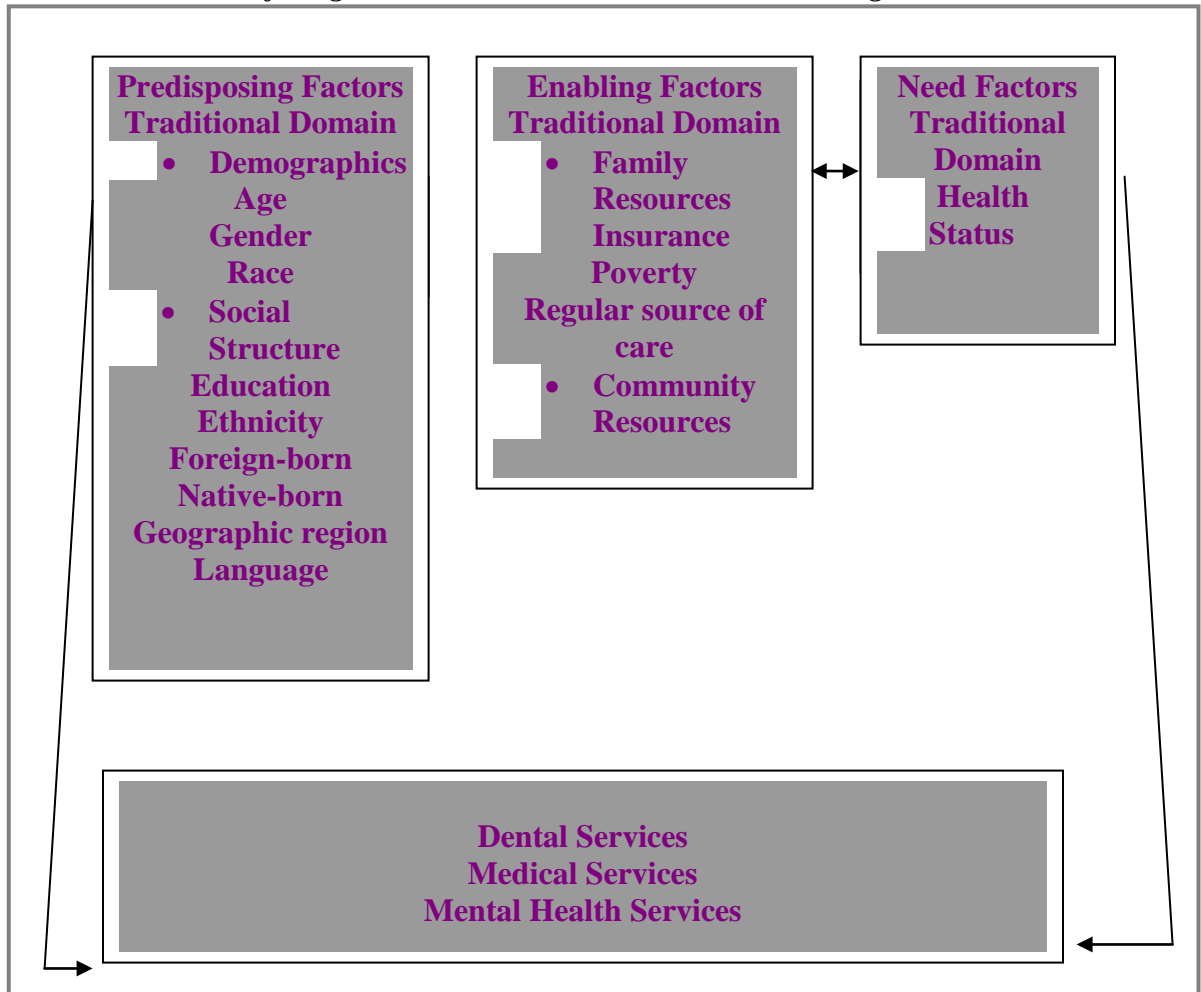
Applicable theoretical concepts

Black immigrants are defined as individuals who were born either in both Spanish and English speaking Caribbean countries and those from African continents. The

BMHS Use is applicable to a study that examines health access, health status, and health utilization of children born to foreign-black mothers. It is applicable because this framework of choice is utilized both domestically and internationally to study engagement and retention into the health care system for people who are living with HIV/AIDS (Mugavero et al. 2007); health care access (Suci 2006); and families coping with mental illness (Eiraldi et al. 2006). Children's age, ethnicity, family structure, household size, perceived health status, parental language preference, poverty level, parental education parental immigration, race and sex, are example of covariates that have been shown to influence health care access and use of services (Ku and Matani 2001).

The predisposing factors that will be used in this investigation will be the child's age, child's gender, child's household educational levels, child's race, mother's nativity status, and the primary language spoken in the home. The enabling factors will include the household poverty as defined by the US, insurance coverage, insurance type, and having a usual/regular source of care. The need factors will include the child's health status, the need for dental, medical and mental health services. The following shows the variables in the study and their connection to Robert Andersen Model developed in 1968.

Figure 2---Framework to study access and utilization of health care services to children with black foreign-born and native-born mothers residing in the US in 2003.



SECTION VIII---CHAPTER ONE SUMMARY

One's health is influenced by many interrelated factors which are economics, social, the environment, and other essential predisposing and enabling characteristics and behaviors. In the year 2000, the World Health Organization (WHO) ranked the US health care system as #37 (World Health Report 2000). This ranking was attributed to the high mortality rates, the massive number of individuals lacking health insurance, and the cost attributed per person to receive health care services among the US population. The rise in racial and ethnic disparities (Kwachi and Kennedy 1999); missed opportunities to

diagnosis preventable diseases (Flores; 1998); and the increase in health care expenditures (Mohanty 2005) have been well documented by academic researchers as contributors to the unintended consequences of being underinsured or uninsured.

This introductory chapter's primary purpose establishes the rationale for a study addressing the health well-being of children being reared by black foreign-born mothers upon the implementation of the Medicaid provision in the PRWORA of 1996. Research on the children of immigrants provides substantial evidence acknowledging that this Medicaid provision resulted in grave unintended consequences for children of immigrants. The children of both the Asian and the Latino communities are the focus of research on PRWORA, but little research exists on the children who are being reared by black immigrant mothers. To establish the need for this study, information gleaned from literature on other immigrant children have been extrapolated to select variables for this new investigation.

The field of public administration is designed with various fundamental values. Some schools of thoughts have argued that this field is based upon humanism and various scholars articulate the need to have skills to plan, develop and advocate for sound budgets for the betterment of the society. Regardless of public administration frameworks that one favors, the good health of a country's constituents can lead to a healthier society. This new study will add to the growing body of literature on the children of immigrants living in the US.

SECTION IX---REMAINING CHAPTERS OUTLINE

The remainder of this study includes four additional chapters which are as follows:

Chapter Two is the literature review and outlines a summary of health care for children in the US with an emphasis on minority children and children of immigrants. The purpose is to develop the rationale for an investigation addressing the needs of children born to black foreign-born mothers. Embedded in this chapter is a discussion on the research questions and the developed hypotheses.

Chapter Three, describes the methodology developed to answer the research questions and hypotheses. This chapter outlines the data source, the sample, the research design, the dependent, key independent variable and control variables, research purposes and statistical analysis techniques. Both descriptive and inferential statistics were utilized.

Chapter Four, provides answers to the research questions and research hypotheses under investigation. All tables utilized are presented and summarized in this chapter.

Chapter Five, provides a summary of the entire study. The discussion consists of the limitations, strengths, weaknesses, policy implications, public administration significance and suggestions for future research. In addition, it explains whether or not the study provides an opportunity to fill gaps in the existing body of research on the health and well-being of the overall black children population in the US especially children of black immigrants.

CHAPTER TWO

LITERATURE REVIEW

**“In a decent society, there are certain obligations that are not subject to tradeoffs or negotiation - health care of our children is one of those obligations.”
(President Obama, March 2009)**

Lack of health insurance is a serious societal problem. Having health care insurance can make a tremendous difference in the amount and type of health care one receives. Adults and children without health coverage uses the health care system less often, are less likely to have a regular source of health care, are more likely to rely upon emergency rooms for their treatment, and often experience unnecessary pain, suffering, and even death (Weigers 1998).

In his seminal book, *Just Health Care*, Norman Daniels (1985) stated that any health care system should address the following questions: (1) What kind of a social good is health care? (2) What are the functions of the health care system? (3) Are their social obligations to provide health care? (4) What inequalities in its distribution are morally acceptable? And (5) What limits do provider autonomy and individual liberties of physicians or patients' place on the just distribution of health care? (Daniels 1985:8)

These classical questions raised by Norman Daniels in the early 1980s regarding the US health care system were critical in that period. Today, they continue to be immensely significant to various professions, such as economics, education, medicine, psychology, political sciences, public health, public administration, public policy and social welfare/social work in addressing the plight of those in need of having access to health care services in the US. A health care system which is culturally and linguistically

competent cost effective, efficient and quality driven; thereby, reducing social inequities in health care outcomes.

Children's health is the foundation for health throughout life and measures of child health is an important indicator of the overall health of our nation (Egerter et al. 2008). Having health insurance, having a usual source of health care, oral health and childhood immunizations contribute to information on determinants and measures of health care utilization for America's children (Federal Interagency Forum on Child and Family Statistics 2008). During the receipt of structured age appropriate health care services; conditions which can lead to serious health problems potentially can be diagnosed. Access to and the utilization of age-appropriate preventative health services and other services for children potentially leads to optimal comfort, happiness and security.

Annually, the US is home to approximately seventy-three million children between 0-17 years. Of that amount, over forty-five percent are the children of minorities (Annie Casey Foundations 2010). Minority children are at increased risk for asthma, ear infections, lead poisoning and other health conditions (Lieu et al. 1993; Park 2002). The purpose of this chapter is to develop the background for the research on the children of black immigrant mothers in need to have the resources to access health and to utilize various health care services mandated for the well-being of children.

Methodology for literature review

To gather information around access and service utilization on the health care of minorities, the timeframe for the review was from 1968-2010. This timeframe was established because the theoretical framework guiding the study originated in 1968. The

essence of the search was to review information around barriers that potentially impact access to health care services for this population of children. To gather information on PRWORA and the Medicaid provision, the timeframe was 1996 to 2010. Articles were included based on titles and their potential relevance to the current investigation.

Given the specificity of the key words selected for the review, articles on immigrant children and the overall population of minority children in the US in need of health care services were included. PRWORA not only impacted the receipt of social services for children, the older immigrant requiring health and other social services for their holistic well-being were also impacted. The research criteria excluded articles on the older immigrant population. To accomplish the study goals, the following search engines and web sites were reviewed:

Table 1 Search Engines

Academic Engines	Major Websites
Medline/Pubmed	American Academy of Pediatrics
Social Sciences	The Carsey Institute
	The Annie B. Casey Foundation
	The Centers for Disease Control and Prevention
	The Centers for Medicaid and Medicare Services
	The Commonwealth Fund
	The Census Bureau
	Families U.S.A.
	The Kaiser Family Foundation
	The Robert Wood Johnson Foundation
	The National Law Center
	The Pew Foundation
	The Poverty Center
	The Urban Institute

To determine the theoretical framework and the connections it plays to analyze access to, the availability of and the utilization of health care services for children of the foreign-born population, the following key words were utilized:

Table 2 Keywords

Theory Framework	Search Words
Access to health care	Barriers to care
Behavioral Model of Health Service Use	Black immigrants in the US
Critical Theory	Black immigrants in Europe
Cultural Competency	Child's Health
Health Belief Model	Dental services and children
Implementation Models	Disabilities services and children
Potential access	Great Society Programs
Realized access	Health disparities and minorities
Social Equity	Health care expenditures
	Health services and minorities
	Immigrant children and health access
	Immigration reform
	Medical home/Medical services to children
	Mental health services
	Minority children and health access
	Personal Responsibility and Work Opportunity Act of 1996

To accomplish the objective of chapter two, the following sections are included:

- Section I provides a brief history on the Immigration Reform Act of 1965. This section is critical to the paper because it highlights the rise in the minority immigrant community and the potential rationale for the Medicaid provision in PRWORA of 1996.
- Section II provides an overview of the PRWORA of 1996 and the emergence of the Medicaid provision that restructured eligibility for immigrants.
- Section III is a brief discussion on health care disparities by highlighting essential social determinants of health care that researchers have hypothesized contributes to the prevalence of disparities. Disparities are highlighted in the adult population to illustrate the need to address children's health care access and utilization at an early age.
- Section IV is an overview of minorities in America and places of origination. This section is important because it shed light on the increase in the number of minorities living in America and the rise in children living in mixed households.
- Section V presents an overview of the overall US population of children. It was developed to demonstrate the rise in the US population of children who are reared by minority parents, the rising poverty among minority children and state resources to address health care provision.

- Section VI is an overview of the health coverage for US children with a purpose of highlighting various types of coverage among children and the level of uninsurance by race and ethnicity.
- Section VII is a discussion on vehicles developed to provide children with health care access covering Employee Sponsored Insurance, Medicaid Program and the State Children's Health Insurance Program and a brief discussion on the reauthorization of SCHIP with new its new changes. Its purpose is to highlight various mechanisms to ensure that America's children have access to an array of services.
- Section VIII provides a summarization of health access and service utilization of dental, medical and mental health services using the theoretical framework and the essential dependent variables for this investigation;
- Section IX discusses cultural competency and social equity theories in public administration and both theoretical approaches applicability to health care for immigrant children.
- Section X is a summation of the major points made throughout the paper and the significance of paper to the field of public administration.
- Section XI provides the research questions under investigation.

SECTION II---BACKGROUND ON IMMIGRATION

Globalization has resulted in the migration of individuals from various countries to the US. This immigration has made the US a melting pot; a diverse place with individuals from various foreign borders (Mullan 2005). An immigrant is defined by the US Census Bureau as an individual who is not a citizen of the US but who resides in the US. When documented, these individuals have legal permission to remain in the US. Types of documentation are visas signifying temporary status and green cards that signifies permanent status. Due to expiration of required visas to enter the US and border crossing, individuals in these situations are identified as undocumented. The US classifies immigrants in various groups which include naturalized citizens, legal permanent residents, refugees, and undocumented immigrants. A brief history of previous

immigration laws is warranted to set the stage for PRWORA and its unintended consequences on the well-being of the population of children being reared by immigrants.

President Lyndon Johnson and Immigration

Scholars have coined President Johnson's administration era, the Golden Society. During his tenure as President, the US witnessed the rise of significant economic, educational, social and public health programs. Along with the passage of Medicaid, Medicare, and various war on poverty programs, on October 3, 1965, President Lyndon B. Johnson signed the Immigrant and Naturalization Act of 1965 also known as the Hart-Cellar Act of 1965 of Public Law No. 89-236) (DiNitto 2000:397). This Act repealed the First Quota Act of 1921 and amended the Immigration and Nationality Act of 1952 (Public Law No. 82-414). Under the old system, annually, foreign countries were allowed only 3 percent of their total population to immigrate to the America. Scholars on immigration reform recognized that early immigration policies resulted in the influx of classes of educated individuals (Kasinitz 1992; Fairchild 2004). Prior to 1965, immigrants have been well educated members of the urban elite seeking to protect their wealth in volatile economies, children of the middle class searching for broader opportunities, and large numbers of poor people looking for a standard of living above mere subsistence.

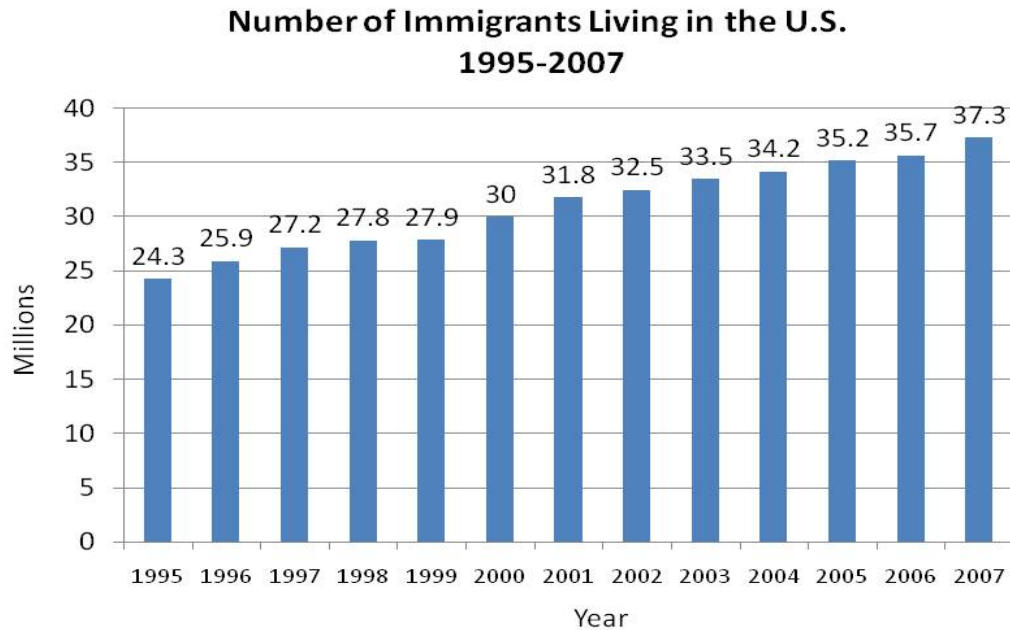
In 1965, The Immigration Act of 1965 (Public Law No. 89-236) changed the entire focus of the American immigration policy by opening the way for a dramatic surge in immigration (Kasinitz 1992:26) It contained three significant policy changes: (1) the restriction on the number of people permitted to enter the U.S.; (2) the establishment of a system based on family reunification that favors the immigrants of relatives of US citizens or relatives of individuals that entered as immigrants; and (3) the emphasis on

economic interest for the US labor market to attract needed occupational skills (Drachman 1995) No one, especially the Bill supporters, envisioned that it would produce such a dramatic change in the ethnic composition of new arrivals to the US (Kasinitz 1992). Initially, immigrants arrived to the US from European countries (Forner 2004:1), but the US experienced significant demographic changes with the passage of the Immigration Act of 1965.

The Current Population Survey (CPS) reports there are an estimated 800,000 immigrants who depart from their native country and migrate to the US annually. The immigrant population in the US has increased substantially and accounts for 12.6 percent of the population (Singh et al. 2008). In 1995, the foreign-born population was 24.3 million. By 2007, the number rose to 37.3 million adults and children. Currently, the foreign-born population has risen to 41 million adults and children (US Census 2010). Since the 1960s, most of the immigrants coming to America have been from Asia, Africa, the Commonwealth Caribbean, and Latin America; a very different demographic from Western Europe included immigrants who flocked to the US before the reform of 1965 (Ddaula 2008:243). These newcomers view the US as the land of opportunities and migrated for various social and economical reasons.

A recent study by the Pew Research Center has estimated that by the year 2050, the Latin population will be the dominant minority group in the US (Pascal 2008). It has been postulated that the Immigration Act of 1965 lead to the increase in the unskilled immigrant population and the on-going immigration debate in this century (Borjas 1999). The following figure is an illustration of the rise in the immigrant population in the US.

Figure 3 *Immigrants in the U.S.*



Source: Center for Immigration Studies analysis of March 1995 through 2007 Current Population Surveys (CPS). The CPS data does not include persons in group quarters, such as prisons and nursing homes. Figures for 1995-1999 have been re-weighted to reflect the large number of immigrants revealed in the 2000 Census.

George Borjas, a Harvard economist is one of the most influential proponents of the body of research arguing that US policies have not screened out sufficient low-skilled wages earners from entering the US. By encouraging welfare to all immigrants, he has argued, America's social policy has encouraged the migration of workers who would otherwise be unable to earn an income above the poverty level (Kretsedemas 2004:7). Today, in the US, public administrators face complex challenges in the provision of services to the immigrant community that is far beyond health care services. With immigrant diverse cultural mix, public administrators' role has become challenging in addressing educational, health and the social welfare needs of immigrants and vulnerable natives in respective states.

SECTION III---PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996

The PRWORA (Public Law No. 104-193) is at the centerpiece of the on-going health care debate regarding the children of immigrants' inability to access an array of health and social services in the US and for adult immigrants. The provision surrounding the debate refers to the limitation of Medicaid eligibility to immigrants arriving to the US after August 1996 for up to five years. Also, it was mandated that the individual states and public housing agencies report names, addresses, and other pertinent information regarding non-citizen recipients to the US Immigration and Naturalization Service (Neubeck and Cazenave 2002:38). A brief history of social and public health programs for America's marginalized population groups is critical to understand the development of PRWORA (Public Law No. 104-193) and its Medicaid limitations to immigrants.

President Franklin D. Roosevelt

During President Franklin D. Roosevelt's tenure as the President of the US, the Social Security Act of 1935 (SSA) became law along with various New Deal initiatives. Embedded within the SSA is the Aid to Dependent Children (ADC) section (Albelda 2002:77). In 1935, ADC emerged to provide single mothers with governmental support, such as, cash benefits to address the needs of their children. ADC was the first welfare program to address the needs of vulnerable women and children. Although originally developed to address the on-going needs of the widow whose husbands were deceased from the World War I, ADC became the program from 1935 to 1996 to address the needs of all vulnerable families. In the 1960s, ADC was renamed the Aid to Families with Dependent Children (AFDC).

President William J. Clinton

The year 1996 was significant for vulnerable immigrants in the US and future immigrants migrating to the US. By the end of August 1996, the US Congress passed both the PRWORA (Public Law No. 104-193) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) (Public Law No. 104-208). Both of these Acts were designed to limit the use of means-tested federal benefits by immigrants, to shift responsibility for immigrant needs to their sponsors or to the states, to achieve federal cost savings (Ku 2009:153). In keeping with President Clinton's election campaign in 1992, to end welfare as we know it, the PRWORA became law on August 22nd 1996. With the passage of PRWORA, known as the Welfare Reform Act of 1996, this Bill required these changes:

Before 1996

- Lawful permanent residents (LPRs) and refugees were eligible for public benefits on the same terms as citizens in Medicaid and on similar terms in the Food Stamps Program (FSP). For FSP, a portion of sponsors' income was deemed available to the immigrants for the first three years in the US, increasing their apparent income and reducing benefits.
- Undocumented migrants were ineligible for the FSP and Medicaid, except for Medicaid coverage of emergency medical conditions.

PRWORA and companion immigration legislation

- *Medicaid*. LPR admitted after August 1996 became ineligible during their first five years in the United States. Restrictions were not applied to refugees, those with forty quarters (ten years) of qualified work, veterans, and other small groups of legal immigrants.
- *Food stamps*. Denied food stamps eligibility to most LPR, regardless of date of entry into the United States. LPR with forty quarters (ten years) of qualified work, veterans, and others remained eligible.
- *Sponsorship*. Required sponsors of newly admitted LPRs to have family income of at least 125 percent of the federal poverty level. Sponsors must sign affidavits stating they will be financially responsible for the immigrants until they become citizens or work for forty quarters (ten years). If immigrants use public benefits, sponsors can be liable to repay the value of the benefits. States are allowed to deny eligibility to LPRs if sponsors' incomes lift their family incomes over eligibility thresholds.

After 1996

- 1997. Eligibility was restored for certain immigrants in SSI. Medicaid eligibility was also restored to those who gained SSI coverage. The State Children Health Insurance Health Insurance Program (SCHIP) was created and most Medicaid immigrant eligibility rules were applied to SCHIP.
- 1998. Food stamp eligibility rules was restored to LPR children, elderly, and disabled who were admitted before August 1996
- 2002. Food stamps eligibility was restored to LPRs who have lived in the United States for more than five years and to all LPR children and disabled regardless of their dates of admission to the United States.
- 2009. States are given the option to restore Medicaid and SCHIP eligibility to all LPR children and pregnant women regardless of their date of admission.

Source: (Ku 2009:155)

The aforementioned summarization of PRWORA highlights the various provisions that states must implement for the continuation of federal support.

The Welfare Reform Act of 1996, Immigrants, and Medicaid Eligibility

The portion of PRWORA that is of significance to this study is the component that limited eligibility for Medicaid benefits to immigrants. Policies do have unintended consequences and PRWORA resulted in various unforeseen challenges for immigrants in America (O'Connor 2004). With the signing of PRWORA, the US ended welfare's common practice of AFDC to native born Americans and members of the immigrant community with legal status. AFDC was renamed Temporary Assistance to Needy Families (TANF).

Immigrants who meet the criteria for various TANF benefits pre PRWORA were no longer entitled to receive these benefits using federal dollars. Under TANF, vulnerable immigrant women and their children were limited to food stamps, supplemental security income and Medicaid when provided by states. PRWORA made both legal and illegal "aliens" ineligible for most federal programs. Legal aliens were deemed not eligible for such assistance until five years after they entered the US from

August 1996 (Hall 1998). Today, this practice continues with the signage of the Patient Protection and Affordable Care Act of 2010 (Public Law No. 111-148) signed into law on March 23, 2010 by President Obama (Zuckerman 2011).

SECTION IV---OVERVIEW ON DISPARITIES

It has been estimated that in 2010, there were over 11.2 million illegal immigrants residing in various states in the US (Zuckerman 2011:1997). In 2010 alone, births to women entering the country illegally were over 350,000 thousands. It is these children that are concerning to members of the US society. These children are entitled to the same benefits of children with native parents, but, fear of deportation and their parent inability to navigate various developed resources in the US sometimes prevent these children from receiving an array of health care services developed to address the well-being of children residing in the US.

A paper on the health care access, health care status and health services utilization of minority children with foreign-born parents will not be complete without an overview of some of the social determinants of health care in the US and the role that these variables play in health care access and service utilization among minorities. A discussion is ever so critical because in 2000, 39 percent of the immigrant children in the US were members of the minority population groups. According to the current CPS, the number of children grew to 46 percent in 2007 and 49 percent in 2010.

America is one of the most industrialized countries in the world. Yet, gross disparities persist in health care outcomes among US adult minority population (Kawachi and Kennedy 1999) and among US children population (Park et al. 2002). The 2002 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic*

and Disparities in Healthcare extensively documents health care disparities in the US by race and ethnicity (Smedley et al. 2002). Inequalities in health denote inherent problems that are systematic, avoidable, and important in understanding health status between different socioeconomic groups in the population (Whitehead 1992).

W.E. DuBois, Booker T. Washington to President William Clinton

For millions of minorities living in the US, especially the black population disparities in health care outcomes are not a new phenomenon. In his seminal work on the state of health of blacks, as early as 1906, W.E. DuBois, stated that the mere occurrence of poverty, psychological stress, and environmental stress contributes to poor health status of this population group (Northington-Gamble and Stone 2006). In 1915, Booker T. Washington started the National Negro Health Week in response to the health disparities affecting Blacks (Centers for Disease Control and Prevention 2010). Like W.E. DuBois, Booker T. Washington recognized the link between health and social and economic well-being.

In an attempt to rectify this social and public health problem, on February 21, 1998, the Clinton Administration committed administrators within the Department of Health and Human Service (DHHS) to develop initiatives to reduce longstanding disparities which affect racial and ethnic minorities by the year 2010. President Clinton's 1998 request, known as the Initiative on Race and Health is not a new phenomenon. In 1985, DHHS was faced with the same daunting challenge. The infamous 1985 report of the Secretary's Task Force on Black and Minority Health identified six causes of death that are responsible for 80% of the annual excess deaths in the African American population (Johnson et al. 1995).

Since President Clinton's initiative, numerous empirical research studying disparities have demonstrated that minorities are treated differently in the health care setting. On some occasions, minorities are not provided with appropriate information to allow them to make life saving decisions (Rothenberg et al. 2004). Despite the economic prosperity of the US since W.E. DuBois and Booker T. Washington statements on the causation of poor health care outcomes, the wide gap in health status, health access and health services utilization between blacks and the Caucasian population in the US continues to be troublesome, serious and a major concern for the US government and communities throughout the nation.

Social determinants of health care

Social determinants of health care have been linked to the on-going racial disparities in health care. It is defined as the social characteristics in which living takes place. Understanding determinants have gained monumental importance and will play a critical role in creating a healthier nation outlined in the Healthy People 2020 objectives. The determinants are unemployment, unsafe workplaces, urban slums, globalization, lack of access to health systems, residence, race and ethnicity, gender and socioeconomics (Ompad et al. 2007).

In the early 1980's limited access to health care services for the minority population was the dominating paradigm utilized to explain health disparities. In the 1990's and in the 21st century, access is not the singular rationale for poor health outcomes in communities of color, but continues to be an important variable. Today, behavioral lifestyles, cultural diversity in health care delivery, discrimination, genetics, racism, provider and patient relationships, psychological stresses, and poverty are

contemporary explanations for health care disparities. The following is a brief explanation for disparities in health in minority communities presented to signify the importance of addressing the health care of children early in their development.

Behavioral lifestyles factors

Good health care outcomes are dependent on many complex interrelationships variables. The role that SES plays in health care outcomes is viewed as a significant cause of disparities. Compelling research has documented that health behaviors have important ramifications on health care outcomes (Lantz et al. 1998). Proponents of the role of behavioral lifestyles have suggested that health professionals have ignored the most important determinants of health which is the patient himself in a socio-cultural context (Pincus et al. 1988).

Behavioral lifestyles impacts health care outcome is possible when someone has the ability to have health care insurance and has the occupational capacity that allows them sufficient income to secure appropriate food resources. The social structures under which groups live can shape values and behaviors in ways that have health consequences (Johnson et al. 1995). In one's quest to solve this problem, the role of the patient in changing behaviors is of paramount importance (Lillie-Blanton and Laveiste 1996).

Cultural diversity factors

Social scientists have argued that one's culture impacts health status, health access, and health service utilization. Since the passage of the Immigration Act of 1965, in the last forty-seven years, the US has become very diverse. The impact of this demographic change is a major challenge and a worthwhile endeavor for social and

public health officials responsible. Given this increase, there is a need for providers of services to become culturally sensitive (Chang and Fortier 1998).

Cultural sensitivity is defined as the clinicians' willingness to identify and incorporate into the care of the patient their culturally based attitudes, values and beliefs about their health and health care expectations (Stewart et al. 1999). Cultural beliefs and practices determine how an individual experience various illnesses and articulate the need for an array of services. The social structures under which groups live can shape their values and behaviors in ways that have health consequences. Developing cultural diversity services is an expensive undertaking for facilities providing medical services to minorities. Nonetheless, review of the literature demonstrates that developing diversity initiatives, such as: interpreter services, recruitment and retention policies, and staff training potentially leads to reduction in health disparities (Andrulis 1998).

Environmental factors

In conducting health services research, socioeconomic status is defined as one's income, level of education and occupational status. Edward Jarvis was one of the first physicians in America to practice psychiatry and to apply statistical methods to the study of health and social problems. As early as 1855, he wrote that:

"Poverty is an inward principle, enrooted deeply within the man and running through all his elements; it reaches his body, His health, his intellect, and his moral powers, as well as his estate... Among those whom the world calls poor, there is less vital force, a lower time of life, more ill health, more weakness, and more early death."
(Steop and Link 1998:1300)

People who live in poverty, who have low levels of education, who work in low-wage jobs, who have few social resources are more likely to suffer adverse health outcome than

people from advantaged communities (Frenk 1998; Lantz et al. 1998; Wilkerson 1997; Hemingway et al. 1997; Johnson et al. 1995).

The role of SES on health outcomes have been significantly documented in the provision of prenatal services to low income women to prevent premature births/low birth weight babies (Hughes & Simpson 1995; Rosenthal and Lobel 2011); cardiovascular diseases (Sanderson et al. 1988); HIV/AIDS (Hatcher et al. 2009) and children's dental health (Guarnizo-Herreno and Wehby 2012). Research has shown that when education and income are controlled and access to free or low cost health services is available, minorities continue to experience poor health outcomes. Health People 2020 launched on October 30, 2010 have increased educational attainment as an essential goal in the elimination of health care disparities. It is the belief that by increasing educational graduation levels, US citizens regardless of place of domicile will play a critical role at increasing health care outcomes in communities in which one resides.

Provider and patient relationship

In the medical community, the primary care provider is responsible for the coordination of all medical interventions. Nonetheless, there is a strong body of literature documenting the differences in treatment received by Blacks as compared to Whites by their primary care provider (Sanderson et al. 1988). So pervasive is this treatment variation that the AMA denounced the differences in treatment stating that it is unjustifiable and must be eliminated (Menefee 1996).

In November 1999, Dr. John Ayanian of the Harvard University School of Medicine published a ground-breaking study in the New England Journal of Medicine articulating that African-American patients were unlikely to receive recommendation

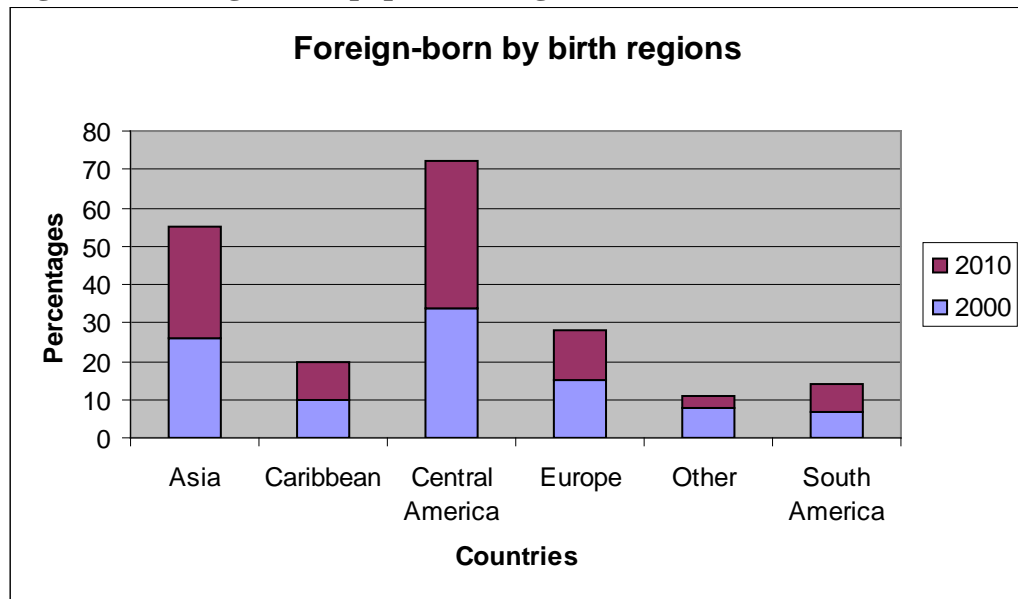
from physicians for kidney transplants. This research brought to the attention of academic scholars the on-going debate on health care disparities connecting it to provider and patient relationships. The landmark study concluded that lack of interpersonal relationships between physicians and patients contribute to disparities. Interpersonal process is the social-psychological aspect of the patient, physician interaction, such as communication, friendliness, explanations, and the ability to be caring and sensitive to patients' needs (Ayanian et al. 1999).

SECTION V---OVERVIEW OF THE US MINORITY POPULATION

This section of the paper provides brief demographics on the US minority population. It is of significance because it highlights some of the needs of minorities living in the US and places into context the need for an investigation on the children with black foreign-born parents. The 2010 US Census continues to demonstrate that the Asian and Hispanic minority groups continue to be the rising population groups in the US.

The Asian community grew from 26% in 2000 to 29% in 2010. The Hispanic community grew from 41% in 2000 to 44% in 2010. Although the growth of the black immigrant group is not as large as the Asian and Latino immigrants, the black immigrant group especially from Africa and the Caribbean contributes to the growing population of immigrants and their children in the US. Figure #4 illustrates the trends in the immigrant population groups. Immigrants from Caribbean countries remained at 10%.

Figure 4 Foreign-Born population region of birth in 2000/2010



Source: U.S. Census Bureau, Current Population Survey, March 2000/2010

African American Population

Prior to the 2000 census, African-Americans were the largest minorities in America comprising 12.5 percent of the US population. Many African-Americans were born in the America, but some have emigrated from Africa, the West Indies/Caribbean and countries in Southern America. The Census Bureau estimates that by 2035, the African-American population will be more than 50 million comprising of 14.3 percent of the population. This table compares the overall white population to the Black population from 1990 to 2050.

Table 3 White and Black population: 1990-2050

Race/Ethnicity	Year 1990	Year 2000	Year 2025	Year 2050
Whites	75.7	71.6	62.0	52.5
Blacks	12.3	12.8	14.2	15.7

Source: The Pew Research Center, US Population Projections 2005-2050

Approximately, 59 percent of all African-Americans live in Central cities with the largest number of this group living in Southeast regions such as the Alabama, District of

Columbia, Georgia, Louisiana, Maryland, Mississippi, and South Carolina (Annie Casey Foundation 2010). While 79 percent of African Americans have completed high school, only 13 percent are college graduates. Many individuals reside in environments with crowded housing; tend to have high rates of unemployment, exposure to a pervasive drug culture, periodic street violence, and high levels of stress and poverty.

African Americans are disproportionately affected by several major health problems that cause premature disability and death. Heart disease, cancer, stroke, unintentional injuries and diabetes are the five leading causes of death in the African-American community. It has been argued that factors contributing to poor health outcomes in this community are discrimination, cultural barriers and lack of health care insurance (National Center for Health Statistic). The 2010 Census has revealed that among the growing minority population in America, 41% of the overall Black population resides in poverty which is disproportionate given that Blacks account for 12.8% of the US population.

African/Caribbean Population

Migration has brought many people from diverse geographic regions and cultural backgrounds to the US. While newcomers may adopt norms of their new environment, they also maintain some of their own traditions which include cultural concepts of health and illness. The 2009 CPS has estimated that beginning with Florida, New York, New Jersey, Massachusetts, Georgia, Connecticut, Maryland, California, Pennsylvania and Texas are states leading the nation with a growing West Indies/Caribbean population (Annie Casey Foundation 2010).

The Caribbean population is heterogeneous, drawing on a variety of Islands, socio-economic and religious identities. Little is known about the provision of health, substance abuse, mental health and related social services to individuals from the Caribbean community. Furthermore, little is known about the health status, health care access, and health service utilization of the children whose parents are of Caribbean ancestry.

Like the Caribbean population group, individuals comprising the sub-Saharan populations are heterogeneous, drawing on a variety of countries from Eastern, Northern, Southern and Western Africa. Beginning with California, New York, Texas, Maryland, Georgia, Virginia, Massachusetts, New Jersey, Minnesota and Illinois (Annie Casey Foundation 2010) are the ten states with the largest population of individuals from Africa.

Like the Caribbean population, there exist a paucity of information on the provision of health, and related services to individuals from the sub-Saharan community. Research is emerging investigating the health status, use of health care resources and treatment strategies of Ethiopian and Nigerian immigrants in the US (Chaumba 2011). What is known is that black children in the US experience approximately twice the mortality rate of White, Asian and Hispanic children (Singh and Kogan 2007).

Among the US population of black children, the chronic disease asthma is one of the most common diseases. From 2001 through 2009, asthma rates among black children increased to 50% (Centers for Disease Control and Prevention May 2011). Blacks are three times likely as other adults to be hospitalized or die from this disease. Emerging research anticipates uncovering the root causes for Asthma leading to more tailored interventions to treat this disease in black communities throughout the US.

Asian and Pacific Islanders Population

The Asian community is enormously diverse across national origins, languages, and religion (Kaufman et al. 1988). Consisting of individuals from China, Cambodians, Hmong, India, Indonesia, Japan, Korea, Vietnamese and other Southeastern countries; the API population is the second fastest growing ethnic minority in America.

Table 4 White and Asian population: 1990-2050

Race/Ethnicity	Year 1990	Year 2000	Year 2025	Year 2050
Whites	75.7	71.6	62.0	52.5
Asians/Pacific Islanders	3.0	4.4	7.5	10.3

Source: Source: The Pew Research Center, US Population Projections 2005-2050

The Census Bureau projects that the API population will grow to 37.6 million individuals in 2050. The states with a large share of the API are Hawaii, California, New Jersey New York, Nevada, Washington, Massachusetts, and Alaska (Annie Casey Foundation 2010). Numerous social and health myths embrace the API community. The API population is known as the “superior minority”/model minority because of educational attainment (Yang 2004). The five leading causes of death for the API population consist of cancer, heart disease, stroke, unintentional injuries, and diabetes. In addition, ovarian cancer, Hepatitis B and C greatly impacts this community health care well-being. What contributes to poor health care outcomes are lack of health care insurance and language (Yu et al. 2008).

Hispanic/Latino Population

Between 1980 and 1990, the Hispanic population in the United States grew 8 times faster than the non-Hispanic and White population. In 2000, Hispanics accounted for 11.3 percent of the US population.

Table 5 White and Hispanic population: 1990-2050

Race/Ethnicity	Year 1990	Year 2000	Year 2025	Year 2050
Whites	75.7	71.6	62.0	52.5
Hispanics	9.0	11.3	16.8	22.5

Source: Source: The Pew Research Center, US Population Projections 2005-2050

Today, the Hispanic community is the fastest growing minority group in the US comprising of 15.4 percent of the US population. This increase is due to the age at immigration and the high fertility rate among Hispanic women.

Table 6 Births by race and ethnicity: 2000-2008

Race	2000	2001	2002	2003	2004	2005	2006	2007	2008
Whites	58.2	57.8	57	56.8	55.9	55.1	54	54	53
Blacks	14.9	14.7	14.4	14.0	14.1	14.1	15	15	15
Hispanics	20.1	21.2	21.8	22.3	23	23.8	24	25	25
Other	6.8	6.4	6.7	6.8	7.1	7	7	7	7

Sources: U.S. Census of Population and Housing, U.S. Current Population Survey, Annie E. Casey Foundation

Like other minority groups in the US, the Hispanic population consists of individuals from various countries in Central and Southern America, Cuba, Mexico, and Puerto Rico. In 2000, the growth of Mexicans increased and continued to increase until a slight decrease in 2007. This decrease has been attributed to the growth of negative immigrant reform in states in the US. Typically, the Hispanic populations resides in Arizona, California, Colorado, Connecticut, Florida, New Mexico, Nevada, New York, New Jersey, and Texas are the leading states where Hispanic reside (Annie Casey Foundation 2010). Today, many Hispanics are moving to Southern States.

The leading causes of death in the adult Hispanic population are cancer, unintentional injuries, stroke, and diabetes (Centers for Disease Control and Prevention May 2011). To the health care environment, Hispanics bring language and cultural differences impacting their health care outcomes. Numerous academic journals have reported that Hispanic children are the most uninsured compared to other minority groups

(Flores et al. 1998). As a group, Latino children face a number of health challenges: such as, diabetes, asthma and the highest teen birth rate in the nation (Manos et al. 2001).

In summary, the information on minorities in the US illustrates the diversity among the US citizens, migration patterns to the various states, educational attainment and common chronic diseases among minorities. Recognizing the increase in the minority population and the rise in the children population, the provision of health care access could reduce chronic diseases among the future minority population by the removal of barriers to health care access.

SECTION VI---OVERVIEW ON THE US CHILDREN POPULATION

The US population of children is diverse and the diversity is reflected in the rise of the minority population. In 2000, 282, 194, 308 individuals resided in the US. Of that amount, 72, 360, 787 consisted of children under the age of eighteen. In 2007, the overall population rose to 301,621, 157 and the children numbers increased to 73,901,733. By 2010, the population rose to 305,191,000; the number of children increased to 79,300,000 (US Census Bureau).

Table 7, provides percentages of the race and ethnicity of these children. Children in the white alone group went from 61 percent in 2000 and decreased to 55 percent in 2009. Together in 2000, the minority population consisting of American Indians, Asians, Blacks, Hispanics, and Native Hawaiian went from being 39 percent to 44 percent in 2009.

Table 7 US Child Population by Race, 2000-2009

Race	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Whites	61.0	61.0	60.0	59.0	59.0	59.0	58.0	57.0	56.0	55.0
Blacks	15.0	15.0	15.0	15.0	15.0	15.0	15.0	15.0	14.0	14.0
Asians	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
American Indians	3.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
Native Hawaiians	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0.0	0.0	0.0
Two or More Races	2.0	2.0	2.0	2.0	2.0	2.0	2.0	3.0	3.0	3.0
Hispanics or Latinos	17.0	18.0	18.0	19.0	19.0	19.0	20.0	21.0	22.0	22.0

Sources: U.S. Census of Population and Housing, U.S. Current Population Survey, Annie E Casey Foundation

A great portion of US children live in poverty (DeNavas-Walt 2011). As can be seen from table #8 on poverty levels, in 2000, 28 percent of children live below 150 percent of the established federal poverty level. Since that time, the percent rose to 31 percent in 2009. Along with the rise in poverty among the US population of children, blacks are disproportionately represented. Table #9 demonstrates that among the US population of children, the children of Blacks are the poorest with their numbers rising from 34 percent in 2000 to 36 percent in 2009.

Table 8 US child poverty levels, 2000-2009

Poverty Levels	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Below 150%	28	28	28	29	29	29	29	29	29	31
Below 200%	39	39	39	39	39	40	40	39	40	42
Below 250%	49	49	49	49	50	50	47	49	47	51

Sources: U.S. Census of Population and Housing, U.S. Current Population Survey, Annie E. Casey Foundation

Table 9 US Poverty by Race of Children, 2000-2009

Race	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
White	10	10	10	10	11	11	11	11	11	12
Black	34	33	34	34	36	36	35	35	34	36
Asians	15	14	14	13	14	13	12	12	12	13
Native Americans	29	27	28	28	29	29	28	27	28	20
Hispanics	31	33	33	32	31	32	35	33	31	35

Sources: U.S. Census of Population and Housing, U.S. Current Population Survey, the Annie E. Casey Foundation

The current CPS data demonstrated that the poverty rates among the native born population were 14.4 percent. Among immigrants, the rate was 19.9 percent. Data stratification revealed the rate for naturalized citizens was 11.3 percent and 26.7 percent for non-citizens. Substantial evidence has demonstrated that children in low socioeconomic status have increased mortality, less likely to see a primary care provider, and more likely to be rated as having fair to poor health (Chen et al. 2002). Research on immigrant children has reported that poverty as a critical social determinant of health care is a contributor to immigrant children being low users of health care services.

State Economy and Immigrants

Health care access is directly related to policies developed in various states and the likelihood of lacking access and use are stronger for families with immigrant members (Yu et al. 2008:2001). Although states are vehicles for change, states are sometimes vulnerable to economic ups and downs affecting the number of people that they can assist and the amount of revenues that states can raise. As illustrated in Table #10, California has been the epicenter for many immigrant adults and their children.

Table 10 Ten Top States for Immigrants from 1990-2009

NUMBER	1990	2000	2007	2008	2009
1	California	California	California	California	California
2	New York	New York	New York	New York	New York
3	Florida	Texas	Texas	Texas	Texas
4	Texas	Florida	Florida	Florida	Florida
5	New Jersey	Illinois	Illinois	Illinois	New Jersey
6	Illinois	New Jersey	New Jersey	New Jersey	Illinois
7	Massachusetts	Massachusetts	Arizona	Massachusetts	Massachusetts
8	Pennsylvania	Arizona	Massachusetts	Arizona	Arizona
9	Michigan	Washington	Georgia	Georgia	Georgia
10	Washington	Georgia	Washington	Washington	Washington

Sources: U.S. Census of Population and Housing, U.S. Current Population Survey, Annie E. Casey Foundation

To implement various provisions in the PRWORA, the aforementioned states utilized state resources to continue providing an array of services to immigrants (Borjas 2003).

Today, immigrants continue to migrate to the aforementioned states, but, Southern States, such as, Georgia, Maryland and Virginia are places of residency being selected by immigrants to rear their children stemming from work opportunities and family connections.

These new epicenter states for immigrants are known to have limited state budgets to deliver public service programs not only for immigrants but for native born residents. States have argued on the increase expenditures for immigrants resulting from the emergency Medicaid Program (DuBard and Massing 2007). With the current recession that began in 2007, states have developed new legislations to limit developed services provided not only to immigrants but overall state population. California has considered capping enrollment in poor children's health program, as an influx of new clients overwhelm it health infrastructure (Rau 2008).

SECTION VII---OVERVIEW OF HEALTH COVERAGE FOR CHILDREN

In the US, in 2010, 16 percent of individuals were without health care insurance.

The demographics of the uninsured population and type of insurance by adults consisted:

Table 11 Health Insurance Coverage in the US: 2010

Race/Ethnicity	Uninsured	Medicaid/Other public	Employee Sponsored
Whites	14.0	15.0	72.0
Blacks	22.0	32.0	45.0
Hispanic	32.0	29.0	39.0
Asian/Pacific Islanders	19.0	14.0	67.0
Native Americans	30.0	28.0	42.0
Multi-racial	15.0	31.0	55.0

Source: Urban Institute Analysis, 2011 ASEC Supplement to the CPS

The percent of blacks without health coverage was 22 percent and 32 percent relied on the federal public financing system to receive required medical interventions. In looking at uninsurance among the US children population, Table #12 illustrates that 10.8 percent of Black children were uninsured. When covered over 52.5 percent were covered by Medicaid, other public health programs and 32.5 percent relied on employee sponsored and individual coverage to access and utilize age appropriate service.

Table 12 Health Insurance Coverage for children in the US: 2010

Race/Ethnicity	Uninsured	Medicaid/Other Public	Employee Sponsored
Whites	7.1	23.5	62.3
Blacks	10.8	52.5	32.5
Hispanic	16.9	48.7	31.0
Asian/Pacific Islanders	9.2	26.4	57.9
Native Americans	---	---	---
Multi-racial	6.7	39.6	46.0

Source: Urban Institute Analysis, 2011 ASEC Supplement to the CPS

To promote access to health care services, the federal government has developed significant public health financing programs which includes Medicare, Medicaid and the

State Children's Health Insurance Program (SCHIP). Medicaid and Medicare were both developed in 1965 as part of President Johnson's Great Society initiatives. The SCHIP program was the President Clinton Administration's attempt at developing incremental steps to universal health services. Through a special initiative emerging in the Bush Administration to reduce the rise of the uninsured, in 2002, the number of health centers substantially increased in the US. This initiative was expanded in the President Obama Administration by providing substantial government resources to the Health Resources and Services Administration (HRSA) in both the American Recovery and Reinvestment Act 2009 (Public Law No. 111-5) and the Patient Protection and Affordable Act of 2010 (Public Law No. 111-148) to significantly expand the health center program. Health centers were first enacted in the Johnson's administration with the mission to provide services to anyone in need of health care services regardless of their ability to finance needed services.

There are various vehicles utilized for Americans to receive an array of health care coverage which include Employee Sponsored Insurance (ESI), Medicaid, Medicare, SCHIP, and various programs being developed at the state and county levels. This following section highlights the Employee Sponsored Insurance, Medicaid, and SCHIP. The roles of private and public insurance are highlighted because of their vital role they play in the lives of children of immigrants. Medicaid and SCHIP are discussed because they are vehicles commonly utilized by states to provide children with access to and the utilization of health care services regardless of the child's immigration status. Also, a brief background is provided on Medicaid Managed Care Program, a private and public

partnership vehicle being undertaken by various states to ensure the delivery of services for millions of Medicaid and SCHIP beneficiaries.

The Employer Sponsored Insurance Program (ESIP)

In the US, most Americans receive health insurance from employment. Health insurance is central to the well-being of individuals living and working in the US. ESI is not mandatory and many Americans refuse to be covered under ESI. Two of the most compelling reasons for coverage refusal are the high cost of premiums, and employment in low-wage jobs. In the twenty-first century, ESI coverage has been on the decline. Researches have argued that this decline is attributed to the state of the economy (Halahan and Chen 2011). The latest CPS report acknowledged that 58.7 percent of the uninsured worked either full-or part-time during 2009 and 14.5 percent of the uninsured lived in households with annual incomes between \$50,000 and \$74,999. Among the foreign-born population, the uninsured rate for naturalized citizens was 20 percent, while the uninsured rate for non-citizens was 45 percent (Kaiser 2009).

Among immigrant families and native families, full time employment is similar but immigrant families are less likely to be offered employers sponsored health coverage (Alker 2006). It is noteworthy to state that this rationale is from the type of employment immigrants have gained which tends to be in the agriculture, construction and service industries. Brown et al (1999) found that Asian, Black, and White immigrant families have job-based health insurance, but only 35 percent of Latino children in immigrant families have ESI.

Given that the typical immigrant in the US is employed in low wage job opportunities, the decline in ESI negatively impacts the children of immigrants. ESI

health coverage is essential for immigrants since their eligibility for public coverage for Medicaid and SCHIP is restricted. Without health care coverage, many of these children will not have a regular source of care and childhood diseases that are potentially preventable can escalate. The medical home concept defined as having a particular person or place a child goes to for sick and preventative care contributes to the facilitation of timely and appropriate use of pediatric services (Folton 1995). Limited resources for children to access health care services move away from the development of the medical home framework.

Medicaid

On July 30, 1965, President Johnson signed H.R. 6675 Public Law 89-97 to establish the Medicaid program as Title XIX of the Social Security Act (Kaiser, 2006). It was designed as a partnership between the federal government and the state entities to provide public funding of health care for low-income children and adults meeting eligibility requirements (Rocha and Kabalka 1999).

From its onset, Medicaid was a medical care extension of federally funded programs for the poor with a focus on the aged, the disabled, dependent children and their mothers. Legislation in 1987 and 2000 further expanded Medicaid coverage to low-income pregnant women, more children and some Medicare beneficiaries who were not eligible for any cash assistance program. Most significant, Medicaid expansion by states through the 1115 Waiver Demonstration has been the increase of coverage for children.

Forty six years later, Medicaid is one of the most significant payor of health care services for low incomers. For healthy children to receive the required EPSDT services; the annual Medicaid expenditure is \$2,135 and for adults, it is \$2,541 (Camarota 2010).

Medicaid was the payer of choice for 23.5 percent white children; 52.5 percent Black children; 48.6 percent Hispanic children, and 26.4 percent Asian children and other Pacific Islander children and 39.6 percent Multi-racial children.

Throughout its history, Medicaid has been the provider of comprehensive services to enrolled beneficiaries. Specific Medicaid benefits for children were established in 1967, with the creation of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. EPSDT is a comprehensive package providing periodic evaluations of health and developmental history, as well as vision, hearing, and dental screening services to children. Federal law and regulations require states to provide EPSDT services to Medicaid eligible children under the age of 21. States are mandated to inform the families of these children of the availability of EPSDT services, their benefits, and where and how to obtain them.

As aforementioned, under federal law, most legal immigrants are not eligible for Medicaid during their first five years in the US except for emergency treatment (Kaushal and Kaestner 2004). Although immigrant children who were born in the US are entitled to Medicaid, parental difficulties to navigate the US health care system and language barriers have impacted children access to health care services (Ku 2007; Ku & Matani 2001). Given parental barriers, one can assume that these children who are eligible for Medicaid might not be beneficiaries of EPSDT services for their health and social well-being. Early services which can detect signs of dental decay, slow developmental milestones and begin the education of parents by providers on the benefit of early treatments.

The State Children's Health Insurance Program (SCHIP)

Fifteen years ago, Congress enacted the State Children's Health Insurance Program (SCHIP). SCHIP was enacted as part of the Balanced Budget Act of 1997 (Public Law 105-33) to reduce the number of uninsured children in America by providing health coverage for America's children in working families (Trafton et al. 2000). SCHIP established as Title XXI of the Social Security Act provide funds to all States to develop health insurance programs to provide children within a certain federal poverty level (FPL) access to comprehensive and coordinated health services. SCHIP is the largest single expansion of health insurance coverage for children since the authorization of Medicaid in 1965. SCHIP builds on Medicaid and covers children in low and moderate-income families whose family incomes are too high to qualify for Medicaid. Under SCHIP, states were given the option to set up a separate child health program, expand Medicaid coverage, or have a combination of both a separate child health program and a Medicaid expansion (The Commonwealth Fund 2007).

All states wishing to implement SCHIP must submit applications and be approved by the Centers for Medicare and Medicaid Services, which is an umbrella agency of the DHHS. At the ending of fiscal year 2010, approximately 7.2 million children were provided with health insurance under this initiative. As of 2010, eighteen states developed a separate SCHIP, eleven states developed a Medicaid SCHIP and twenty developed a combination SCHIP. Unlike the Medicaid program which is an entitlement program and receives an increase by the federal government to address the increase rise in health care cost, the SCHIP is a block grant program and increases are not automatic.

The emergence of SCHIP in 1997 has been a contributing factor in the provision of health care services to millions of the US poor children whose parents earn too much

to be eligible for the regular Medicaid Program. It has been argued that the emergence of SCHIP not only attributed to increase access to health care, but the quality of medical care provided to children (Newacheck 2004). The restriction of Medicaid for legal permanent residents embedded in PRWORA remains with the establishment of SCHIP.

SCHIP was reauthorized on February 5, 2009 by President Barack Obama's Administration and runs through 2013. Embedded in the new SCHIP is a new legislation, the Immigrant Children's Health Improvement Act (ICHIA), a legislation developed to remove restrictions placed on the ability of legal immigrants from accessing services. Today, SCHIP is known as, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) (Public Law No. 111-3). Section 214 of CHIPRA permits states the flexibility to ensure coverage without the 5 year delay of certain children and pregnant women under the Medicaid Program and CHIP (Capps 2009). In addition, CHIPRA mandates developing electronic medical record for children, comprehensive dental benefits, mental health parity, children's health care quality standards, and funds to be awarded in the form of competitive grants to states for outreach activities and obesity demonstration projects. For the first time, through CHIPRA, children who are enrolled in private coverage that does not include dental benefits can receive dental coverage.

Medicaid Managed Care Programs

All across America, states are developing applications to gain approval from CMS to enroll the AFDC population, the disabled another population groups into managed care organizations providing services to Medicaid beneficiaries. CMS is the branch of the Department of Health and Human Services (DHHS) which regulates and monitors the Medicare, Medicaid and the State Children's Health Insurance Program and a critical

agency in the implementation of the Affordable Care Act of 2010. The aforementioned federal programs in 2009 financed comprehensive medical and social support interventions for approximately 58 million beneficiaries. Of that number, 29 million were non disabled children and 9.2 million were the elderly providing health coverage and long term care assistance (Kaiser 2010).

To control high Medicaid expenditures, states are increasingly relying on Health Maintenance Organizations/Managed Care Organizations (Simms et al. 1994). The premise of the managed health care program is to promote health and achieve cost savings by emphasizing primary and preventative care from a single source (Ziring et al. 1998). Managed care programs provide enrolled members a personal doctor or a medical home to increase the continuity of care and potentially reduce the amount of doctor shopping (Garvin 1999).

There are various avenues for states to enroll Medicaid, Medicare and SCHIP beneficiaries into managed care. For the Medicaid population, two of the most common processes are through the 1915 (b) waiver or the 1115 Medicaid Demonstration Program. For states to begin these managed care enrollment, applications must be discussed and approved by CMS. States are reliant upon managed care entities to provide children enrolled in these private organizations the receipt of mandated EPSDT services; therefore, contracts awarded must keep health care systems accountable by the collection of data on the screening, care and treatment provided to Medicaid beneficiaries.

The aforementioned section on health care financing programs for children provides an illustration on the array of programs in the US for realized and potential access for the receipt of health care for America's children.

SECTION VIII---THEORETICAL FRAMEWORK AND CHILD HEALTH SERVICES

In addressing the health care access, health care status and health care utilization of immigrant children, covariates from the framework developed by Robert Andersen is essential. This section is organized into: (1) Access and utilization of dental services; (2) Access and utilization of medical services; and (3) Access and utilization of mental services. Dental, medical, mental health services were selected as variables because in studies on children of immigrants, evaluating access and utilization have not been stratified specifically for children reared by black foreign-born mothers.

Access and utilization of dental services

Each year, 17 million poor children have limited access to dental services and go without the receipt of dental care (Pew Research Center 2010). Low utilization of this critical service among the US children has been attributed to low Medicaid reimbursement and limited dental practitioners in low income communities. On February 5, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Along with providing access to medical services to children from zero to seventeen years of age; Public Law No: 111-3 mandates that children enroll in CHIPRA receive comprehensive oral health care services which are age appropriate (Horner 2009). In addition, CHIPRA will provide dental services for children with private insurance upon declaration that private insurance does not cover children's dental benefits.

The American Academy of Pediatric Dentistry, The American Dental Association, and the Bright Futures Committee recommends that a child receives two visits per year to a dental professional beginning at age one (Liu 2007). This first visit is

critical because parents can learn about oral health issues and steps to promote oral hygiene. The US Surgeon General Report Oral Health in America released in 2000, stated that dental caries is the most common chronic childhood disease (Chu 2007). For the poor and young minority children, disparities exist in dental health care and treatment (Southward 2006). Through the EPSDT Program mandated by the Medicaid Program, states receiving funds from CMS are required to provide dental services to enrolled children.

Although there are developed standards for the provision of quality and effective dental services to children in the US, children especially minority children are not recipients of dental services. In early childhood, early evidence of tooth decay lead to poor nutrition, needless pain, poor self-esteem, missed school days and medical complications in later life. Limited utilization of dental services have been attributed to lack of health insurance, lack of pediatric dental providers in minority communities, unawareness of the benefits of dental services by the caregivers, and the availability of financial resources to pay for services (Dasanayake 2002).

Disparities in the access and utilization of dental services reflect family income, parental education, race and ethnicity and urban and rural residence (Edelstein 2002). Using the National Survey of Children's Health, Liu et al. (2007) examined disparities in dental insurance coverage and dental care among US children. Children who had natural teeth at the time of the interview were the study population. It was concluded that children in poverty had the highest rate of no dental insurance and that public dental insurance is not a predictor of access to dental services. As compared to white children, US born minority children lacked dental insurance.

Looking at the underutilization of oral health services among minorities in Alabama's Medicaid program it was concluded that low usage of dental care among minorities is complex (Dasanayake 2000). It stems from variables, such as gender, age, location of dental services and the duration of dental eligibility. Another study completed in California among children ages two to eleven years aiming to determine factors associated with dental utilization found that predictors are the age of caregivers, and a mix of parental, child and household factors are contributors to low utilization (Isong 2005).

Although the US Surgeon General Report: Oral Health in America was completed in 2000, the information on health disparities in oral health care for both children and the adult population persists. Disparities in oral health status, access and service utilization is evident among the minority children population (Edelstein 2002). Limited access is not due to lack of insurance but other economical, social and environmental variables. In communities of color, an essential environmental factor for low access to dental services is the shortage of dental providers accepting Medicaid. This public health crisis in low income communities intensified by the case of a young Baltimore resident, Diamante Driver, whose life was shortened resulting from an untreated dental abscess.

In 2010, the Health Resources and Services Administration commissioned the Institute of Medicine to complete two reports on the future of Oral Health Care in America. The first report was published on May 4, 2011, entitled, *Advancing Oral Health Care in America* and the second report published on July 13, 2011, *Improving Access to Oral Health Care for Vulnerable and Underserved Population*. Both reports acknowledge various barriers to care for the receipt of dental health care services and

suggested the need to increase the future dental workforce in the US (Advancing Oral Health 2011; Improving Access to 2011).

To address work force shortage, federal government offices, such as, the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Prevention and Control (CDC), Centers for Medicare and Medicare Services (CMS) and the Health Resources and Services Administration (HRSA) have formed partnerships. AHCQ will develop dental quality standards, CDC will develop educational initiatives on oral health hygiene, CMS continues to enforce program accountability among states receiving Medicaid funds for EPSDT services and HRSA continues to develop advertisement campaigns to encourage medical and dental students to partake in the National Service Corps and Loan Forgiveness Programs to increase future workers in low income and rural communities throughout the nation. In addition, the American Dental Association, an advocacy organization for oral healthcare providers engages in discussions with the oral health care community, various dental schools and other allied dental programs to consider new professionals who are suited to provide dental services to increase access to this critical health service for all Americans (Reznik 2012). Various federal initiatives to increase stems from the awareness that millions of US citizens do not have access to health care because they live where there are not enough health professionals to meet basic needs (Sumaya 2012). It is the belief that loan repayment, scholarship and loan programs will help to encourage and enable clinicians to work in underserved areas.

Access and utilization of medical service

It has been well documented that children of immigrants are low users of medical services. Using the March 1996 CPS and the 1994 National Health Interview Survey,

Brown et al. (1999) completed a comprehensive study on immigrant children. The study examined health insurance coverage and access to health care services among first-generation immigrant children and U.S. citizen or nonimmigrant children in immigrant families, compared to children in nonimmigrant families. Two research questions guided this investigation which were as follows: (1) Are children who are non-citizens immigrants at higher risk of being uninsured than citizen children in native-born families and (2) Are US citizen children in immigrant families at higher risk of being uninsured than those whose parents were born in the US?

Children were classified into three groups of immigration and citizenship categories which are: (1) Non-citizen immigrant child which refers to a child who was not born in the US and it not a US citizen; (2) US citizen child in an immigrant family which refers to a child who is a citizen and has one or more parents who are foreign born, regardless of whether they are US citizens; and (3) US citizen child with both parents born in the US or in a single parent family, the one parent being US born.

The investigation concluded that non-citizen children and citizen children in immigrant families are more likely to lack health insurance coverage than children whose parents were born in the US Latino children were the most disadvantaged having the highest rates of uninsurance ranging from 16 percent for citizens to 53 percent for noncitizens. Asian citizen children with US born parents have the lowest uninsured rate of any group, but Asian children in immigrant families have uninsured rate that is more than two times for children in native born families. Black noncitizen children had a 37 percent rate of uninsurance compared to Black citizen children in immigrant families and

those with U.S. born parents. White children have the lowest rates of uninsurance in all groups of children.

Ku and Matani (2001) investigated how immigrant status affects insurance coverage and the use of medical, dental and mental health services by adults and children. Using data from the 1997 National Survey of America's Family, the main research question was to what extent are the differences in insurance status and usual source of care related to being an immigrant, as opposed to other social and economic differences? The study, like the Brown et al study, looked at three groups of immigrant children and their families; non-citizens, citizen children and naturalized citizens.

As compared to children whose parents are citizens, the investigation found that non-citizen children had less Medicaid, less job-based insurance, are at a greater risk for being uninsured, and are less likely to have a usual source of care. Citizen children with non-citizen parents were eligible for Medicaid, but they were still less likely to participate, citizen children with non-citizen parents had significantly fewer doctor/nurse and emergency room visits than did children of citizens. Children of citizen parents have greater access to medical care than do children of non-citizens.

In looking at various groups of children, the Hispanic population was associated with getting less medical care. In looking at health status, Latinos reported poorer health status than non-Latinos. People who reported fair or poor health status used much more health care services, but this was not small for the Hispanic immigrant population. The health care access of naturalized citizens was similar to that of native born.

It has been argued that states have been architects of significant policy innovations. In addressing insurance coverage in various states, researchers have studied

variations in health care access and use among children in the US immigrant families. Using NSCH, Yu et al (2008) investigated the health status and health care access of children from immigrant families in 6 states with a large immigrant population of immigrants. The study purpose was to examine the independent effects of state of residence and use of health care while controlling for covariates commonly used to study the needs of children of immigrants.

Unlike, previous studies looking at three immigrant groups, this study looked at 4 immigrant family types which were: (1) foreign-born child; (2) U.S. born child with two foreign-born parents; (3) US born child with one foreign-born parent; and (4) U.S. born child with nonimmigrant families. California, Florida, Illinois, New Jersey, New York, and Texas were the states of focused. It was concluded that most foreign-born children, US born child with two foreign-born parents; US born child with one foreign-born parent were typically Hispanic living in Texas and resided in households with incomes below the 100 percent of the poverty level. Of the four groups of children, foreign born children had the highest rate of uninsurance, were without personal health care provider, and limited preventative services in the past twelve months.

The health care need of children of immigrants is important in other countries. In Canada, immigrants have been shown to access health care services less often than the native-born Canadians. Guttermann et al. (2005) investigated whether recently immigrated parents access effective preventive care for their infants as well as nonimmigrant by measuring immunization status of 2 year olds. Researchers concluded that there are no significant differences in assessing immunization services for immigrant parents as compared to native-parents. Immunizations coverage was higher for children

of Southeast and Northeast Asians children living in Ontario, Canada as compared to the non-immigrant population.

Access and utilization of mental services

In 2000, the Surgeon General Report entitled, *Mental Health*, warned that the nation is facing a public crisis in mental health care for infants, children and adolescents and that culture counts. It is estimated that one in every five children and adolescents in the US has a mental disorder. These children have mental health problems interfering with normal development and functioning (Sturm 2003). Also, the report highlights the growing disparities in the use of mental health services among the US minority population groups.

Research on the utilization of mental health services demonstrates that compared to their white counterparts blacks are less likely to receive accurate diagnoses (Williams 2007). Compelling arguments for low utilization are historical misdiagnosis, inadequate treatment and lack of cultural understanding (Dana 2002). As early as February 2012, national newspapers and credible black media outlets called attention to mental health illness being overly diagnosed in black communities. Black Americans are far more likely than their white countrymen to be labeled schizophrenia; one of psychiatry's most serious and intractable diagnoses (Heady 2012). To examine whether blacks would exhibit higher rates of clinical schizophrenia diagnoses when controlling for SES. Finding suggests that blacks exhibit higher rates of clinical diagnoses schizophrenia than whites (Gara et al. 2012). The authors would like mental health practitioners to challenge their own diagnostic assessment and internal belief systems in the treatment of individuals from other racial groups.

Types of mental disorders being diagnosed includes as attention deficit disorder with or without hyperactivity, autism, bipolar, depression, and schizophrenia. Mental disorders have both financial and emotional upheavals for families and various communities and it is critical that the mental health needs of our nations' children be addressed. The National Survey of Drug Use and Health was utilized to investigate whether children in age groups 12-17 diagnosed with major depression received care and treatment within the previous year. It was found that non-Hispanic whites who received any major depression treatment was 40 percent compared with 32 percent in blacks, 31 percent in Hispanics, and 19 percent in Asians (Cummings and Druss 2011). The researchers posit that it was difficult to ascertain whether these differences resulted from access to care, professionals not making referrals or the stigma attached to the receipt of mental health treatment among racial groups.

Studies on minority children in need of mental health services do not specifically address the need of black children of immigrants. Research on the mental health needs of children of immigrants is mostly conducted in the United Kingdom and other European nations. The growing immigrant population in the UK has lead to research on ethnic differences with the premise to make mental health services accessible and sensitive to children belonging to diverse groups. In a study conducted by Goodman (2008) Black African and Indian children appears to enjoy better mental health than White British children. On the other hand, Black Caribbean, Pakistani and Bangladeshi children mental health needs do not differ from that of British children.

Evaluating mental health in children being reared by Black immigrants living in the US is critical. There is evidence that there exist an unmet need among the US

population of minority children for mental health services. Significant is the need for research because a large number of the Black immigrant resides in low-income communities. People with mental illness are overrepresented in high-poverty neighborhoods and these communities are particularly vulnerable (Aneshensel 1996).

Chow et al (2003) evaluated whether disparities would vary with residence in community with different poverty levels among Asians, Blacks, Latinos and Whites. The data source was the New York State Office of Mental Health Patient Characteristics Survey. It was concluded that Blacks and Hispanic who used the mental health system were younger than 18 years compared with Whites and Asians. When accessing the mental health system, Blacks living in poor communities were more likely to use emergency and inpatient services. In addition, Blacks were less likely to be referred to the mental health system by their social support systems as compared to being referred by social service agencies.

Ongoing mental illness has on-going psychosocial well-being not only for the children, but for their family members. There is evidence that despite the increase in funds in spending for health care to reduce health care disparities, inequities in mental health services continues in the US. Using the National Survey of American Families and the National Health Interview and the Community Tracking Survey, (Alegria 2003 and Kataoka et al. 2002) investigated unmet need for mental health care among US children. It was concluded that among children in need of mental services, Latino children in need did not receive care. In regards to access to mental health base on health coverage, there was no significant difference in unmet need between uninsured and

privately insured children. Minority children in need of mental health services are not being served by the system.

The caregiver of a child plays a significant role in recognizing the mental health needs of children. The parents of minority children are less likely to recognize and report mental health problems than the children of white parents. Studies have reported that cultural factors may influence whether parents recognize problems in their children (Robert 2005). Recognizing the barriers influencing disparities in access and utilization among the US minority children population could lead to the utilization of this critical services to this population of children (Kataoka 2002).

SECTION IX---MULTICULTURALISM AND THE PUBLIC ADMINISTRATOR

Throughout this literature review, data presented from the US Census Bureau and various academic institutions highlight the growing diversity and melting pot of the US. As aforementioned, the Hispanic population is the largest minority group followed by Asians and Blacks from the Commonwealth Caribbean and African nations. These demographic trends of the US emerging racial and ethnic population groups demonstrate the need for public administrators to become not only culturally competent in the delivery of services to consumers but ensuring that services are based on social equity principles.

The debate surrounding health disparities among the US population argues that the system does not reflect social equity and needs to become culturally competent in service delivery. The concept social equity is rooted in the social justice theoretical framework egalitarianism. This concept resurfaced and brought to the attention of political scholars by John Rawls, in his classic book, *A Theory of Justice*. Mr. Rawls enhanced the level of analysis of the social justice theory egalitarianism and defined the

concept of social equity as justice as fairness (Rawls 1971). He argued that in any given society, the principle the “veil of ignorance” should be the guide in daily interactions. Members of the society are challenged to use personal sense of justice to derive principles of equity without the basis of knowing their own situation (Wooldridge and Gooden 2009:223). Although the concept of social equity was coined approximately forty-one years ago, the concept is essential to critically analyze developed policies by the US federal, state and local officials for marginalized citizens.

Public Administration and Social Equity

The history of the field of public administration consists of men and women, such as, Henry Fayol, Frances Perkins and Dwight Waldo championing the needs of the vulnerable. Whether advocating for the rights of workers to be treated with fairness, the rights of the residents of Settlement House, the outcry for public servants to consider justice as fairness, recognizing the needs of the emerging communities and questioning the essence of democracy and bureaucracy; early public administrators were crusaders for the needs of the less fortunate. Although public administrators have contributed to create a more equitable, fairer and more just America, the field has more to contribute (Frederickson 2010:74).

The guiding principles of the field of public administration are administrative efficiency, individual rights, social equity and political responsibility. The principle social equity was included upon a challenge by H. George Frederickson to the practice of public administration. He defined social equity as justice, fairness and equality and posited that this principle should be embraced by public administration (Frederickson 2010:76). Because public administrators are responsible to carry-out developed laws and

policies, like humans, they struggle with fairness, justice and equality. Developed laws are not clear and the public administrator is placed in positions to ascertain which programs developed are being implemented which are equitable for some and inequitable for others. Given the ongoing disparity debate in education, health care access, health utilization and variation in socioeconomic status among minorities, understanding the management role of the public administrator in addressing the eradication of disparities is critical to the field of public administration.

Public Administration and Workforce Competency

Public administrator scholars writing on culturally competency have argued that cultural competency is fundamental to a good government (Major-Norman and Gooden 2012:3). Furthermore, organizations can improve service delivery by understanding the values and norms of the target population (Wyatt-Nichol and Naylor 2012:63). The outcry for the incorporation of cultural competency in public administration derives not only from the increase in the immigrant population groups, but, the graying of the US, race relationships, gender differences and same sex orientation.

Cultural competency is postulated to involve systems, agencies, and practitioners with the capacity to respond to the unique need of the population whose culture are different from mainstream American culture (Brown 2012:332). It is the hope that by enhancing the training of the future public servant workforce, recruiting individuals representing society's multicultural groups and developing legislation enforcing the potential needs of newcomers, inequalities in service development and service provision will be eradicated.

Since the writing of *Towards a Culturally Competent System of Care* (Cross et al. 1989), federal, state, local governments and organizations have striven to incorporate concepts developed by Cross to implement funded programs. The signage of the Patient Protection and Affordable Act of 2010 (Public Law No. 111-148) is another attempt by the federal government to address the development of a culturally trained workforce. Embedded in the ACA are mandates that federal agencies develop Minority Health Offices throughout the DHHS. Offices located at the Agency for Health Care Quality and Research, Food and Drug Administration, Centers of Medicare and Medicare Services, Health Resources and Services Administration and Substance Abuse and Mental Health Administration are required to develop sound partnerships among federal partners. In addition future funding opportunities from aforementioned agencies should provide responses on whether hired staff members on grant applications are culturally and linguistically competent in addressing the growing diversity among the US population groups. By establishing these offices mandated in the ACA, it is posited that they will serve in the capacity of watchdogs ensuring that the welfare of the US's diversity and funded programs are developed under the rubric of social equity and the themes of cultural competency.

Cultural Competency, Social Equity, Public Management, and PRWORA Integration

Should the term multiculturalism be of significance to public administrators? Mitchell Rice argues that such a term is critical for the future of the profession and that multiculturalism and social equity are interconnected (Rice 2005:66). Social equity in public service should include four tenets: (1) Public administrators require that citizens and clients be treated the same regardless of needs; (2) Public administrators are required

to provide more and better services to those who need it the most; (3) Public administrators should be evaluated on steps to enhance fairness, justice and equity in outcomes; and (4) Public administrators should take into account procedural fairness, access, quality, and outcomes (Rice 2005:67).

Richard Chapman argues that ethics in government is about moral standards in the public service (Chapman 1993:1). From the early history of the US constitution, ethical values and virtues dominate the democracy. Concepts such as trust, loyalty, benevolence, unselfishness; such virtues as prudence, temperance, fortitude and justice; and such values as faith, hope and love were essential in the formation of a democracy (Gawthrop 1998:2). Since 1996, recent policies developed by the US governments have negatively impacted the well-being of immigrants and their families. The PRWORA arising from President Clinton's Administration and the Deficit Reduction Act of 2005 from the Bush Administration are mere examples of reducing immigrant eligibility for developed health and social services. H. George Frederickson caution public administrators to be critical of developed policies. In policy implementation two critical questions must be considered. First, is whether an existing or proposed public program is effective or good? Second is for whom the program is effective or good (Frederickson 2010:81).

The implementation of PRWORA is an acceptable illustration on the management of public administrators using cultural competency and social equity principles to ensure that children of immigrants receive health care in the US. One can argue that moral standards such as justice guided these public servants to take the leap of faith and continued the provision of essential services for children. States used revenues from taxes to ensure that eligible children were beneficiaries of health resources. Aggressive

outreach programs emerged in low income communities with high immigrant penetration to educate parents on health care resources for their children.

From the signing of the PRWORA in 1996 to the present, public administrators working in various bureaucratic levels of governments have been placed in difficult situations. In addressing the unique needs of America's diversity, public administrators are uniquely placed within organization and can play an integral role ensuring that organizations recruit a culturally trained workforce. With developed knowledge in administration, these public servants being viewed as administrative experts, change agents and strategic partners can educate internal and external stakeholders on the growing needs of those in need of an array of resources for the well-being of children. The task facing individuals with overall responsibility for the public service includes understanding the nature of problems, devising procedures to minimize problems and ensuring that those that cannot be resolved are dealt with satisfactorily within accordance with the values and standards of the society (Chapman 1993:6).

SECTION X---LITERATURE REVIEW SUMMARY

The economic, social and political aspects of immigration have caused multiple controversy regarding economic benefits, ethnicity, impact on upward social mobility, jobs growth, levels of criminality, moral values, nationalities, political loyalties, race, religion, settlement patterns, and work benefits. Violence, drugs, child abuse and neglect, unequal access to quality education, and lack of affordable quality health care, threatens our nation's children, and immigrant children are not immune (Novelli and Goyer 2004:156).

The immigrant children and the group of children born in the US to immigrant parents are at great risk for living in poverty compromising their health, safety and their futures. Public administrators are faced in making difficult decisions. On one hand, one must adhere to the code of ethics in their selected professions, while being professionally responsible to abide by developed work place requirements.

Policies sometimes conjure up unintended consequences and PRWORA was not immune to this policy phenomenon. Substantial research asserts that PRWORA undermined the health access, status and service utilization of Asian and Latino children of immigrants. Compelling research have found that immigrant children are much less likely to have public or private health insurance than native citizens and that children of immigrants are more than twice as likely to be in "poor or fair" health as children of US-born parents. Given the increase in both the Asian and Latino population groups; it is critical that academic scholars critically examine the well-being of this population of children.

This review highlighted the need to investigate the black population of children reared by black foreign-born mothers. A research on this specific population of children could expand the knowledge on health service research, pediatric health services and research in public administration. New literature findings can contribute to current scholarly information on health care disparities and the unique dilemmas public administration encounter implementing developed federal, state and local policies. By determining factors resulting from PRWORA, public administrators working at implementing various federal, state and local programs will develop additional knowledge. New information can lead this profession to continue to advocate for

eradication of health care disparities among the nation's minority communities, recommending data stratification by sub-population, and working with other national advocacy organizations for a more culturally trained workforce to address America's diversity with an onward commitment to justice and fairness.

SECTION X1---RESEARCH QUESTIONS

The review of the literature led to the development of the following research questions:

- (1) What are the demographic characteristics of the children from zero to seventeen whose mothers identified as foreign-born and native-born from the NSCH?
- (2) Are there differences in socio-demographics, health status and utilization of dental, medical and mental health services among children of foreign-born compared to children with native-born black mothers?
- (3) Is there an association between age, education, health status, gender, insurance type, language, regions, source of care and poverty levels in the receipt of dental, medical and mental health services among children of foreign-born compared to children with black native-born mothers?
- (4) Was the Medicaid provision in the PRWORA associated with service utilization of dental, medical and mental services of children between the ages of 8-17 among children of foreign-born compared to children with black native-born mothers?

CHAPTER THREE

METHODOLOGY AND MATERIALS

The July 2004 NSCH was used to investigate whether the Medicaid provision in PRWORA for immigrants is associated with health care access, health care status, and health care service utilization of dental, mental health, and medical services to children from 8-11 and 12-18. The NSCH was designed and directed by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau and conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics (CDCHCHS). Both agencies HRSA and CDC are under the umbrella of the DHHS. The NSCH is a stratified self reported sample and collects a series of responses on the well-being of children in all 50 states in the US and the District of Columbia. NSCH is a nationally representative survey instrument and its sample size is 102,353 children from zero to seventeen years whose caretakers were interviewed from January 2003 to July 2004. Of those, 11,535 children had mothers who identified as foreign-born.

The sample population for this comparative research consisted of 651 children whose mothers identified as being black foreign-born and 7,815 children whose mothers identified as black native-born. This investigation using the CDC age group stratified the children from the NSCH into four categories which were 0-3; 4-7; 8-11; and 12-17. The variables selected for this investigation are the same variables that researchers have utilized in previous research that investigates children of immigrants and the general population of children in the US looking at health care access and utilization (Newacheck 2004).

SECTION 1

METHODOLOGY

A. Study Goals

The primary independent variable in this study concerns the immigrant status of a child's mother: black foreign-born or black native-born. Mothers were selected rather than fathers because the immigrant mother plays more important role in whether her child goes for medical care services and where these medical services are received (Weathers et al. 2008). By 2004, PRWORA was being implemented by states for approximately eight years. Therefore, PRWORA could have some association with access to and service utilization by the age cohorts from 8-11 and 12-17 because these children were between the ages of 0-3 and 4-7 upon the completion of the survey and post PRWORA implementation.

This study was to ascertain whether the Medicaid provision for immigrants in the PRWORA is associated with differential utilization of dental, of medical, of mental health and of any health services, among children 8-17 years born to Black foreign-born mothers. Although the white native population group is commonly used as the reference group in studies looking at health and well-being of minority children, this study utilized Black natives as the reference group to investigate whether differential access and utilization are pronounced among this population of US children.

B. Conceptual Framework

The Behavioral Health Model of Health Service Use

The theoretical framework guiding this investigation is the original Behavioral Health Model of Health Service Use developed by Robert Andersen in 1968. The framework relates an individual access to and use of health care services to three

characteristics: which are the predisposing, enabling and need factors. This framework informs the current study of health care access and utilization by the children of black foreign-born mothers. The following research questions and research hypotheses guided this study:

C. RESEARCH QUESTIONS

The study: (1) describe the socio-demographic characteristics of children with a black foreign-born mother as compared to children with a black native-born mother; (2) compares health care status among children with a black foreign-born mother as compared to children with a black native-born mother; (3) compares health care access among children with a black foreign-born mother as compared to children with a black native-born mother; and (4) compares the utilization of dental, medical and mental health services among children with a black foreign-born mother as compared to children with a black native-born mother.

Research Questions:

- (1) What are the demographic characteristics of the children from zero to seventeen whose mothers identified as foreign-born and native-born from the NSCH?
- (2) Are there differences in socio-demographics, health status and utilization of dental, medical and mental health services among children of foreign-born compared to children with native-born black mothers?
- (3) Is there an association between age, education, health status, gender, insurance type, language, regions, source of care and poverty levels in the receipt of dental, medical and mental health services among children of foreign-born compared to children with black native-born mothers?
- (4) Was the Medicaid provision in the PRWORA associated with service utilization of dental, medical and mental services of children between the ages of 8-17 among children of foreign-born compared to children with black native-born mothers?

RESEARCH HYPOTHESES

Hypotheses for Question #2:

Null Hypothesis

(H₀): There are no differences in socio-demographics, including health status characteristics among children with a Black foreign-born mother as compared to children with a Black native-born.

Alternative Hypothesis

(H_i): There are differences in socio-demographics and health status characteristics among children with a Black foreign-born mother as compared to children with a Black native-born.

Hypotheses for Question #3:

(H₀): There are no differences in the receipt of dental services, of medical services, and of mental health services among children whose mothers self-identified as black foreign-born compared to children whose mothers self-identified as black native-born?

(H_i): There are differences in the receipt of dental services, of medical services, and of mental health services among children whose mothers self-identified as black foreign-born compared to children whose mothers self-identified as black native-born?

Hypotheses for Question #4:

Null Hypothesis

(H₀): Medicaid is not associated with reduced utilization of dental, medical, and mental health services of children between the ages of 8-11 and 12-17 whose mothers identified as black foreign-born as compared to children with mothers identified as native-born black due to the Medicaid provision in the PRWORA of 1996.

Alternative Hypothesis

(H_i) Medicaid is associated with reduce service utilization of dental, medical and mental health services of children between the ages of 8-11 and 12-17 whose mothers identified as black foreign-born as compared to children with mothers identified as native-born black due to the Medicaid provision in the PRWORA of 1996.

D. Study Variables

Children health access, health status and health utilization are influenced by the child's age, ethnicity, family structure, perceived health status, parental language preference, poverty level, parental education, parental immigration status, race and sex.

All variables selected for this study were included in the NSCH. Each variable is the original survey question, the corresponding section of the survey, the question level of measurement, the original code in the survey manual and the new code utilized for this analysis. The 2003 NSCH is available at <http://www.cdc.gov/nchs/slaits/nsch.htm>. The survey instrument is available in both English and Spanish.

DEPENDENT VARIABLES

To determine the health service utilization of the study children population, this study investigated the receipt of a (i) dental, (ii) medical, and (iii) mental health services. Through out this section SC denotes sample child. The following identifies the specific data sources for the various three dependent variables:

- ***Dental Services***

The survey question to operationalize receipt of dental care was:

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S4Q09-- During the past 12 months/since his/her birth, did the child see a dentist for any routine preventative dental care, including checks-ups, screening, and sealants? Include all types of dentist, such as orthodontists, oral surgeons, and all other dental specialists.	Health Care Access and Utilization	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=No 1=Yes

- **Medical Services**

The survey question to operationalize receipt of medical care was:

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S4Q01-- During the past 12 months/Since (his/her) Birth, did (S.C.) see a doctor, nurse, or health care professional for any kind of medical care, including sick-child, well-child check-ups, physical exams, and hospitalizations?	Health Care Access and Utilization	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=No 1=Yes

- **Mental Services**

The survey question to operationalize receipt of mental health was:

SURVEY QUESTION	SURVEY SECTION	LEVE OF MEASUREMENT	CODE	RECODE
S4Q23—During the past 12 months/ Since/ (his/her) birth did (SC) receive any mental health care or counseling?	Health Care Access and Utilization	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=No 1=Yes

MAIN EXPLANATORY VARIABLES

- **Blacks Parental Status**

Combination of two study questions SQII (S11Q03---Was (S.C's) mother born in the US) and New-Race was combined to create parental status.

VARIABLE NAME	LEVEL OF MEASUREMENT	CODE	RECODE
Blacks parental status	Nominal	1=Native-born Whites 2=Foreign-born Blacks 3=Native born Blacks 4=Other	0=Native-born 1=Foreign-born

EXPLANATORY CONTROL VARIABLES

Predisposing Variables

- **Children’s Age**

The four categories were selected because 0-3 refers to new born through toddler; 4-7 refers to pre-school; 8-12 refers to school age children and 12-17 refers to pre-adolescent to adolescent.

SURVEY QUESTION	SURVEY SECTION	LEVEL MEASUREMENT	CODE	RECODE
AGE_Child	Initial Demographics	Interval	0=0;1=1; 2=2; 3=3; 4=4; 5=5; 6=6; 7=7; 8=8; 9=9; 10=10; 11=11; 12=12; 13=13; 14=14; 15=15;16 =16 and 17=17	0-3=1 4-7=2 8-11=3 12-17=4

- **Household Education**

The variable name in the survey is EDUCATIONR.

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S1Q05A--What is the highest level of education attained by anyone in your household?	Initial Demographic	Interval	1=Less than HS 2=HS Graduate 3=More than HS 96=Don’t Know 97=Refuse	1=Less than HS 2=HS Graduate 3=More than HS

- **Hispanic Origin**

The variable was selected because it addresses the ethnicity of the Hispanic or Latino population. This variable was combined with the RACE-MAIN variable to determine the racial classification of mothers to be used in the study

SURVEY QUESTION	SURVEY SECTION	MEASUREMENT	CODE	RECODE
S11Q01-Is (S.C) of Hispanic or Latino origin?	Additional demographics	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=No 1=Yes

- **Household Language**

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S1Q06 What is the primary language spoken in your home?	Initial Demographic	Nominal	1=English 2=Spanish 3=Any other language 4=Don't know 5=Refused	1=English 2=Spanish 3=Another language

- **Mother's Race**

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
RACE_MAIN Race classification for all states.	Additional Demographics	Interval	1=White 2=Black 3=Multiple Race 4=Other	1=White 2=Black 3= Multiple Race 4=Other

- **Parental Status**

The NewRace_4 variable was created by combining RACE_MAIN and S11Q01. This combination yielded the number of Hispanics in the survey. S11Q01 is the question that focused on the number of Hispanics in the study.

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
RACE_MAIN and S11Q01 was combined to create	Additional Demographics	Interval		1=White 2=Black 3= Hispanic 4=Multiple Race 5=Other

- *Children's Gender*

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S1Q01—Is (CHILD) male or female?	Initial Demographics	Nominal	1=Male 2=Female 6=Don't know 7=Refused	1=Male 2=Female

- *Regions*

The variable is state. All 50 states and the District of Columbia were recoded into the four regions commonly used by the U.S. Census Bureau to investigate state trends.

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	SURVEY CODE	RECODE
State	Initial Demographics	Interval	The states were coded from 1-51.	1=Northeast 2=Midwest 3=Southeast 4=West

*Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

*Midwest: Iowa, Indiana, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

*Southern: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina Tennessee, Texas, Virginia, and West Virginia.

*West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Washington, Wyoming, and Utah.

Enabling Variables

- *Child's Insurance Coverage*

The survey question was renamed into child's insurance coverage.

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S3Q01—Does (S.C.) have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicaid?	Health Insurance	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=Uninsured 1=Insured

- *Child's Insurance Type*

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S3Q02)—Is (he/she) insured by Medicaid or the State Children's Health Insurance Program, SCHIP?	Health Insurance	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=No Medicaid/SCHP 1=Yes

- *Child's Medical Home/Regular source of care*

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
S5Q01--Do you have one or more persons you think of as (S.C.)'s personal doctor or nurse?	Medical Home	Nominal	0=No 1=Yes 6=Don't know 7=Refused	0=No 1=Yes

- *Household Poverty Level*

From the survey, poverty levels of the population were developed base on the US Department of Health and Human Services (DHHS) guidelines for 2003.

SURVEY QUESTION	SURVEY SECTION	LEVEL OF MEASUREMENT	CODE	RECODE
POVERTY-LEVELR Derived. Poverty level of this household based on DHHS guidelines.	Initial demographics	Interval	1=-less than 100% 2=100-133%, 3=133-150%, 4=150-185%, 5=185-200%, 6=200-300%, 7=300-400% 8=400 above	1=-less than 100% 2=100-133%, 3=133-150%, 4=150-185%, 5=185-200%, 6=200-300%, 7=300-400% 8=400 above

Need Variables

- ***Child’s Health***

The original question was renamed Child’s Health.

SURVEY QUESTION	SURVEY SECTION	LEVE OF MEASUREMENT	CODE	RECODE
S2Q01-- In general, how would you describe (SC)’s health? Would you say his/her health is excellent, very good, good fair, or poor?	Health and Functional Status	Interval	1=Excellent 2=Very good 3=Good 4=Fair 5=Poor 6=Don’t know 7=Refused	1=Excellent 2=Very good 3=Good 4=Fair 5=Poor

F. Institutional Review Board

This study utilized a secondary data based that is a publicly available file and is accessible by downloading the manual and data dictionary from the CDC’s website.

Given this reason, an application for waiver was filed with and approved by the University of Baltimore’s Institutional Review Board.

SECTION II---MATERIALS

G. Study Instrument/Data Source

The NSCH is a module of the State and Local Area Integrated Telephone Survey, (SLAITS) conducted by the NCHS and CDC. SLAITS collects data at the State and local levels and is funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. SLAITS uses the same Random-Digit-Dial (RDD) telephone design approach and sampling frame as the ongoing National Immunization Survey (NIS). Data are collected at telephone centers in different parts of the US. The NSCH was developed to investigate the well-being of the U.S. children and is divided into eleven sections: (1) Age-Eligibility Screening and Demographics Characteristics; (2) Health and Functional Status; (3)

Health Insurance Coverage; (4) Health Care Access and Utilization; (5) Medical Home; (6) Early Childhood (0-5 years); (7) Middle Childhood and Adolescence (0-17 years); (8) Family Functioning; (9) Parental Health; (10) Neighborhood Characteristics; and (11) Additional Demographics Characteristics.

The NSCH, the instrument for this investigation is both reliable and valid. Reliability is of central concern to social scientists because measuring instruments are not completely valid (Nachmias and Nachmias 1987:172). Validity of a measurement instrument ensures that the researcher is asking correct questions to provide responses to the questions to be answered. Since 2004, the NSCH has been used in countless articles on pediatric health care services. (Pit et al, 2008; Singh et al. 2008; Flores & Tomany-Korman 2008; Flores et al. 2006; van Dyck et al. 2004; Blumberg et al. 2003). Evidence originating from the utilization of the NSCH is being utilized to address the well-being of the general pediatric population of children at the federal, state, local and county levels; thereby, influencing policy adjustments.

H. Study Sample/Study Population

In 2003, approximately seventy three million children between the aged of zero to seventeen years resided in the US. The frequency distribution conducted of the unweighted number found 11,535 thousand children.

Table 13 Immigrant children in the NSCH

Race/Ethnicity	Foreign-born mothers	Native-born mothers
Blacks	651	7,815
Hispanic	3,220	4,154
Multi-racial	224	3,115
White	2,260	64,290

The sample population for this research consisted of 651 children whose mothers' self-identified as black foreign-born and 7,815 children whose mothers identified as black native-born. The sample was stratified into the following groups:

Table 14 Study population by age groups

Age	Native-Born	Foreign-Born	Unweighted Total	Native-Born	Foreign-Born	Weighted Total
0-3	1,618	161	1,779	1,699,923	204,728	1,904,651
4-7	1,583	132	1,715	1,685,720	214,064	1,899,784
8-11	1,740	160	1,900	1,889,458	214,948	2,104,406
12-17	2,874	198	3,072	2,989,201	247,064	3,236,265
Total	7,815	651	8,466	8,264,302	880,804	9,145,106

I. Type of Research Design

Using the NSCH, a quantitative retrospective study was conducted. For the purpose of this quantitative study, variables were selected from the Age-Eligibility Screening and Demographics Characteristics, Health Insurance Coverage, Health Care Access and Utilization, Medical Home, and Additional Demographics Characteristics sections of the study instrument.

SECTION III---ANALYTICAL STRATEGY

J. Data Analysis

The NSCH is a complex multi-stage survey designed. For this investigation, the Statistical Package Software (SPSS) version 17.0 for Windows (SPSS Inc, Chicago, IL) was the main data management and statistical software. Estimates were weighted as required and the Survey Data Analysis Program (SUDAAN) version 10.0 served as the secondary statistical software to account for the complex sample design and to compute standard errors (SUDAAN Language Manual 2008). Frequencies distributions of all variables to be used in this study were completed and descriptive and inferential statistics were the focus of this study.

Descriptive Statistics

The main objective of descriptive methods is to provide summaries that can help the reader understand the salient characteristics of the research sample and the variable relationships (Tashakkori and Teddlie 1988:113). Descriptive statistics make large groups of data more understandable and are more concerned with the characteristics of a given population (Huck et al. 1974) Descriptive statistics refers to frequency distribution, measures of central tendency, measures of variability, and the standard deviation. To provide a response to question number one, descriptive statistics was utilized looking at the weighted numbers. A null and alternative hypothesis was not developed for question #1 because it is a descriptor developed to ascertain the socio-demographics of the children of immigrants. The question was as follows:

Research Question:

(1) What are the demographic characteristics of the children from zero to seventeen whose mothers self-identified as foreign-born and native-born from the NSCH?

Literature on immigrant children in the U.S. have hypothesized that these children have poorer health status, lower levels of access and lower services utilization.

Descriptive statistics are not sufficient to test hypotheses in research investigation; therefore, inferential statistics are utilized. The following is a description of the type of bi-variate and the multi-variate inferential statistics that was utilized in this investigation.

Inferential Statistics

Inferential statistics are used to infer something about the population from which the sample was drawn based on the characteristics of the sample. (Salkind 2003:168) It is an analysis method for testing hypotheses and is based on estimation of how much error is involved in obtaining a difference between groups or a relationship between variables.

(Tashakkori and Teddlie 1988:115) To provide an answer to question #2, the inferential statistic, the Chi-Square, was utilized. To provide answers to questions #3 and #4, the inferential statistic, binary logistic regression was employed. All questions utilized the NSCH weighted observations to ensure generalizability.

Bivariate Analysis

Bivariate analysis is the simultaneous analysis of two variables. It examines the strength, direction and statistical significance between each dependent variable and the independent variables. (Kachigan 1986) Bivariate analysis results could be misleading; therefore, there is a need to perform multivariate analysis. Chi-Square analyses were used for measuring strength of association or proportions among the study groups. It is the statistical analyses for this study because Chi-Square applies to categorical variables.

The following question was used to conduct the bivariate analyses:

Research Question:

(2) Are there differences in socio-demographics, health status and utilization of dental, medical and mental health services among children of foreign-born compared to children with native-born black mothers?

Multivariate analysis

Multivariate analysis looks at relationships between multiple variables and the outcome of interest when controlling statistically for all of the other variables in the model and is extensively used in psychology, sociology and the health sciences. The type of multivariate to be discussed in this study will be logistic regression and were utilized to test research questions #3 through #4. The logistic regression model provides odd ratios, which quantify the relationship between the independent (explanatory) variable and the dependent (criterion) variable.

The type of multivariate analysis to be used will be binary logistic regression. It is used because the research has three dependent variables which are nominal/categorical. In addition, the model has independent variables which are interval, ratio and nominal making logistic regression a good choice to quantify the potential association between parental nativity and their children's ability to access and utilize dental, medical and mental health services. In addition, it was used to provide a response to the association of Medicaid to children's access and utilization in age cohort 8-17 post PRWORA.

A significance level of 0.05 was used for all statistical tests using SUDDAN version 10.0. To provide a response to developed question #3 twelve regression models were developed. Twelve models were used because it include a newly created dependent variable, any service developed to test first whether the study population will have access and utilized the three main dependent variables. The first four models utilized the independent variable, parental nativity status which refers to mothers who identified as Black foreign-born and coded as 1 and Black native-born coded as 0. The second four models were developed without the parental nativity variable and the last four included parental nativity status but the independent variable regular source of care was removed from the analysis. The research question guiding this analysis was:

Research Questions:

(3) Is there an association between age, education, health status, gender, insurance type, language, regions, source of care and poverty levels in the receipt of any, dental, medical and mental health services among children of foreign-born compared to children with black native-born mothers?

The regression models with parental status were as follows:

$$P(Y=1)=(b_0+b_1X_1+b_2 X_2+b_3 X_3+b_4 X_4+ b_5X_5+ b_6X_6 +b_7 X_7+b_8 X_8+b_9 X_9+ b_{10} X_{10})$$

Where

Y represents the dependent variable in which 0 represents no services received and 1 represents services received.

b_0 represents the constant;

b_1 through b_{11} represents the coefficient or control variables and research variables of interest

Any service

(b_0 +age+parentalstatus+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

Dental service

(b_0 +age+parentalstatus+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

Medical services

(b_0 +age+ parentalstatus +education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

Mental services

(b_0 +age+parental status+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

The regression models by the removal of parental status were as follows:

$P(Y=1)=(b_0+b_1X_1+b_2 X_2+b_3 X_3+b_4 X_4+ b_5X_5+ b_6X_6 +b_7 X_7+b_8 X_8+b_9 X_9)$

Where

Y represents the dependent variable in which 0 represents no services received and 1 represents services received.

b_0 represents the constant;

b_1 through b_9 represents the coefficient or control variables and research variables of interest

Any service

(b_0 +age+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

Dental services

(b_0 +age+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

Medical services

(b_0 +age+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

Mental services

(b₀+age+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare)

The regression models by the removal of source of care race were as follows:

$$P(Y=1)=(b_0+b_1X_1+b_2 X_2+b_3 X_3+b_4 X_4+ b_5X_5+ b_6X_6 +b_7 X_7+b_8 X_8+b_9 X_{9+})$$

Where

Y represents the dependent variable in which 0 represents no services received and 1 represents services received.

b₀ represents the constant;

b₁ through b₉ represents the coefficient or control variables and research variables of interest

Any service

(b₀+age+parentalstatus+education+gender+healthstatus+language+ insurance type+region+poverty)

Dental service

(b₀+age+parentalstatus+education+gender+healthstatus+language+ insurance type+region+poverty+sourceofcare)

Medical services

(b₀+age+ parentalstatus +education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare

Mental services

(b₀+age+parental status+education+gender+healthstatus+language+ insurance type+region+poverty+sourceofcare)

An essential concern of this paper was an examination of the Medicaid provision in the PRWORA and developed to answer the fundamental public administration significance.

Hence, another logistic regression question was developed to ascertain Medicaid’s role.

The following question guided this analysis:

(4) Was the Medicaid provision in PRWORA for immigrants associated with reduce access and utilization of health care services to children from 8-17 whose mothers self-identified as Black foreign-born from the NSCH?

The regression model with parental status includes:

$$P(Y=1)=(b_0+b_1X_1+b_2 X_2+b_3 X_3+b_4 X_4+ b_5X_5+ b_6X_6 +b_7 X_7+b_8 X_8+b_9 X_{9+} b_{10} X_{10} b_{11} X_{11}+b_{12} X_{12})$$

Where

Y represents the dependent variable in which 0 represents no Medicaid and 1 represents having.

b₀ represents the constant;

b₁ through b₁₂ represents the coefficient or control variables and research variables of interest

Medicaid

(b₀+age+parentalstatus+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare+dental+medical+mental)

The regression model without parental status includes:

$P(Y=1)=(b_0+b_1X_1+b_2 X_2+b_3 X_3+b_4 X_4+ b_5X_5+ b_6X_6 +b_7 X_7+b_8 X_8+b_9 X_9+ b_{10} X_{10} b_{11} X_{11})$

Where

Y represents the dependent variable in which 0 represents no Medicaid and 1 represents Medicaid.

b₀ represents the constant;

b₁ through b₁₁ represents the coefficient or control variables and research variables of interest

Medicaid

(b₀+age+education+gender+healthstatus+language+insurance type+region+poverty+sourceofcare+dental+medical+mental)

The regression model without regular source of care was as follows:

$P(Y=1)=(b_0+b_1X_1+b_2 X_2+b_3 X_3+b_4 X_4+ b_5X_5+ b_6X_6 +b_7 X_7+b_8 X_8+b_9 X_9+ b_{10} X_{10} b_{11} X_{11}+b_{12} X_{12})$

Where

Y represents the dependent variable in which 0 represents no Medicaid and 1 represents having.

b₀ represents the constant;

b₁ through b₁₂ represents the coefficient or control variables and research variables of interest

Medicaid

(b₀+age+parentalstatus+education+gender+healthstatus+language+insurance type+region+poverty+dental+medical+mental)

TABLE 15 Summary of Variables, National Survey of Children's Health, 2003

Survey Questions	Survey Numbers	Survey sections	Variables
During the past 12 months/since his/her birth. Did child see a dentist for any routine preventative care, including checks ups, screening, and sealants? Include all types of dentist, such as orthodontists, oral surgeons and all other dental specialists.	S4Q09	HCAU	DV
During the past 12 months/since his/her birth. Did child see a doctor, nurse, or health care professional for any kind of medical care, including sick-child, well-child check-ups, physical exams, and hospitalizations.	S4Q01	HCAU	DV
During the past 12 months/since his/her birth. Did child receive any mental health care or counseling?	S4Q23	HCAU	DV
Was Sample Child's mother born in the U.S.	S11Q03	AD	IV
AGE_Child		ID	IV
Child's Health	S2Q01	HFS	IV
RACE-MAIN	S11Q01	AD	IV
What is the primary language spoken in your home?	S1Q06	ID	IV
Is Child male or female?	S1Q01	ID	IV
State		ID	IV
Does SC have any kind of health insurance, prepaid plans such as HMOs or government plans such as Medicaid?	S3Q01	HI	IV
Is he/she insured by Medicaid/State Children's Health Insurance Program, SCHIP?	S3Q02	HI	IV
Do you have one or more persons you think of as sample child's personal doctor or nurse?	S5Q01	MH	IV
POVERTY-LEVELR		ID	IV

CHAPTER FOUR

DATA RESULTS

This chapter provides the univariate, bivariate, and multivariate results of research questions under examination.

		TABLE 16				
		CASE VARIABLE SUMMARY				
		VARIABLES	TOTAL	%	MISSING	%
The variable summary (Table 16) was developed to illustrate all predisposing, enabling, and need factors in the study. It provides both the total number with accompanying percentages.		Education	85,766	83.8	16,587	16.2
		Gender	85,953	84.0	16,400	16.0
		Child's Health	85,994	84.0	16,359	16.0
		Language	85,985	84.0	16,368	16.0
		Region	84,013	82.1	18,340	17.9
		Insurance	85,915	83.9	16,438	16.1
		Insurance Type	79,647	77.8	22,706	22.2
		Poverty	79,328	77.5	23,025	22.5
		Source of Care	85,847	83.9	16,506	16.1
		Dental	63,495	62.0	38,858	38.0
		Medical	85,826	83.9	16,527	16.0
		Mental Health	80,268	78.4	22,085	21.6

The total missing numbers along with percentages are presented, as well. The variables containing the most missing responses were dental services (38%) followed by poverty (22.5%), insurance type (22.2%) and mental health services (22.1%). These variables remained in this study because there were still sufficient numbers to test the significance of the research under investigation.

SECTION 1---UNIVERATE RESULTS

As reported in the NSCH and the US Census Bureau, in 2003, approximately 73 million children were residents of the US. Table 17, is the overall weighted summary of the descriptive findings of Hispanics, Blacks, Multi-racial and White children whose parents are immigrants and native born stratified into four age groups. The data was weighted to adjust for the complex survey design of the NSCH and is necessary to calculate national estimates. Hence, the investigation results could be generalized to the

overall population of US children whose mothers identified as black foreign-born and black native-born.

The overall mean age of the overall population was 8.79 with a standard error of 0.02. The mean is a measure of summary average and is used to rank data being examined. The population of children from 2003-2004 were diverse consisting of 48 percent Hispanics, 34 percent whites, 10 percent blacks, and 8 percent multi-racial. The following discussion highlights the study seven predisposing variables, five enabling variables and three dependent variables for the overall population of children.

Foreign-born-Predisposing Factors

Children of foreign-born mothers who self-identified as multi-racial (87%) resided in household in which parents had more than a high school education followed by Whites (84.9%), blacks (77.6%) and Hispanics (29.1%). Foreign-born White women (53.2%) were parents of boys followed by Hispanics (52.1%), blacks (51.7%) and Multi-racial (45.9%). English was commonly spoken among multi-racial mothers (96.1%) followed by blacks (87.1%); Whites (81.75.9%) and Hispanics (13.7%). Geographic variation in regions among families was revealed. Children in multiracial households (45.8%) resided in the West followed by Hispanics (42.7% and Whites (30.2%). Blacks (45.8%) resided in the Northeast and in the South (39.7%).

Enabling Factors

The children of Multi-racial mothers (87.4%) were covered by private insurance followed by Whites (86.3%); blacks (62%) and Hispanics (34.8%). Hispanics (65.20%) were covered by Medicaid followed by blacks (38%), Whites (13.7%) and multi-racial (12.6%). In looking at poverty rates, the children of Multi-racial mothers (48.4%) and

Whites (43.7%) lived in household where the incomes were 400% and over of the FPL. Hispanic children (51.5%) resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high among the children of Whites mothers (87.0%) followed by Multi-racial (86.8%); blacks (81.9%) and Hispanics (59.9%).

Need Factors

The utilization of dental services was high among the children of Multi-racial mothers (97.2%); followed by Whites (95.0%); blacks (93.0%) and Hispanics (84.6%). Medical services were high among blacks (87.1%) followed by Whites (86.3%); Multiracial (81.1%) and Hispanics (75.6%). The utilization of mental health services in the last twelve months were the least common among blacks (98%) followed by Hispanics (95.8%); Whites (94.9%); and Multi-racial (94.8%). The children whose parents identified as Multi-racial (75%) reported their health status as excellent followed by Whites (70.1%); Blacks (60%) and Hispanics (35.7%).

Native-born---Predisposing Factors

The descriptive analysis revealed that among the children of Whites (76.3%) and blacks (76.3%), followed by Multi-racial (71.9%); and Hispanics (57.5%) where the education levels were more than high school. Native-born black women (51.4%) were parents of boys followed by Whites (50.6%), Multi-racial (49.8%) and Hispanics (47.1%). The household language English was common among all children except Hispanics (87.3%). There was geographic variation in regions among families. Blacks (61.3%) resided in the South followed by Whites (35.8%). On the other hand Hispanics (44.7%) resided in the West followed by Multiracial (32.6%).

Enabling Factors

The children of Whites mothers (82%) were covered by private insurance followed by Multi-racial (65.7%); Hispanics (65.7%) and blacks (52.2%). Blacks (47.8%) were covered by Medicaid followed by Hispanics (34.3%), Multi-racial (34.3%) and whites (18.0%). In looking at poverty rates, the children of Whites mothers (33.8%) lived in household where the incomes were 400% and over of the FPL followed by Multi-racial (27.2%) and Hispanics (20.5%). Blacks (32.1%) and Hispanics (21.3%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high among the children of White mothers (89.9%) followed by Multi-racial (85.2%); Hispanics (82.1%) and blacks (76.8%)

Need Factors

The utilization of dental services was high among the children of Whites mothers (95.4%); followed by Multi-racial (92.7%); Hispanics (91.7%) and blacks (88.5%). Medical services were high among Whites (89.3%) followed by Multi-racial (88.0%); Hispanics (86.4%) and Blacks (84.1%). The utilization of mental health services in the last twelve months were the least common among blacks (94.5%) followed by Whites (92.7%); Hispanics (92.5%); and Multi-racial (90.8%). The children whose parents identified as Whites (69%) reported their health status as excellent followed by Multi-racial (61.5%); Hispanics (58.2%) and blacks (52%).

TABLE--17 Characteristics of Children from the National Survey of Children Health, 2003-2004

Predisposing/ Enabling/ Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multiracial		Whites		Blacks		Hispanics		Multiracial	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Predisposing Factors																
Age Group																
0-3	373,213	22.3	204,728	23.2	957,999	28.6	86,916	31.6	8,127,331	20.5	1,699,923	20.6	800,093	28.4	442,738	26.1
4-7	363,480	21.8	214,064	24.3	854,816	25.5	74,288	22.1	8,712,514	21.9	1,685,720	20.4	626,620	22.2	410,019	24.1
8-11	390,202	23.4	214,948	24.4	700,118	20.9	70,603	17.8	8,780,835	22.1	1,889,458	22.9	612,169	21.7	372,707	21.9
12-17	543,424	32.5	247,064	28.0	835,539	25.0	96,925	28.5	14,119,598	35.5	2,989,201	36.2	780,281	27.7	473,136	27.9
Household Education																
Less than HS	26,431	1.6	41,326	4.8	1,219,704	37.2	4,089	1.2	854,808	2.2	583,175	7.1	210,093	7.5	78,575	4.6
High School	224,394	13.5	152,698	17.6	1,105,172	33.7	38,825	11.8	8,972,700	22.6	3,035,923	36.8	825,823	29.4	400,890	23.7
More than HS	1,407,295	84.9	672,709	77.6	953,959	29.1	285,490	86.9	29,828,488	75.2	4,634,622	56.2	1,773,779	63.1	1,214,914	71.7
Children's Gender																
Male	887,934	53.2	454,901	51.7	1,744,710	52.1	150,987	45.9	20,302,557	51.1	4,153,955	50.3	1,392,137	50.5	857,673	50.5
Female	780,828	46.8	424,333	48.3	1,603,537	47.9	177,668	54.1	19,401,204	48.9	4,107,565	49.7	1,425,784	49.5	840,647	49.5
Household Language																
English	1,360,304	81.7	767,093	87.1	458,009	13.7	315,923	96.1	39,649,996	99.8	8,256,415	99.9	2,564,457	91.1	1,696,065	99.9
Spanish	304,804	18.3	113,533	12.9	2,884,286	86.3	12,719	3.9	89,010	0.2	7,887	0.1	250,142	8.9	2,535	0.1
Regions																
Northeast	420,940	25.5	399,995	45.8	453,883	13.6	57,495	17.6	7,856,586	19.6	1,053,320	13.0	375,154	13.4	244,827	14.7
Midwest	235,244	14.2	56,315	6.4	260,881	7.8	28,241	8.7	10,001,425	25.8	1,522,460	18.8	295,896	10.6	346,416	20.8
South	497,345	30.1	346,554	39.7	1,200,470	35.9	91,165	27.9	13,482,468	32.3	4,873,916	60.2	932,776	33.4	507,572	30.4
West	498,706	30.2	70,713	8.1	1,427,663	42.7	149,376	45.8	7,647,658	23.9	647,544	8.0	1,189,219	42.6	569,783	34.1
Enabling Factors																
Insurance Coverage																
Uninsured	121,052	7.2	86,440	9.8	930,274	28.1	17,515	5.5	2,181,129	5.5	553,521	6.7	244,646	8.7	127,680	7.5
Insured	1,548,909	92.8	794,364	90.2	2,385,068	71.9	310,538	94.5	37,512,074	94.5	7,694,460	93.3	2,563,118	91.3	1,568,573	92.5
Insurance Type																
Private	1,312,616	86.3	485,149	62.0	820,795	34.8	268,176	87.4	30,575,371	82.0	3,540,334	52.2	1,624,349	65.7	1,019,283	65.7
Medicaid	208,208	13.7	297,368	38.0	1,536,151	65.2	38,778	12.6	6,722,638	18.0	4,094,874	47.8	923,109	34.3	533,318	34.3

TABLE--17 Characteristics of Children from the National Survey of Children Health, 2003-2004

Predisposing/ Enabling/ Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multiracial		Whites		Blacks		Hispanics		Multiracial	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Poverty																
Less than 100%	107,024	7.0	134,995	17.9	1,410,432	51.5	18,759	6.7	3,085,727	8.4	2,391,310	32.1	548,008	21.3	316,984	20.1
100 – 133	75,152	4.9	53,311	7.1	433,454	15.8	7,231	2.6	1,996,881	5.4	918,979	12.3	204,644	7.9	129,111	8.2
133 – 150	37,276	2.5	50,995	6.7	141,551	5.2	5,353	1.9	1,205,640	3.3	422,190	5.7	126,630	4.9	62,622	4.0
150 – 185	62,837	4.1	63,839	8.4	229,339	8.4	10,090	3.6	2,451,756	6.7	682,948	9.2	228,610	8.9	124,480	7.9
185 – 200	44,069	2.9	28,012	3.7	79,482	2.9	8,617	3.1	1,363,601	3.7	292,806	3.9	108,895	4.2	71,046	4.5
200 – 300	259,055	17.0	124,831	16.5	208,705	7.6	30,598	10.9	7,385,488	20.1	1,079,732	14.5	454,394	17.6	250,217	15.9
300 – 400	270,549	17.8	132,364	17.5	80,928	3.0	63,779	22.8	6,884,678	18.7	717,827	9.6	376,885	14.6	194,767	12.3
400% and over	664,450	43.7	167,722	22.2	157,220	5.7	135,378	48.4	12,452,069	33.8	947,406	12.7	526,701	20.5	428,806	27.2
Regular source of care																
No	216,684	13.0	159,071	18.1	1,337,446	40.1	43,259	13.2	3,995,814	10.1	1,908,306	23.2	501,736	17.9	249,792	14.4
Yes	1,448,097	87.0	721,733	81.9	1,997,386	59.9	283,682	86.8	35,661,124	89.9	6,328,829	76.8	2,307,257	82.1	1,440,348	85.2
Need Factors																
Dental Services																
No	63,219	5.0	41,179	7.0	306,872	15.4	6,444	2.8	1,382,440	4.6	668,379	11.5	157,864	8.3	82,588	7.3
Yes	1,201,901	95.0	543,798	93.0	1,686,302	84.6	221,013	97.2	28,873,053	95.4	5,155,876	88.5	1,747,267	91.7	1,047,029	92.7
Medical Services																
No	227,895	13.7	113,066	13.1	816,780	24.4	62,057	18.9	4,221,675	10.7	1,309,537	15.9	382,950	13.6	203,752	12.0
Yes	1,438,907	86.3	766,034	87.1	2,525,025	75.6	266,326	81.1	35,396,125	89.3	6,924,664	84.1	2,434,823	86.4	1,491,295	88.0
Mental Health																
No	1,491,317	94.9	803,202	98.0	2,943,449	95.8	275,821	94.8	34,729,059	92.7	7,395,861	94.5	2,399,806	92.5	1,419,153	90.8
Yes	80,783	5.1	16,556	2.0	130,027	4.2	15,057	5.2	2,727,749	7.3	428,132	5.5	194,329	7.5	143,916	9.2
Children's Health Status																
Excellent	1,171,456	70.1	528,051	60.0	1,193,988	35.7	246,885	75.0	27,411,124	69.0	4,297,744	52.0	1,638,769	58.2	1,045,096	61.5
Very good	342,881	20.5	195,683	22.2	804,470	24.0	54,782	16.7	8,721,230	21.9	2,232,951	27.0	699,004	24.8	434,587	25.6
Good	140,458	8.4	131,331	14.9	1,016,641	30.4	24,547	7.5	2,967,015	7.5	1,373,150	16.6	368,626	13.1	176,501	10.4
Fair	13,850	0.8	20,550	2.3	319,031	9.5	2,337	2,337.0	537,677	1.4	380,750	3.7	98,115	3.5	36,605	2.2
Poor	1,674	0.1	5,190	0.6	14,165	0.4	182	0.1	96,227	0.2	49,336	0.6	13,533	0.5	5,812	0.3

SECTION II---CONTEXUAL DEMOGRAPHIC ANALYSIS OF CHILDREN

The first research question, a descriptor, looked at the demographic, economical, health status characteristics and receipt of dental, medical and mental health services of the children from the NSCH by looking specifically at four age group categories: 0-3; 4-7; 8-11 and 12-17. Tables 18-21 present means, frequency distributions, standard errors, and percentages of study variables among children of immigrants and children of natives whose race and ethnicity were blacks, Latinos, multi-racial and whites. Looking at the children in the NSCH separately is essential to this investigation; the children in the later cohorts 8-11 and 12-17 became significant to provide the answer to the association of the Medicaid provision in the PRWORA of 1996.

The following discussion describes only variables such as household education, regional variations, household incomes, insurance type and receipt of medical services.

The descriptive research question was:

(1) What are the demographic characteristics of the children from zero to seventeen whose mothers identified as foreign-born and native-born from the NSCH?

Children age 0-3 of foreign-born versus native-born by race/ethnicity

Table 18 is the descriptive summary for children age 0-3 and represents both foreign-born and native-born children whose mothers identified as Whites, blacks, Hispanics and Multi-racial.

Foreign-born-----Predisposing Factors

Among the age group 0-3, children of Whites (85.5%), followed by Multi-racial (84.0%), blacks (70.5%) and Hispanics (27.4%) whose mothers identified as foreign-born tended to live in households where the education levels were more than high school.

Foreign-born black women (52.4%) were parents of boys followed by Hispanics (52.3%),

Whites (51.3%) and Multi-racial (38.7%). The household language English was commonly spoken among the children of multi-racial foreign-born mothers (96.2%) followed by blacks (81.8%) and Whites (75.9%). There was geographic variation in regions among families. Whites (30.8%) resided in the West; blacks (49.0%) resided in the Northeast; Hispanics (41.5%) selected the South and Multiracial (40.0%) resided in the West.

Enabling Factors

The children of Multi-racial mothers (84.2%) were covered by private insurance followed by Whites (81.5%); Blacks (51.1%) and Hispanics (28.0). Hispanic (72.0%) were covered by Medicaid followed by blacks (48.7%), whites (18.5%) and multi-racial (15.8%). In looking at poverty rates, the children of Multi-racial mothers (54.3%) and Whites (46.6%) lived in household where the incomes were 400% and over of the Federal Poverty Level (FPL). Hispanic (54.0%) and blacks (27.7%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high among the children of Multi-racial mothers (94.3%) followed by Whites (92.1%); blacks (85.5%) and Hispanics (63.1%)

Need Factors

The utilization of dental services was high among the children of Multi-racial mothers (100%); followed by Whites (92.7%); blacks (84.3) and Hispanics (81.7%). Medical services were high among Whites (94.3%) followed by blacks (92.5); Multiracial (87.3%) and Hispanics (84.2%). The utilization of mental health services in the last twelve months were the least common among Multi-racial (100%) followed by Blacks (100%); Whites (99.1%); and Hispanics (98.6%). The children whose parents

identified as Multi-racial (82.4%) reported their health status as excellent followed by Whites (65.1%); Blacks (55.8%) and Hispanics (42.3%)

Native-born---Predisposing Factors

The descriptive analysis revealed differences among the children of foreign-born and native-born children. Similarities were common among the children of Whites (76.3%) and blacks (76.3%), followed by Multi-racial (71.90%), and Hispanics (57.5%) where the education levels were more than high school. Native-born black women (51.4%) were parents to birth boys followed by Whites (50.6%), Multi-racial (49.8%) and Hispanics (47.1%). The household language English was common among all children except Hispanics (87.3%). There was geographic variation in regions among families. Blacks (61.3%) resided in the South followed by Whites (35.8%). On the other hand Hispanics (44.7%) resided in the West followed by Multiracial (32.6%).

Enabling Factors

The children of Whites mothers (76.8%) were covered by private insurance followed by Multi-racial (59.9%); Hispanics (57.9%) and blacks (39.2%). Blacks (60.8%) were covered by Medicaid followed by Hispanics (42.1%), Multi-racial (40.1%) and whites (23.2%). In looking at poverty rates, the children of Whites mothers lived in household where the incomes were 400% and over of the FPL followed by Multi-racial (22.4%). Blacks (38.3%) and Hispanics (20.9%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high among the children of White mothers (90.9%) followed by Multi-racial (88.8%); Hispanics (80.0%) and blacks (77.0%).

Need Factors

The utilization of dental services was high among the children of Multi-racial mothers (97.6%); followed by Whites (89.8%); Hispanics (88.1%) and blacks (85.9%). Medical services were high among Whites (96.5%) followed by Hispanics (94.5); Multiracial (93.5%) and Blacks (92.2%). The utilization of mental health services in the last twelve months were the highest among multi-racial children (99.3%); Whites (99.2%); Blacks (98.3%) and Hispanics (97.2%). The children whose parents identify as Whites (72.9%) reported their health status as excellent followed by Multi-racial (65.1%); Hispanics (63.1%) and blacks (60.9%)

TABLE--18 Characteristics of Age Group 0-3 from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling Need Factors Independent Variables	Foreign-Born								Native Born							
	Whites		Blacks		Hispanics		Multiracial		Whites		Blacks		Hispanics		Multiracial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Predisposing Factors																
Household Education																
Less than HS	1.1	0.7	5.9	2.9	40.1	2.9	2.7	2.0	2.3	0.3	2.3	1.1	8.1	1.7	5.4	1.6
High School	13.1	2.6	23.5	4.9	32.5	2.5	13.4	6.0	21.4	0.6	21.4	1.9	34.4	2.7	22.6	2.4
More than HS	85.8	2.7	70.5	5.3	27.4	2.2	84.0	6.2	76.3	0.6	76.3	2.0	57.5	2.8	71.9	2.7
Children's Gender																
Male	51.3	3.6	52.4	5.8	52.3	2.7	38.7	6.9	50.6	0.7	51.4	2.0	47.1	2.9	49.8	3.1
Female	48.7	3.6	47.6	5.8	47.7	2.7	61.3	6.9	49.4	0.7	48.6	2.0	52.9	2.9	50.2	3.1
Household Language																
English	75.9	3.2	81.8	3.8	11.8	1.6	96.2	1.8	99.7	0.1	99.9	0.1	87.3	1.9	99.6	0.33
Spanish	24.1	3.2	18.2	3.8	88.2	1.6	3.8	1.8	0.3	0.1	0.1	0.1	12.7	1.9	0.4	0.33
Regions																
Northeast	27.1	3.1	49.0	5.9	12.7	1.4	25.9	5.8	18.8	0.5	10.8	1.3	11.4	1.5	16.6	1.46
Midwest	13.1	2.0	9.1	2.5	9.7	1.3	6.7	2.5	25.6	0.6	15.8	1.3	11.5	1.3	22.9	2.3
South	29.0	3.0	32.9	5.6	41.5	2.7	26.8	6.6	35.8	0.7	61.3	2.1	32.4	2.6	28.0	2.61
West	30.8	3.8	9.1	3.6	36.1	2.7	40.0	8.1	19.8	0.6	12.1	2.0	44.7	2.9	32.6	3.2
Enabling Factors																
Insurance Type																
Private	81.5	3.0	51.1	6.3	28.0	2.6	84.2	6.0	76.8	0.6	39.2	2.0	57.9	3.0	59.9	3.03
Medicaid	18.5	3.0	48.7	6.3	72.0	2.6	15.8	6.0	23.2	0.6	60.8	2.0	42.1	3.0	40.1	3.03
Uninsured	2.88	0.2	1.6	0.2	7.5	0.4	3.50	0.21	2.7	0.2	0.5	0.1	0.4	0.1	0.17	0.05
Poverty																
Less than 100%	8.4	2.3	27.7	5.8	54.0	3.1	5.1	2.5	10.1	0.5	38.3	2.0	20.9	2.9	24.7	3.05
100 – 133	4.2	1.4	10.8	3.9	15.5	2.3	0.7	0.5	6.5	0.4	9.3	1.4	9.1	1.7	8.2	1.67
133 – 150	3.6	1.2	5.7	2.4	4.6	1.2	2.1	1.3	3.8	0.3	5.5	1.1	3.6	1.0	4.2	0.98
150 – 185	3.6	1.3	10.7	3.3	9.8	1.7	2.6	1.8	7.0	0.4	8.6	1.2	10.0	1.9	5.9	1.06
185 – 200	3.6	1.0	6.7	3.9	2.5	0.9	0.7	0.5	3.7	0.3	4.8	1.3	3.7	0.8	5.3	1.11
200 – 300	14.8	2.3	11.8	4.1	4.1	1.0	8.2	2.6	19.1	0.5	12.1	1.3	17.0	2.4	15.1	2.05
300 – 400	16.2	2.6	13.5	5.1	2.6	0.6	25.2	9.4	16.4	0.5	7.5	1.0	10.5	1.9	13.6	2.12
400% and over	46.6	3.8	13.1	3.9	6.4	1.2	54.3	8.4	33.4	0.7	13.2	1.3	16.2	1.7	22.4	2.94

TABLE--18 Characteristics of Age Group 0-3 from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling Need Factors Independent Variables	Foreign-Born								Native Born							
	Whites		Blacks		Hispanics		Multiracial		Whites		Blacks		Hispanics		Multiracial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Regular source of care																
No	7.9	1.8	14.2	4.1	36.9	2.8	5.7	2.2	9.1	0.4	23.0	1.6	20.0	2.3	11.8	1.75
Yes	92.1	1.8	85.5	4.1	63.1	2.8	94.3	2.2	90.9	0.4	77.0	1.7	80.0	2.3	88.8	1.75
Need Factors																
Dependent Variables																
Dental Services																
No	7.3	3.1	15.7	9.4	18.3	4.0	0.0	0.0	10.2	0.9	14.1	2.3	11.9	3.7	2.4	0.97
Yes	92.7	3.1	84.3	9.4	81.7	4.0	100.0	0.0	89.8	0.9	85.9	2.27	88.1	3.7	97.6	0.97
Medical Services																
No	5.7	1.7	8.0	2.7	15.8	2.0	12.7	8.3	3.5	0.3	7.8	1.1	5.5	1.5	6.5	2.17
Yes	94.3	1.7	92.0	2.7	84.2	2.0	87.3	8.3	96.5	0.3	92.2	1.1	94.5	1.5	93.5	2.17
Mental Health																
No	99.1	0.5	100.0	0.0	98.6	0.7	100.0	0.0	99.2	0.1	98.3	0.6	97.2	1.6	99.3	0.52
Yes	0.9	0.5	0.0	0.0	1.4	0.7	0.0	0.0	0.8	0.1	1.7	0.6	2.8	1.6	0.7	0.52
Children's Health Status																
Excellent	77.0	2.9	55.8	5.8	42.3	2.8	82.4	4.5	72.9	0.6	60.9	2.0	63.1	2.9	65.1	3.08
Very good	14.8	2.3	24.9	5.1	23.1	2.2	12.4	4.0	19.8	0.6	24.9	1.8	21.2	2.3	20.0	2.63
Good	7.7	2.0	16.3	4.3	27.5	2.4	5.2	2.1	6.0	0.3	10.6	1.2	12.7	2.4	11.4	2.06
Fair	0.3	0.3	3.0	1.7	6.7	1.4	0.0	0.0	1.2	0.1	2.8	0.6	3.0	1.1	3.5	1.41
Poor	0.2	0.2	0.0	0.0	0.4	0.4	0.0	0.0	0.1	0.0	0.1	0.4	0.0	0.1	0.3	0.25

Children age 4-7 of foreign-born versus native-born by race/ethnicity

Table 19 is the descriptive summary for children age 4-7 and represents both foreign-born and native-born children whose mothers identified as Whites, blacks, Hispanics and Multi-racial.

Foreign-born-----Predisposing Factors

Among the age group 4-7, children of Multi-racial (88.3%), followed by Whites (86.4%), blacks (79.0%) and Hispanics (28.5%) whose mothers identified as foreign-born tended to live in households where the education levels were more than high school. Foreign-born black women (56.4%) were parents of boys followed by Whites (49.7%), Hispanics (49.3%) and Multi-racial (45.6%). The household language English was commonly spoken by Blacks (86.6%) followed by Whites (76.8%); Multi-racial (45.0) and Hispanics (12.6%). There was geographic variation in regions among families. Hispanics (50.1%) resided in the West followed by Multi-racial (34.8%) and Whites (32.1%). Blacks (42.4%) tended to reside in the South.

Enabling Factors

The children of Multi-racial mothers (86.5%) were covered by private insurance followed by Whites (80.3%); blacks (46.8%) and Hispanics (23.8). Hispanic (67.3%) was covered by Medicaid followed by blacks (48.0%), Multi-racial (7.8%) and Whites (2.3%). In looking at poverty rates, the children of Whites mothers (44.9%) followed by Multi-racial (36.4%) and blacks (30.7%) lived in household where the incomes were 400% and over of the FPL. Hispanic (49.7%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high

among the children of Multi-racial mothers (91.2%) followed by blacks (89.3%); Whites (83.3%) and Hispanics (64.1%).

Need Factors

The utilization of dental services was high among the children of Multi-racial mothers (95.3%); followed by Whites (92.2%); blacks (94.2) and Hispanics (85.0%). Medical services were high among blacks (93.0%) followed by Whites (88.9%); Hispanics (87.3%); Hispanics (80.3%) and Multi-racial (75.5%). The children whose parents identify as Whites (73.5%) reported their health status as excellent followed by Multi-racial (70.5%); blacks (68.0%) and Hispanics (35.9%)

Native-born---Predisposing Factors

The descriptive analysis revealed differences among the children of foreign-born and native-born children. The children of Whites (76.4%) followed by Multi-racial (69.4%); Hispanics (64.4%) and blacks (54.3%) resided in households where the education levels were more than high school. Multi-racial women (52.5%) were parents of boys followed by Whites (51.3%), Hispanics (50.8%) and blacks (50.6%). The household language English was common among all children except Hispanics (89.1%). There was geographic variation in regions among families. Blacks (58.7%) resided in the South followed by Whites (35.8%). On the other hand Hispanics (41.6%) resided in the West followed by Multiracial (31.5%).

Enabling Factors

The children of White mothers (76.9%) were covered by private insurance followed by Multi-racial (57.1%); Hispanics (56.0%) and blacks (39.2%). Blacks (55.3%) were covered by Medicaid followed by Multi-racial (39.1%), Hispanics (37.1%)

and Whites (18.5%). In looking at poverty rates, the children of Whites mothers (32.9%) lived in household where the incomes were 400% and over of the FPL followed by Multi-racial (25.7%). Blacks (34.0%) and Hispanics (18.1%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care was high among the children of White mothers (91.5%) followed by Hispanics (84.5%); Multi-racial (84.1%); Hispanics (80.0%) and blacks (79.40%).

Need Factors

The utilization of dental services was high among the children of Whites mothers (95.3%); followed by Hispanics (92.2%); Blacks (90.5%) and Multi-racial (90.5%). Medical services were high among Multi-racial (91.9%) followed by Whites (90.7); Hispanics (87.4%) and blacks (85.4%). The utilization of mental health services in the last twelve months were the least common among Hispanics (96.1%) followed by Whites (95.3%); blacks (94.0%) and Multi-racial (91.7%). The children whose parents identify as Whites (69.5%) reported their health status as excellent followed by Multi-racial (66.5%); Hispanics (63.1%) and blacks (55.8%)

TABLE--19 Characteristics of Age Group 4-7 from the National Survey of Children's Health, 2003-2004

Predisposing / Enabling / Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multi-racial		Whites		Blacks		Hispanics		Multi-racial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Predisposing Factors																
Household Education																
Less than HS	2.6	1.6	2.3	1.3	36.4	3.2	0.3	0.2	2.3	0.3	6.9	1.2	5.4	1.5	1.9	0.8
High School	11.0	2.6	18.7	5.4	35.1	3.3	11.4	5.5	21.4	0.6	38.8	2.0	30.2	3.0	28.6	3.2
More than HS	86.4	2.9	79.0	5.5	28.5	3.0	88.3	5.5	76.4	0.6	54.3	2.0	64.4	3.0	69.4	3.3
Children's Gender																
Male	49.7	4.2	56.4	6.7	49.4	3.3	45.6	8.9	51.3	0.7	50.6	2.0	50.8	3.0	52.5	3.6
Female	50.3	4.2	43.6	6.7	50.6	3.3	54.4	8.9	48.7	0.7	49.4	2.0	49.2	3.0	47.5	3.6
Household Language																
English	76.8	3.8	86.6	5.0	12.6	2.4	45.0	3.5	99.8	0.1	100.0	0.0	89.1	2.6	100.0	0.0
Spanish	24.0	3.8	13.4	5.0	87.4	2.4	55.0	3.5	0.2	0.1	0.0	0.0	10.9	2.6	0.0	0.0
Regions																
Northeast	24.8	3.4	37.2	6.1	12.1	1.6	17.6	5.7	18.8	0.5	11.8	1.4	14.5	1.9	16.4	2.4
Midwest	11.6	2.2	5.2	3.0	8.2	1.2	13.5	5.7	26.7	0.6	21.8	1.7	12.5	1.6	22.0	2.6
South	31.5	3.8	42.4	6.6	29.6	2.9	34.1	8.1	35.8	0.7	58.7	2.0	31.4	2.7	30.0	3.2
West	32.1	4.3	15.2	6.8	50.1	3.3	34.8	9.7	18.7	0.6	7.8	1.4	41.6	3.1	31.5	3.9
Enabling Factors																
Insurance Type																
Private	80.3	3.4	46.8	6.7	23.8	2.5	86.5	5.2	76.9	0.6	42.7	2.0	56.0	3.1	57.1	3.6
Medicaid	2.3	0.2	48.0	7.2	67.3	3.4	7.8	4.2	18.5	0.6	55.3	2.0	37.1	3.0	39.1	3.8
Uninsured	7.7	2.2	10.0	4.3	30.4	3.1	6.11	3.59	5.77	0.35	4.60	0.82	10.86	2.42	6.00	1.46
Poverty																
Less than 100%	5.3	2.1	15.2	6.7	49.7	3.6	6.0	3.6	8.1	0.5	34.0	2.1	18.1	2.6	23.8	3.6
100 – 133	5.6	2.6	8.5	3.4	16.9	2.9	1.4	0.9	5.2	0.4	12.8	1.3	7.1	1.4	9.2	1.6
133 – 150	0.8	0.5	5.8	4.0	5.0	1.3	5.2	3.2	3.7	0.3	5.3	1.0	7.7	1.8	2.7	0.8
150 – 185	3.8	2.4	7.9	3.1	11.7	2.2	3.6	1.9	6.5	0.4	8.3	1.1	9.5	1.9	8.4	2.1
185 – 200	3.0	1.0	0.8	0.8	3.3	0.9	0.8	0.6	3.6	0.3	2.7	0.6	3.3	1.1	4.6	1.1
200 – 300	15.1	2.6	14.6	5.0	7.3	1.6	8.4	3.6	21.5	0.6	14.4	1.3	19.0	2.3	16.2	2.9
300 – 400	21.6	3.6	16.5	5.4	1.9	0.7	38.1	10.4	18.3	0.6	9.9	1.1	18.8	2.3	9.4	1.7
400% and over	44.9	4.6	30.7	6.0	4.2	0.9	36.4	8.3	32.9	0.7	12.6	1.1	16.6	2.0	25.7	3.0

TABLE--19 Characteristics of Age Group 4-7 from the National Survey of Children's Health, 2003-2004

Predisposing / Enabling / Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multi-racial		Whites		Blacks		Hispanics		Multi-racial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Regular source of care																
No	16.7	3.7	10.7	3.6	35.9	3.1	8.8	3.4	8.5	0.4	20.6	1.7	15.5	2.2	15.9	3.4
Yes	83.3	3.7	89.3	3.6	64.1	3.1	91.2	3.4	91.5	0.4	79.4	1.7	84.5	2.2	84.1	3.4
Need Factors																
Dependent Variables																
Dental Services																
No	5.8	1.9	5.8	2.4	15.0	2.7	4.7	5.6	4.7	0.3	9.2	1.2	7.8	1.9	9.5	2.6
Yes	94.2	1.9	94.2	2.4	85.0	2.7	95.3	5.6	95.3	0.3	90.8	1.2	92.2	1.9	90.5	2.6
Medical Services																
No	11.1	2.8	7.0	3.3	19.7	2.4	24.4	10.2	9.3	0.5	14.4	1.5	12.6	2.2	8.1	1.9
Yes	88.9	2.8	93.0	3.3	80.3	2.4	75.5	10.2	90.7	0.5	85.4	1.5	87.4	2.2	91.9	1.9
Mental Health																
No	99.3	0.3	98.3	1.0	95.9	2.1	94.8	3.3	95.3	0.3	94.0	1.1	96.1	1.0	91.7	2.4
Yes	0.7	0.3	1.7	1.0	4.1	2.1	5.2	3.3	4.7	0.3	6.0	1.1	3.9	1.0	8.3	2.4
Children's Health Status																
Excellent	73.5	3.4	68.0	6.3	35.9	3.3	70.5	7.7	69.5	0.7	55.8	2.0	60.0	3.0	66.5	3.4
Very good	15.7	2.4	17.2	4.9	26.5	3.0	26.0	7.6	22.4	0.6	23.9	1.7	22.1	2.3	24.0	3.1
Good	9.3	2.5	13.8	4.8	29.4	2.9	1.6	0.7	6.5	0.3	16.4	1.5	12.4	2.0	8.0	1.8
Fair	1.3	1.0	0.9	0.7	7.5	1.8	2.0	1.5	1.3	0.2	2.9	0.6	4.4	2.0	1.2	0.6
Poor	0.1	0.1	0.1	0.1	0.6	0.4	0.0	0.0	0.2	0.1	1.0	0.7	1.1	0.8	0.3	0.2

Children age 8-11 of foreign-born versus native-born by race/ethnicity

Table 20 is the descriptive summary for children age 8-11 and represents both foreign-born and native-born children whose mothers identified as Whites, blacks, Hispanics and Multi-racial.

Foreign-born-----Predisposing Factors

Among the age group 8-11, children of Multi-racial (91.5%), followed by Whites (89.3%), blacks (79.0%) and Hispanics (30.6%) whose mothers identified as foreign-born tended to live in households where the education levels were more than high school. Foreign-born Whites women (59.6%) were parents of birth boys followed by Multi-racial (52.4%), Hispanics (51.7%) and blacks (48.2%). The household language English was commonly spoken by Multi-racial (95.4%) followed by Whites (88.1%); blacks (85.8%) and Hispanics (12.6%). There was geographic variation in regions among families. Multi-racial (48.0%) resided in the West followed by Hispanics (41.0%). Blacks (55.2%) tended to reside in the Northeast and Whites 32.8% resided in the South.

Enabling Factors

The children of Whites mothers (83.4%) were covered by private insurance followed by Multi-racial (78.2%); blacks (62.3%) and Hispanics (25.6%). Hispanic (63.3%) was covered by Medicaid followed by blacks (32.9.0%), Multi-racial (13.9%) and Whites (10.7%). In looking at poverty rates, the children of Multi-racial mothers (51.7%) followed by Whites (40.1%) lived in household where the incomes were 400% and over of the FPL. Hispanic (53.3%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high among the

children of White (86.6%) followed by Multi-racial (83.2%); blacks (79.4%) and Hispanics (59.0%).

Need Factors

The utilization of dental services was high among the children of Multi-racial mothers (98.2%); followed by Whites (95.5%); blacks (95.7%) and Hispanics (89.7%). Medical services were high among blacks (88.0%) followed by Whites (85.5%); Multi-racial (81.1%) and Hispanics (69.1.4%). The utilization of mental health services in the last twelve months were the least common among blacks (99.0%) followed by Whites (95.3%); Multi-racial (95.2%) and Hispanics (94.8%). The children whose parents identify as Multi-racial (71.4%) reported their health status as excellent followed by Whites (68.9%); blacks (59.8%) and Hispanics (30.0%)

Native-born---Predisposing Factors

The descriptive analysis revealed differences among the children of foreign-born and native-born children. The children of Whites (75.0%) followed by Multi-racial (73.2%); Hispanics (64.2%) and blacks (56.9%) resided in households where the education levels were more than high school. White women (52.2%) were parents of boys followed by Multi-racial (50.8%), Hispanics (50.1%) and blacks (49.3%). The household language English was common among all children. In this age cohort, only 6.4% of children residing in Hispanic households spoke Spanish. There was geographic variation in regions among families. Blacks (61.6%) resided in the South followed by Whites (34.5%); Hispanics (33.7%) and Multi-racial (28.2%).

Enabling Factors

The children of White mothers (78.1%) were covered by private insurance followed by Multi-racial (65.8%); Hispanics (59.3%) and blacks (47.0%). Blacks (45.6%) were covered by Medicaid followed by Hispanics (31.1%); Multi-racial (26.7%) and Whites (16.5%). In looking at poverty rates, the children of Multi-racial mothers (32.8%) followed by Whites (32.6%) and Hispanics (25.5%) lived in household where the incomes were 400% and over of the FPL. Blacks (26.8%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care was high among the children of Multi-racial mothers (90.8%) followed by Whites (90.3%); blacks (80.1%) and Hispanics (80.1%).

Need Factors

The utilization of dental services was high among the children of Whites mothers (96.6%); followed by Multi-racial (94.3%); blacks (90.8%) and Hispanics (90.8%). Medical services were high among Whites (85.8%) followed by Multi-racial (83.9%); blacks (82.7%) and Hispanics (78.5%). The utilization of mental health services in the last twelve months were the least common among blacks (93.4%) followed by Hispanics (93.3%); Whites (91.1%) and Multi-racial (89.1%). The children whose parents identify as Whites (69.9%) reported their health status as excellent followed by Hispanics (61.9%); Multi-racial (61.3%) and blacks (49.7%).

TABLE--20 Characteristics of Age Group 8-11 from the National Survey of Children's Health, 2003-2004

Predisposing/ Enabling/ Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multi-Racial		Whites		Blacks		Hispanics		Multi-racial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Predisposing Factors																
Household Education																
Less than HS	0.0	0.0	2.6	2.2	38.0	3.6	1.9	1.9	2.1	0.2	6.1	1.0	8.3	2.5	5.0	2.4
High School	10.7	2.6	18.4	4.3	31.3	3.1	6.6	3.1	22.9	0.6	37.0	1.9	27.5	3.0	21.8	3.1
More than HS	89.3	2.6	79.0	4.6	30.6	2.8	91.5	3.6	75.0	0.6	56.9	1.9	64.2	3.4	73.2	3.6
Children's Gender																
Male	59.6	4.1	48.2	5.4	51.7	3.4	52.4	8.0	52.2	8.0	49.3	0.7	50.1	1.9	50.8	3.39
Female	40.4	4.1	51.8	5.4	48.3	3.4	47.6	8.0	47.8	0.7	50.7	1.9	49.9	3.4	49.2	3.83
Household Language																
English	88.1	2.9	85.8	3.7	12.6	1.8	95.4	3.2	99.9	0.1	99.9	0.1	93.6	1.6	99.9	0.1
Spanish	11.9	2.9	14.2	3.7	87.4	1.8	4.6	3.2	0.1	0.1	0.1	0.1	6.4	1.6	0.1	0.1
Regions																
Northeast	23.5	3.1	55.2	5.3	15.5	2.5	15.1	4.9	20.4	0.5	34.5	1.4	12.5	1.7	12.2	2.3
Midwest	12.9	2.1	6.5	2.0	4.9	0.9	7.7	2.9	25.3	0.5	17.8	1.4	8.4	1.3	21.5	2.6
South	32.8	3.7	35.3	5.0	38.6	3.3	29.2	6.7	34.5	0.7	61.6	1.9	33.7	3.3	28.2	3.3
West	30.7	4.5	2.9	1.0	41.0	3.3	48.0	8.2	19.8	0.7	6.6	1.1	33.7	3.5	38.2	4.1
Enabling Factors																
Insurance Type																
Private	83.4	3.0	62.3	5.4	25.6	2.6	78.2	6.9	78.1	0.6	47.0	1.9	59.3	3.4	65.8	3.6
Medicaid	10.7	2.5	32.9	5.5	63.3	3.7	13.9	6.8	16.5	0.6	45.6	1.9	31.1	3.1	26.7	3.2
Uninsured	6.6	2.1	7.3	2.5	30.6	3.1	9.0	4.1	5.4	0.3	7.4	1.1	9.5	2.1	7.6	2.5
Poverty																
Less than 100%	6.4	2.5	16.9	4.5	53.3	3.5	5.4	3.2	8.4	0.5	26.8	1.8	16.8	2.8	14.2	2.4
100 – 133	6.4	2.3	7.6	3.1	17.7	2.8	7.0	3.9	5.0	0.3	12.5	1.3	8.0	1.7	10.3	2.7
133 – 150	1.5	0.6	6.2	3.3	3.9	1.1	0.0	0.0	3.1	0.3	5.9	1.0	4.7	2.2	2.9	0.9
150 – 185	6.1	1.9	8.4	3.6	3.9	0.9	4.3	2.6	7.1	0.4	10.0	1.3	7.6	2.1	6.0	1.3
185 – 200	2.1	0.8	5.2	2.1	1.8	0.7	2.8	2.8	3.8	0.3	4.7	0.8	6.3	1.7	2.8	1.0
200 – 300	22.6	4.3	18.3	4.7	9.3	1.7	13.3	4.6	20.3	0.6	17.2	1.5	17.0	2.3	17.9	2.7
300 – 400	14.7	2.6	21.8	4.6	3.9	1.2	15.6	5.2	19.7	0.6	10.5	1.1	13.9	2.3	13.2	2.1
400% and over	40.1	4.1	15.6	3.3	6.2	1.2	51.7	8.5	32.6	0.7	12.6	1.0	25.6	3.0	32.8	4.3

TABLE--20 Characteristics of Age Group 8-11 from the National Survey of Children's Health, 2003-2004

Predisposing/ Enabling/ Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multi-Racial		Whites		Blacks		Hispanics		Multi-racial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Regular source of care																
No	13.4	2.7	20.6	4.3	41.0	3.3	16.8	6.8	9.7	0.5	19.9	1.6	19.0	3.0	9.2	1.9
Yes	86.6	2.7	79.4	4.3	59.0	3.3	83.2	6.8	90.3	0.5	80.1	1.6	81.0	3.0	90.8	1.9
Need Factors																
Dental Services																
No	4.5	2.2	4.3	1.7	10.3	2.2	1.8	1.4	3.4	0.3	9.2	1.1	6.6	2.2	5.7	1.9
Yes	95.5	2.2	95.7	1.7	89.7	2.2	98.2	1.4	96.6	0.3	90.8	1.1	90.8	2.2	94.3	1.9
Medical Services																
No	14.5	3.0	12.0	3.0	30.9	3.1	18.9	4.8	14.2	0.5	17.3	1.3	21.5	3.2	16.1	2.9
Yes	85.5	3.0	88.0	3.0	69.1	3.1	81.1	4.8	85.8	0.5	82.7	1.3	78.5	3.2	83.9	2.9
Mental Health																
No	95.3	1.3	99.0	0.7	94.8	1.5	95.2	2.9	91.1	0.4	93.4	1.0	93.3	1.2	89.1	2.3
Yes	4.7	1.3	1.0	0.7	5.2	1.5	4.8	2.9	8.9	0.4	6.6	1.0	6.7	1.2	10.9	2.3
Children's Health Status																
Excellent	68.9	3.5	59.8	5.3	30.0	3.0	71.4	8.1	69.6	0.6	49.7	1.9	61.9	3.3	61.3	3.7
Very good	22.8	3.2	24.2	4.5	25.2	2.9	15.9	6.7	21.3	0.6	26.9	1.6	21.5	2.7	28.5	3.5
Good	7.7	1.6	12.8	3.6	31.1	3.1	12.5	6.4	7.7	0.4	17.9	1.6	14.1	2.4	9.2	1.5
Fair	0.5	0.3	3.2	2.2	13.6	2.7	0.1	0.1	1.2	0.1	5.4	1.0	1.8	0.6	0.7	0.3
Poor	0.1	0.1	0.0	0.0	0.1	0.1	0.0	0.0	0.3	0.1	0.0	0.1	0.7	0.6	0.3	0.2

Children age 12-17 of foreign-born versus native-born race/ethnicity

Table 21 is the descriptive summary for children age 12-17 and represents both foreign-born and native-born children whose mothers identified as Whites, blacks, Hispanics and Multi-racial.

Foreign-born-----Predisposing Factors

Among the age group 11-17, children of Multi-racial (85.3%), followed by blacks (81.1%), Whites (80.1%) and Hispanics (30.3%) whose mothers identified as foreign-born tended to live in households where the education levels were more than high school. Foreign-born Hispanics women (55.0%) were parents of boys followed by Whites (52.4%), blacks (50.3%) and Multi-racial (47.9%). The household language English was commonly spoken by Multi-racial (97.9%) followed by blacks (93.1%); Whites (84.9%) and Hispanics (17.9%). There was geographic variation in regions among families. Multi-racial (57.3%) resided in the West followed by Hispanics (44.1%). Blacks (46.7%) tended to reside in the South followed by Whites (28.1).

Enabling Factors

The children of Multi-racial mothers (87.4%) were covered by private insurance followed by Whites (87.1%); blacks (75.4%) and Hispanics (45.1%). Hispanic (35.6%) was covered by Medicaid followed by blacks (21.4%), Multi-racial (12.3%) and Whites (11.6%). In looking at poverty rates, the children of Multi-racial mothers (51.3%) followed by Whites (43.5%) lived in household where the incomes were 400% and over of the FPL. Hispanic (48.7%) children resided in households where incomes were less than 100% of the FPL. Having a regular source of care were high among the children of White (86.2%) followed by Multi-racial (79.4%); blacks (74.5%) and Hispanics (52.6%).

Need Factors

The utilization of dental services was high among the children of Multi-racial mothers (98.5%); followed by Whites (95.5%); blacks (90.8%) and Hispanics (80.5%). Medical services were high among Multi-racial (79.8%) followed by Whites (79.7%); blacks (77.3%) and Hispanics (66.2%). The utilization of mental health services in the last twelve months were the least common among blacks (95.6%) followed by Hispanics (94.2%); Multi-racial (91.1%) and Whites (89.4%). The children whose parents identify as Multi-racial (74.8%) reported their health status as excellent followed by Whites (64.1%); Blacks (56.6%) and Hispanics (32.5%).

Native-born---Predisposing Factors

The descriptive analysis revealed differences among the children of foreign-born and native-born children. The children of Whites (74.0%) followed by Multi-racial (72.2%); Hispanics (64.2%) and blacks (56.9%) resided in households where the education levels were more than high school. White women (52.2%) were parents of boys followed by Multi-racial (50.8%), Hispanics (50.1%) and blacks (49.3%). The household language English was common among all children. In this age cohort, only 6.4% of children residing in Hispanic households spoke Spanish. There was geographic variation in regions among families. Blacks (61.6%) resided in the South followed by Whites (34.5%); Hispanics (33.7%) and Multi-racial (28.2%).

Enabling Factors

The children of White mothers (84.9%) were covered by private insurance followed by Multi-racial (71.3%); Hispanics (69.2%) and blacks (48.9%). Blacks (46.4%) were covered by Medicaid followed by Hispanics (28.1%); Multi-racial (25.4%)

and Whites (14.2%). In looking at poverty rates, the children of Whites mothers (35.4%) followed by Multi-racial (27.8%) and Hispanics (23.9%) lived in household where the incomes were 400% and over of the FPL. Blacks (30.8%) children resided in households where incomes were less than 100% of the FPL followed by Multi-racial (17.2%). Having a regular source of care was high among the children of Whites mothers (88.1%) followed by Hispanics (83.3%); Multi-racial (78.9%); and Blacks (73.2%).

Need Factors

The utilization of dental services was high among the children of Whites mothers (95.6%); followed by Multi-racial (91.8%); Hispanics (91.0%) and blacks (86.2%). Medical services were high among Whites (86.6%) followed by Hispanics (83.5%); Multi-racial (82.7%) and blacks (79.6%). The utilization of mental health services in the last twelve months were the least common among blacks (93.9%) followed by Whites (89.4%); Hispanics (85.5%) and Multi-racial (85.7%). The children whose parents identify as Whites (69.0%) reported their health status as excellent followed by Multi-racial (54.1%); Hispanics (48.7%) and blacks (46.3%)

TABLE--21 Characteristics of Age Group 12-17 from the National Survey of Children Health, 2003-2004

Predisposing/Enabling/ Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multiracial		Whites		Blacks		Hispanics		Multiracial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Predisposing Factors																
Household Education																
Less than HS	2.4	1.7	7.7	4.0	34.1	3.0	0.2	0.2	2.0	0.2	7.2	0.9	7.4	2.1	6.0	1.72
High School	17.6	2.4	11.2	3.6	35.6	3.0	14.6	5.1	23.9	0.5	36.9	1.5	27.5	2.6	21.8	2.91
More than HS	80.1	2.8	81.1	4.9	30.3	2.5	85.3	5.1	74.0	0.5	55.9	1.5	65.1	2.9	72.2	3.09
Children's Gender																
Male	52.3	3.0	50.2	5.3	55.0	3.0	47.9	7.2	50.7	0.5	50.1	1.5	50.1	2.8	49.2	3.01
Female	47.7	3.0	49.8	5.3	45.0	3.0	52.1	7.2	49.3	0.5	49.9	1.5	49.9	2.8	50.8	3.01
Household Language																
English	84.9	2.8	93.1	2.5	17.9	2.2	97.9	1.3	99.7	0.1	99.9	0.1	94.6	1.2	100.0	0.03
Spanish	15.1	2.8	6.9	2.5	82.1	2.2	2.1	1.3	0.3	0.1	0.1	0.1	5.4	1.2	0.0	0.03
Regions																
Northeast	26.2	2.4	42.4	5.3	14.6	1.8	12.0	4.2	20.1	0.4	14.3	1.2	15.4	1.8	13.3	2
Midwest	17.7	2.1	5.2	2.1	7.7	1.5	7.4	3.1	25.7	0.4	19.5	1.2	9.8	1.2	17.1	1.93
South	28.0	2.5	46.7	5.3	33.7	2.8	23.3	5.2	33.8	0.5	59.5	1.6	35.8	2.8	34.8	2.79
West	28.1	3.2	5.6	2.1	44.1	3.0	57.3	6.9	20.4	0.5	6.7	1.2	39.0	2.8	34.7	3.14
Enabling Factors																
Insurance Type																
Private	87.1	2.0	75.4	4.6	45.1	3.7	87.4	3.8	84.9	0.5	48.9	1.6	69.2	2.9	71.3	2.77
Medicaid	11.6	1.8	21.4	4.2	35.6	3.0	12.3	3.7	14.2	0.4	46.4	1.6	28.1	2.7	25.4	2.57
Uninsured	9.4	2.3	13.0	4.3	35.1	2.9	2.5	1.2	6.3	0.3	9.3	1.1	9.0	1.3	11.6	2.7
Poverty																
Less than 100%	7.7	2.4	13.4	5.0	48.7	3.3	9.5	4.5	7.5	0.4	30.8	1.5	18.5	2.7	17.2	3.06
100 – 133	3.9	1.2	2.6	1.2	13.5	2.2	2.3	2.0	5.2	0.3	13.7	1.2	7.4	1.1	5.6	1.19
133 – 150	4.2	1.6	8.7	3.6	6.7	1.8	0.2	0.2	2.8	0.2	5.9	0.9	4.3	1.3	5.8	1.48
150 – 185	3.3	0.8	7.2	3.0	7.1	1.4	3.2	1.9	6.2	0.3	9.4	0.9	8.2	1.4	10.9	1.93
185 – 200	2.9	0.8	2.4	1.7	3.8	1.3	7.3	3.8	3.7	0.2	3.6	0.5	3.9	1.2	5.0	1.25
200 – 300	15.7	2.6	20.0	4.6	10.4	1.7	13.9	4.9	19.5	0.4	13.7	1.0	17.7	2.0	14.7	1.88
300 – 400	18.7	2.2	17.6	4.3	3.6	0.8	12.4	4.9	19.6	0.5	10.3	0.8	16.2	2.0	13.1	1.79
400% and over	43.5	3.0	28.2	4.6	6.2	1.2	51.3	7.7	35.4	0.5	12.6	0.9	23.9	2.1	27.8	2.73

TABLE--21 Characteristics of Age Group 12-17 from the National Survey of Children Health, 2003-2004

Predisposing/Enabling/ Need Factors Independent Variables	Foreign-Born								Native-Born							
	Whites		Blacks		Hispanics		Multiracial		Whites		Blacks		Hispanics		Multiracial	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Regular source of care																
No	13.8	2.0	25.5	5.0	47.0	3.0	20.6	5.3	11.9	0.4	26.8	1.4	16.7	2.3	21.1	3.04
Yes	86.2	2.0	74.5	5.0	52.6	3.0	79.4	5.3	88.1	0.4	73.2	1.4	83.3	2.3	78.9	3.04
Need Factors																
Dental Services																
No	4.5	1.2	9.2	4.0	19.5	3.0	1.5	0.6	4.4	0.3	13.8	1.1	9.0	2.2	8.2	1.84
Yes	95.5	1.2	90.8	4.0	80.5	3.0	98.5	0.6	95.6	0.3	86.2	1.1	91.0	2.2	91.8	1.84
Medical Services																
No	20.3	2.5	22.7	4.6	33.8	2.9	20.2	6.4	13.4	0.4	20.4	1.2	16.5	2.2	17.3	2.78
Yes	79.7	2.5	77.3	4.6	66.2	2.9	79.8	6.4	86.6	0.4	79.6	1.2	83.5	2.2	82.7	2.78
Mental Health																
No	89.4	1.9	95.6	1.8	94.2	1.2	91.1	5.8	89.4	0.3	93.9	0.7	85.5	2.2	85.7	2.2
Yes	10.6	1.9	4.4	1.8	5.8	1.2	8.1	5.8	10.6	0.3	6.1	0.7	14.5	2.2	14.3	2.2
Children's Health Status																
Excellent	64.1	2.9	56.6	5.3	32.5	2.7	74.8	6.0	66.0	0.5	46.3	1.5	48.7	2.8	54.1	3.04
Very good	26.0	2.7	22.6	4.0	21.5	2.5	13.9	4.7	23.3	0.5	30.1	1.4	33.3	2.9	29.8	3.04
Good	8.8	1.7	16.6	4.6	34.1	3.0	10.3	4.3	8.8	0.3	19.3	1.3	13.2	2.0	12.7	2.02
Fair	1.1	0.5	2.3	2.0	11.4	2.0	0.9	0.9	1.6	0.1	3.7	0.6	4.6	1.4	2.9	0.64
Poor	0.0	0.0	2.0	1.6	0.5	0.3	0.2	0.2	0.3	0.1	0.7	0.2	0.2	0.1	0.5	0.36

SECTION III---BIVARIATE ANALYSES OF STUDY POPULATION

Bivariate analyses were conducted to examine the strength, direction and statistical significance between each dependent variable and independent variables (Kachigan 1986). To determine whether associations existed between children of black native-born and black foreign-born mothers, Chi square analyses were completed for each age group category. Analysis of the age groups was completed separately to determine the influence of the Medicaid provision in the PRWORA of 1996. Results were later utilized to develop the regression question on Medicaid's association in the receipt of dental, medical and mental health services. This section examines the following question:

Are there differences in socio-demographics, health status and utilization of dental, medical and mental health services among children of foreign-born compared to children with native-born black mothers?

The Null Hypothesis and the Alternative hypothesis were:

Null Hypothesis

(H₀): There are no differences in socio-demographics, health status and utilization of dental, medical and mental health services among children of foreign-born compared to children with native-born black mothers?

Alternative Hypothesis

(H_i): There are differences in socio-demographics and health and utilization of dental, medical and mental health services among children of foreign-born compared to children with native-born black mothers?

Table 22 presents frequency distribution, variable percentages, standard errors, and overall significance levels completed using weighted numbers. Significance level was set at 0.05. The narrative discussion highlights the various predisposing, enabling and need factors differences by age developed age cohorts.

Children age 0-3 of foreign-born versus native-born black mothers

Predisposing Factors

Among the age group 0-3, socio-demographical differences were identified in predisposing factors which included: household language, and residence for children born to Black foreign-born mothers compared to children born to Black native-born mothers. Children (99.9%) residing in the households of black natives spoke English compared to children residing with foreign-born mothers (81.8%). Geographic variation existed among the children of native-born mothers and foreign-born mothers. Children whose parents were native-born (61.3%) tended to reside in the South. On the other hand, Black foreign-born mothers and their children (49%) resided in the Northeast.

Enabling Factors

Differences were found among enabling factors which included: children's type of insurance, and having a regular source of care. When covered by insurance type, black-natives tended to be covered by Medicaid (60.8%). Children of black foreign-born were covered by private insurance (51.1%). The children of foreign-born mothers (85.5%) tended to have a regular source of care compared to children of black native-born mothers (77.0%).

Need Factors

There were no statistical differences between the two groups of children in health status and the receipt of dental and medical services. However there were differences in mental health services between the two groups. The children of native-born mothers reported a higher receipt of mental health services.

Summary Analysis

Chi-Square analysis revealed that in regards to household education, children's gender, health status, poverty levels, children's health status, the receipt of dental and medical care there were no differences between the two groups of children. Statistical differences were evident in children's household language, place of residences, insurance type, having a regular source of care and receipt of mental health services.

Children age 4-7 of foreign-born versus native-born black mothers

Predisposing Factors

Differences were found among predisposing factors which included: household education, language, and regional variations. Among the age group 4-7, (79.0%) of children of foreign-born mothers resided in household in which the mothers had more than a high school education compared to children of native-born mothers (54.3%). Children of Black native mothers (100%) household language were English compared to children residing with Black foreign-born mothers (86.6%). Geographic variation existed, children whose parents were native-born (58.7%) tended to reside in the South. On the other hand, children of Black foreign-born mothers resided in the Northeast (49%).

Enabling Factors

Differences were found among enabling factors which included: poverty, and having a regular source of care. In looking at household incomes, the children of foreign-born (30.7%) tended to reside in households where income levels were above 400 of the FPL compared to children of native-born mothers residing in household (34.0%) in which incomes were less than 100%. Having a regular source of care was (89.3%) for the

children of Black foreign-born mothers compared to children born to native-born (79.4%) mothers.

Need Factors

There were differences in the need factors which included: the receipt of medical and mental health services. The children of foreign-born (93%) reported higher utilization of medical services compared to children of native-born mothers (85.4%). In looking at mental health services, the children of black native-born mothers' utilization rate (6.0%) was higher compared to the children of Black foreign-born mothers (1.7%).

Summary Analysis

Chi-Square analysis revealed that in regards to household education, household language, places of residence, household poverty levels, having a regular source of care, the receipt of medical and mental health services, there are significant statistical differences between the two groups of children. Statistical differences were not evident in children's gender, insurance type, age, child's health and the receipt of dental services.

Children age 8-11 of foreign-born versus native-born black mothers

Predisposing Factors

Differences were found among predisposing factors which included: household education, household language and places of residence. Among the age group 8-11, the children of foreign-born resided in households where (79%) of the mothers had more than a high school education compared with children of native-born mothers (57%). Children residing with black native mothers (99.9%) the household language was English compared to children residing with black foreign-born mothers (85.8%). In looking at the places where children resided, the Northeast (55.2%) ranks the highest for children of

foreign-born mothers compared to children of native-born mothers resided in southern states (61.6%).

Enabling Factors

Insurance type, household poverty and having a regular source of care were enabling factors under investigation; only insurance type reported differences. Among the age group 8-11, 45.6% of the children of native-born mothers were covered by Medicaid compared to the children of foreign-born mothers (30.5%).

Need Factors

There were differences in the need factors which included: the receipt of dental and mental health services. In looking at dental services, children of foreign-born mothers reported a higher utilization of dental services compared to children of native-born mothers. Seven percent of the children of native-born mothers reported receipt of mental health services compared to children of foreign-born mothers (1.0%).

Summary Analysis

Chi-Square analysis revealed statistical differences in household education, household language, places of residence, insurance type, poverty levels, receipt of dental services and mental health services. There were no significant statistical differences between the two groups of children in gender, poverty levels, having a regular source of care, and the receipt of medical services.

Children age 12-17 of foreign-born versus native-born black mothers

Predisposing Factors

Differences were identified in predisposing factors which included: household education, household language, and residence of children born to black foreign-born

mothers compared to children born to black native-born mothers. The children of foreign-born mothers (81.1%) resided in households where mothers had more than a high school education compared to children of native-born mothers (55.9%). English was spoken in the households of children of black native-mothers (99.9%) compared to the children of Black foreign-born mothers (93.1%). In comparing geographic variations, (59.5%) of the children of native-born mothers resided in the South compared to children of black foreign-born mothers who resided in the South (46.7%) followed by the North (42.4%).

Enabling Factors

Differences were identified in enabling factor which included: insurance type, and poverty levels. The children of Black-native mothers (90.8%) tended to be insured compared to the children of black foreign-born mothers (87.1%). The children of black native-born mothers (51.1%) were covered by Medicaid compared to children of black foreign-born mothers (24.6%). Children of black foreign-born mothers (28.2%) tended to reside in households where annual income levels were 400% over the FPL compared to children born to black native-born mothers with annual household income (30.8%) was less than 100% of the FPL.

Summary Analysis

Chi-Square analysis revealed statistically significant differences in household education, household language, geographic residences, insurance type, and poverty levels. There were no significant statistical differences between the two groups of children in gender, having a regular source of care, children's health status, the receipt of dental services, medical services and mental health services.

SUMMARY OF BIVARIATE ANALYSIS

Among the US population of Black children, there were statistical differences in household education among all age cohorts except age cohort 0-3. Differences were found among all age groups in household languages, and places of residences. In looking at enabling factors, statistical differences were reported in insurance type for all age cohorts except 4-7. Differences were found in FPL among age cohort 4-7 and 12-17. Only age cohort 0-3 and 4-7 reported having a regular source of care.

Analysis of the need variables revealed that there were no differences in reported health status among all groups. In the receipt of dental services, there were no differences among all groups except in age cohort 8-11. There were no differences in the receipt of medical services among cohorts 0-3, 8-11 and 12-17. Differences in the receipt of mental health services for children were reported among all age cohorts except for cohort 12-17.

BIVARIATE RELATIONSHIP TO WELFARE REFORM ACT OF 1996

A critical objective for this study was to investigate whether the Medicaid provision in the PRWORA of 1996 was associated with accessing and utilizing services among children of black foreign-born and native mothers. The bivariate analysis revealed that by looking critically at age cohorts 8-11 and 12-17; there are statistically significant differences among the age 8-11 and 12-17 groups. Differences exist in parental education, household languages, and insurance type. More children of black foreign-born mothers were covered by private insurance and not Medicaid.

There are no differences in having a regular source of care to receive appropriate health care services and reported health status. Differences were found in the receipt of dental and mental health services, but not medical services in age cohort 8-11. In looking

at age cohort 12-17, there are no differences in the receipt of dental services, medical services and mental health services between these two groups of children.

TABLE--22 Bivariate Association of Children with Black Foreign-Born and Native-Born Mothers, NSCH 2003-2004

Predisposing/Enabling/ Need Factors	Ages 0 – 3 years					Ages 4 – 7 years					Ages 8 - 11 years					Ages 12 - 17 years					
	Foreign-Born Blacks 204,728		Native-Born Blacks 1,699,923			Foreign-Born Blacks 214,064		Native-Born Blacks 1,685,720			Foreign-Born Blacks 214,948		Native-Born Blacks 1,889,458			Foreign-Born Blacks 214,948		Native-Born Blacks 2,989,201			
	%	SE	%	SE	P	%	SE	%	SE	P	%	SE	%	SE	P	%	SE	%	SE	P	
Household Education					0.08					0.00					0.00						0.00
<i>Less than HS</i>	5.95	2.9	8.7	1.12		2.3	1.3	6.9	1.2		2.6	2.2	6.1	0.9		7.7	4.0	7.2	0.9		
<i>High School</i>	23.5	4.9	34.43	1.91		18.7	5.4	38.8	2.0		18.4	4.3	37	1.9		11.2	3.6	36.9	1.5		
<i>More than HS</i>	70.5	5.3	57.51	1.98		79.0	5.5	54.3	2.0		79.0	4.6	56.9	1.9		81.1	4.9	55.9	1.5		
Children's Gender					0.09					0.41					0.85						0.98
<i>Male</i>	52.4	5.8	51.6	1.99		56.4	6.7	50.6	2.0		48.2	5.4	49.3	1.9		50.2	5.3	50.1	1.5		
<i>Female</i>	47.6	5.8	48.4	1.99		43.6	6.7	49.4	2.0		51.8	5.4	50.7	1.9		49.8	5.3	49.9	1.5		
Household Language					0.00					0.01					0.00						0.01
<i>English</i>	81.8	3.8	99.9	0.07		86.6	5.0	100	0.0		85.8	3.7	99.9	0.1		93.1	2.5	99.9	0.1		
<i>Spanish</i>	18.2	3.8	0.13	0.07		13.4	5.0	0.01	0.0		14.2	3.7	0.1	0.0		6.9	2.5	0.1	0.1		
Regions					0.00					0.00					0.00						0.00
<i>Northeast</i>	49	5.9	10.8	1.33		37.2	6.1	11.8	1.4		55.2	5.3	34.5	1.4		42.4	5.3	14.3	1.2		
<i>Midwest</i>	9.1	2.5	15.8	1.34		5.2	3.0	21.8	1.7		6.5	2.0	17.8	1.4		5.2	2.1	19.5	1.2		
<i>South</i>	32.9	5.6	61.3	2.1		42.4	6.6	58.7	2.0		35.3	5.0	61.6	1.9		46.7	5.3	59.5	1.6		
<i>West</i>	9.1	3.6	12.1	1.95		15.2	6.8	7.8	1.4		2.9	1.0	6.6	1.1		5.6	2.1	6.7	1.2		
Enabling Factors																					
Insurance Type					0.04					0.31					0.02						0.00
<i>Private</i>	46.4	5.9	37.66	2.0		46.8	6.7	42.7	2.0		62.3	5.4	47	1.9		65.7	5.1	44.2	1.5		
<i>Medicaid</i>	44.5	5.9	58.64	2.0		43.2	7.0	52.7	2.0		30.5	5.2	45.6	1.9		21.4	4.2	46.4	1.6		
<i>Uninsured</i>	9.11	3.0	3.7	0.74		10	4.3	4.6	0.8		7.2	2.5	7.4	1.1		13	4.3	9.32	1.1		
Poverty					0.81					0.02					0.15						0.00
<i>Less than 100%</i>	27.7	5.8	38.3	2.01		15.2	6.7	34	2.1		16.9	4.5	26.8	1.8		13.4	5.0	30.8	1.5		
<i>100 – 133</i>	10.8	3.9	9.3	1.35		8.5	3.4	12.8	1.3		7.6	3.1	12.5	1.3		2.6	1.2	13.7	1.2		
<i>133 – 150</i>	5.7	2.4	5.5	1.1		5.8	4.0	5.3	1.0		6.2	3.3	5.9	1.0		8.7	3.6	5.9	0.9		
<i>150 – 185</i>	10.7	3.3	8.6	1.23		7.9	3.1	8.3	1.1		8.4	3.6	10	1.3		7.2	3.0	9.4	0.9		
<i>185 – 200</i>	6.7	3.9	4.8	1.27		0.8	0.8	2.7	0.6		5.2	2.1	4.7	0.8		2.4	1.7	3.6	0.5		
<i>200 – 300</i>	11.8	4.1	12.1	1.33		14.6	5.0	14.4	1.3		18.3	4.7	17.2	1.5		20	4.6	13.7	1.0		
<i>300 – 400</i>	13.5	5.1	7.5	0.95		16.5	5.4	9.9	1.1		21.8	4.6	10.5	1.1		17.6	4.3	10.3	0.8		
<i>400% and over</i>	13.1	3.9	13.2	1.31		30.7	6.0	12.6	1.1		15.6	3.3	12.6	1.0		28.2	4.6	12.6	0.9		

TABLE--22 Bivariate Association of Children with Black Foreign-Born and Native-Born Mothers, NSCH 2003-2004

Predisposing/Enabling/ Need Factors	Ages 0 – 3 years					Ages 4 – 7 years					Ages 8 - 11 years					Ages 12 - 17 years					
	Foreign-Born Blacks 204,728		Native-Born Blacks 1,699,923			Foreign-Born Blacks 214,064		Native-Born Blacks 1,685,720			Foreign-Born Blacks 214,948		Native-Born Blacks 1,889,458			Foreign-Born Blacks 214,948		Native-Born Blacks 2,989,201			
	%	SE	%	SE	P	%	SE	%	SE	P	%	SE	%	SE	P	%	SE	%	SE	P	
Regular source of care					0.05					0.02					0.89						0.80
<i>No</i>	14.2	4.1	27.0	1.65		10.7	1.7	20.6	4.3		20.6	4.3	19.9	1.6		25.5	5.0	26.8	1.4		
<i>Yes</i>	85.5	4.1	77.0	1.65		89.3	3.6	79.4	1.7		79.4	4.3	80.1	1.6		74.5	5.0	73.2	1.4		
Need Factors																					
Dental Services					0.87					0.22					0.02						0.26
<i>No</i>	15.7	9.4	14.1	2.27		5.8	1.9	9.2	1.2		4.3	1.7	9.2	1.1		9.2	4.0	13.8	1.1		
<i>Yes</i>	84.3	9.4	85.9	2.27		94.2	2.4	90.8	1.2		95.7	1.7	90.8	1.1		90.8	4.0	86.2	1.1		
Medical Services					0.92					0.05					0.11						0.64
<i>No</i>	8.0	2.7	7.8	1.07		7.0	3.3	14.4	1.5		8.0	3.0	17.3	1.3		22.7	4.6	20.4	1.2		
<i>Yes</i>	92.0	2.7	92.2	1.07		93.0	3.3	85.4	1.5		92.0	3.0	82.7	1.3		77.3	4.6	79.6	1.2		
Mental Health					0.01					0.01					0.00						0.39
<i>No</i>	100.0	0.0	98.3	0.61		98.3	1.0	94.0	1.1		99.0	0.7	93.4	1.0		95.6	1.8	93.9	0.7		
<i>Yes</i>	0.0	0.0	1.7	0.61		1.7	1.0	6.0	1.1		1.0	0.7	6.6	1.0		4.4	1.8	6.1	0.7		
Children's Health Status					0.05					0.02					0.89						0.25
<i>Excellent</i>	55.8	5.8	60.9	1.96		68	6.3	55.8	2.0		59.8	5.3	49.7	1.9		56.6	5.3	46.3	1.5		
<i>Very good</i>	24.9	5.1	24.9	1.78		17.2	4.9	23.9	1.7		24.2	4.5	26.9	1.6		22.6	4.0	30.1	1.4		
<i>Good</i>	16.3	4.3	10.6	1.22		13.8	4.8	16.4	1.5		12.8	3.6	17.9	1.6		16.6	4.6	19.3	1.3		
<i>Fair</i>	3.0	1.7	2.8	0.61		0.9	0.7	2.9	0.6		3.2	2.2	5.4	1.0		2.3	2.0	3.7	0.6		
<i>Poor</i>	0.0	0.0	0.7	0.35		0.1	0.1	0.98	0.7		0	0.0	0.1	0.1		2	1.6	0.7	0.2		

*Significant at the $P \leq .05$

SECTION IV---MULTIVARIATE REGRESSION MODELS ANALYSIS

Multivariate analysis models were used to identify the characteristics that were associated with utilization of dental, medical and mental health services. In addition, a separate multivariate model was developed to determine the association of Medicaid and the receipt of dental, medical and mental health services. Tables 23 through 26 present the odds ratios (OR), the confidence intervals (CI) and the p-value from the logistic regression models performed. The first research question focused on:

Is there an association between age, education, health status, gender, insurance type, language, regions, source of care and poverty levels in the receipt of dental, medical and mental health services among children whose mother identified as foreign-born and native-born black mothers?

The Null Hypothesis and the Alternative hypothesis were:

Null Hypothesis

(H₀): There are no associations between age, education, health status, gender, insurance type, language, regions, source of care and poverty levels in the receipt of dental, of medical and of mental health services among children whose mother identified as foreign-born and native-born black mothers?

Alternative Hypothesis

(H_i): There are associations between age, education, health status, gender, insurance type, language, regions, source of care and poverty levels in the receipt of dental, of medical and of mental health services among children whose mother identified as foreign-born and native-born black mothers?

Logistic regression models were performed to answer this multivariate question. These outcomes (dental, medical, and mental health services) were treated as dichotomous variables and were coded as “1” if the service was received and “0” if the service was not received. Three separate regression models were developed for each of the outcome variables: the full model with all variables, the second model without mothers’ parental status and the model without regular source of care but included the

parental status. These models were developed to ascertain whether mothers' parental status is associated with any of the selected dependent variables.

In developing the regression models for the first regression question, the following were references for the variables in the study. Age group 0-3; less than high school for household education; male referring to children's gender; excellent referring to children's health status; English referring to children's household language; northeast as the place of domicile; uninsured as insurance type for children; less than 100% of the FPL, not having a regular source of care and native-born Black mother.

The Hosmer-Lemeshow Test commonly used to determine the goodness of fit of a model was utilized to assess the fit of the regression model to the data. The results of the Hosmer-Lemeshow test must not be significant; a significant results ($p > .05$) means that the model is a good fit for the data. The questions taken from the NSCH were as follows:

- **Dental Services**

During the past 12 months/since his/her birth, did the child see a dentist for any routine preventative dental care, including checks-ups, screening, and sealants? Include all types of dentist, such as orthodontists, oral surgeons, and all other dental specialist?

- **Medical Services**

During the past 12 months/Since (his/her) Birth, did (S.C.) see a doctor, nurse, or health care professional for any kind of medical care, including sick-child, well-child check-ups, physical exams, and hospitalizations?

- **Mental Services**

During the past 12 months/ Since/(his/her) birth did (SC) receive any mental health care or counseling?

Regression Model for Any Health Services

The Cox and Snell R Square for the dependent variable "any service" were 0.0369. This procedure estimates the variance accounting for the analysis. In this regression analysis for any service received in the last 12 months, one can assert that

3.7% of the variance had been accounted. The Hosmer and Lemeshow Test for the full model reported a high p-value which suggests that the model adequately fit the data. The Hosmer-Lemeshow was significant at 0.2963. Table 23 presents the results for regression model for any service.

The first model found no statistically significant differences among the children of black foreign-born mothers compared to children of black native-mothers in the receipt of any services (dental, medical and mental health services). The odds ratio was (OR) =1.34; 95% confidence intervals (CI) =0.45-4.00.

Factors associated with receipt of any services were household language. Children in households in which English is spoken are more likely to receive a service (OR of 0.14; CI= 0.03 to 0.07), children residing in the South (OR=0.39; CI=0.17 to 0.91) are less likely to receive services compared to children in the Northeast, children in households with incomes between 200-300 of FPL (OR= 3.92; CI=1.49 to 10.36, 400 and above FPL with an OR=5.20; CI=1.81 to 14.94) are more likely to receive services compared to children in household less than 100% of the FPL, and children with a regular source of care OR=3.49; CI=2.25 to 5.24 are more likely than those without a source of care.

The second model without parental status had a Cox and Snell R Square for the dependent variable any service of 0.0255 illustrating that 2.5% of the variance has been accounted. The Hosmer and Lemeshow Test reported a good fit of the model to the data. The Hosmer significance was at 0.5809.

Without parental status, the variables household language (OR=0.21; CI= 0.05-0.90), residing in the South (OR=0.40; CI=0.17-0.90), having public insurance, such as

Medicaid and the State Children's Health Insurance Program (OR=2.05; CI=1.02 to 4.12), residing in households in which annual income were between 300-400 (OR=3.69; CI=1.41 to 9.64) and 400 FPL and above (OR=4.88; CI=1.74 to 13.68) and having a regular source of care (OR 3.71; CI=2.40 to 5.73) were associated with receiving any services in the last twelve months.

The third model without regular source of care found no statistically differences among the children of black foreign-born mothers compared to children of native mothers. The OR=1.20; CI=0.42 to 3.45. The Cox and Snell R Square for dependent variable any service were 0.0255 illustrating that 2.5% of the variance has been accounted. The Hosmer and Lemeshow Test for the model suggested that the model was a good fit for the data. The Hosmer significance was at 0.2963.

With the removal of regular source of care, factors leading to receipt of any service were household language (OR=0.16; CI 0.04-0.76), having public insurance, such as Medicaid and the State Children's Health Insurance Program (OR=2.51; CI=1.26-5.02), and residing in households in which annual income were between 200-300 FPL (OR=2.26; CI=1.08-4.73; 3:00-400 FPL (OR=4.89; CI=1.84-12.99 and 400 and above the federal poverty level (OR=6.86; CI 2.40-19.61). Children in age cohort 12-17 (OR=0.43; CI=0.19-0.99) were less likely compared to children in age cohort 0-3 to have a regular source of care.

TABLE-- 23 Logistic Regression Analysis for Any Services for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need Factors	Parental Status				Without Parental Status				Regular Source			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI
Predisposing Factors												
Parental Status												
Black Natives (Ref)	1.00								1.00			
Black Immigrants	1.34	0.60	0.45	4.00					1.20	0.73	0.42	3.45
Children's Age												
0-3 (Ref)	1.00								1.00			
4-7	1.17	0.74	0.46	3.00					1.15	0.74	0.44	3.01
8-11	0.81	0.62	0.35	1.88					0.81	0.62	0.34	1.89
12-17	0.49	0.08	0.22	1.09					0.43	0.05*	0.19	0.99
Household Education												
Less than HS (Ref)	1.00				1.00				1.00			
High School	0.82	0.70	0.3	2.28	0.84	0.74	0.31	2.28	0.81	0.69	0.29	2.27
More than HS	1.35	0.56	0.49	3.75	1.38	0.53	0.50	3.77	1.4	0.52	0.5	3.91
Children's Gender												
Male (Ref)	1.00				1.00				1.00			
Female	0.89	0.61	0.58	1.38	0.90	0.63	0.59	1.38	0.9	0.63	0.59	1.38
Household Language												
English (Ref)	1.00				1.00				1.00			
Spanish	0.14	0.02*	0.03	0.7	0.21	0.04*	0.05	0.90	0.16	0.02*	0.04	0.76
Regions												
Northeast (Ref)	1.00				1.00				1.00			
Midwest	0.47	0.12	0.18	1.22	0.47	0.12	0.19	1.20	0.45	0.10	0.18	1.16
South	0.39	0.03*	0.17	0.91	0.40	0.03*	0.17	0.90	0.37	0.02*	16.00	0.87
West	0.34	0.11	0.09	1.28	0.37	0.14	0.10	1.37	0.31	0.09	0.08	1.21

Enabling Factors												
Insurance Type												
Uninsured	1.00				1.00				1.00			
Private	1.13	0.75	0.53	2.42	1.18	0.68	0.55	2.53	1.49	0.30	0.7	3.19
Medicaid/CHIP	1.94	0.06	0.98	3.85	2.05	0.04*	1.02	4.12	2.51	0.01*	1.26	5.02
Poverty												
Less than 100% (Ref)	1.00				1.00				1.00			
100-133	0.98	0.95	0.52	1.86	0.95	0.87	0.50	1.79	0.98	0.95	0.52	1.84
133-150	2.09	0.18	0.72	6.10	2.07	0.18	0.72	5.93	2.07	0.18	0.71	6.04
150-185	1.41	0.30	0.73	2.71	1.32	0.40	0.69	2.55	1.53	0.21	0.78	2.99
185-200	2.29	0.14	0.75	6.98	2.26	0.15	0.74	6.85	2.33	0.13	0.78	6.94
200-300	1.95	0.09	0.91	4.16	1.86	0.10	0.89	3.89	2.26	0.03*	1.08	4.73
300-400	3.92	0.01*	1.49	10.36	3.69	0.01*	1.41	9.64	4.89	0.00*	1.84	12.99
400% and over	5.20	0.00*	1.81	14.94	4.88	0.00*	1.74	13.68	6.86	0.00*	2.40	19.61
Regular source of care												
No source of care (Ref)	1.00				1.00							
Yes source of care	3.49	.000*	2.25	5.42	3.71	.000*	2.40	5.73				
Need Factor												
Children's Health Status	1.00				1.00				1.00			
Excellent (Ref)	1.08	0.73	0.68	1.72	1.04	0.88	0.65	1.65	1.06	0.81	0.67	1.68
Very Good	1.61	0.18	0.81	3.22	1.49	0.26	0.74	3.00	1.55	0.20	0.79	3.03
Good	1.36	0.65	0.36	5.19	1.23	0.76	0.32	4.66	1.52	0.52	0.42	5.53
Fair	1.19	0.89	0.11	12.88	1.17	0.90	0.10	13.12	1.56	0.71	0.15	15.65
Poor												

*Significant at the P<=.05

CI=Confidence Interval

OR=Odd Ratio

Data Source: CDC/HRSA, National Survey of Children's Health

Regression Model for Dental Services

The Cox and Snell R Square for dependent variable dental services were 0.0316 illustrating that 3.1% of the variance has been accounted. The Hosmer and Lemeshow Test for the full model showed that it adequately fit for the data. The Hosmer was significant at 0.0629. Table 24 presents the results for regression model for dental service.

The model found no statistically significant differences among the children of black foreign-born mothers compared to children of black native-mothers in the receipt of dental services. The odds ratio (OR) for dental service was (OR) =1.36; 95% confidence interval (CI) of 0.76 to 2.46.

Factors associated with the receipt of dental services were: Children in age cohort 8-11 (OR=1.67; CI=1.03-2.71) were more likely to receive dental services compared to children in age cohort 0-3; children with Medicaid (OR=1.98; CI= 1.20-3.25) compared to children who were uninsured; children whose household incomes 400 FPL an above (OR=2.26; CI=1.33-3.84) compared to children whose incomes were 100% or less; children having a regular source of care (OR=1.62; CI=1.20-2.18) compared to children without a source of care.

Without parental status, the Cox and Snell R Square for the dependent variable dental service were 0.0316 illustrating that 3.1% of the variance has been accounted. The Hosmer and Lemeshow Test for the model reported a good fit of the data. The Hosmer significance was at 0.1457.

Children living in a household where the educational level was more than high school (OR=2.10; CI=1.10-4.00) compared to households less than 100%; household

where the English language was spoken (OR =0.21; CI=0.05-0.90) compared to Spanish, Children with, Medicaid and the State Children's Health Insurance Program (OR =1.93; CI=1.17-3.20) were more likely compared to children who were uninsured, children residing in households in which annual income was 400 and above the FPL (OR=2.26; CI=1.34-3.83) were more likely, and children having a regular source of care (OR=1.68; CI=1.25-2.26), were more likely compared to children without a source of care to have received a dental visit.

Without the regular source of care variable in the third model, the Cox and Snell R Square for dependent variable dental were 0.0316 illustrating that 3.2% of the variance has been accounted. The Hosmer and Lemeshow Test for the model showed that it adequately fit the data. The Hosmer significance was at 0.1457. This model without regular source of care found no statistically differences among the children of Black immigrant mothers compared to children of native mothers. The (OR=1.32; 95%; CI= 0.73 to 2.42.

Factors associated with receipt of dental services were household education whereby more than high school was obtained (OR=2.11; CI=0.00-4.00), having insurance, such as private coverage (OR=1.73; CI=1.03-2.91), and Medicaid/Children's Health Insurance Program (OR=2.16; CI=1.31-3.57), and residing in households in which annual income 400 % above the FPL (OR=2.47; CI=1.46-4.18).

TABLE-- 24 Logistic Regression Analysis for Dental Services for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need Factors	Parental Status				Without Parental Status				Regular source of care			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI
Predisposing Factors												
Parental Status												
Black Natives (Ref)	1.00								1.00			
Black Immigrants	1.36	0.30	0.76	2.46					1.32	0.36	0.73	2.42
Children's Age												
0-3 (Ref)	1.00								1.00			
4-7	1.62	0.06	0.98	2.68					1.64	0.06	0.98	2.73
8-11	1.67	0.04*	1.03	2.71					1.63	0.05*	1.00	2.64
12-17	1.03	0.89	0.65	1.64					1.01	0.97	0.63	1.61
Household Education												
Less than HS (Ref)	1.00				1.00				1.00			
High School	1.39	0.29	0.75	2.58	1.41	0.29	0.75	2.62	1.37	0.31	0.74	2.52
More than HS	2.06	0.03*	1.09	3.88	2.10	0.03*	1.10	4.00	2.11	0.02*	1.12	3.95
Children's Gender												
Male (Ref)	1.00				1.00				1.00			
Female	0.89	0.41	0.68	1.17	0.89	0.41	0.68	1.17	0.89	0.38	0.68	1.16
Household Language												
English (Ref)	1.00				1.00				1.00			
Spanish	0.55	0.36	0.15	2.02	0.21	0.60	0.05	0.90	0.57	0.38	0.15	2.11
Regions												
Northeast (Ref)	1.00				1.00				1.00			
Midwest	0.97	0.91	0.58	1.64	0.94	0.83	0.57	1.57	0.97	0.91	0.58	1.62
South	0.86	0.51	0.55	1.34	0.83	0.42	0.54	1.29	0.83	0.42	0.53	1.30
West	1.04	0.92	0.47	2.28	1.03	0.94	0.48	2.24	1.01	0.98	0.45	2.24

TABLE-- 24 Logistic Regression Analysis for Dental Services for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need Factors	Parental Status				Without Parental Status				Regular source of care			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI
Enabling Factors												
Insurance Type												
Uninsured	1.00				1.00				1.00			
Private	1.60	0.07	0.96	2.69	1.59	0.68	0.94	2.68	1.73	0.04*	1.03	2.91
Medicaid/CHIP	1.98	0.01*	1.20	3.25	1.93	0.01*	1.17	3.20	2.16	0.00*	1.31	3.57
Poverty												
Less than 100% (Ref)	1.00				1.00				1.00			
100-133	1.08	0.72	0.71	1.65	1.09	0.68	0.71	1.67	1.05	0.83	0.69	1.59
133-150	0.87	0.65	0.49	1.56	0.88	0.66	0.49	1.57	0.90	0.72	0.50	1.61
150-185	1.20	0.44	0.76	1.90	1.21	0.42	0.76	1.91	1.25	0.35	0.79	1.99
185-200	1.33	0.43	0.66	2.67	1.32	0.43	0.66	2.67	1.38	0.37	0.69	2.76
200-300	1.35	0.22	0.83	2.20	1.39	0.19	0.85	2.26	1.44	0.13	0.89	2.31
300-400	1.55	0.11	0.91	2.63	1.56	0.09	0.83	2.63	1.68	0.05*	0.99	2.83
400% and over	2.26	0.00*	1.33	3.84	2.26	0.00*	1.34	3.83	2.47	0.00*	1.46	4.18
Regular source of care												
No source of care (Ref)	1.00				1.00							
Yes source of care	1.62	.000*	1.2	2.18	1.68	.000*	1.25	2.26				
Need Factor												
Children's Health Status												
Excellent (Ref)	1.00				1.00				1.00			
Very Good	1.03	0.87	0.76	1.38	0.99	0.93	0.73	1.34	1.02	0.88	0.76	1.38
Good	0.97	0.89	0.66	1.44	0.95	0.80	0.64	1.41	0.92	0.68	0.63	1.35
Fair	0.92	0.83	0.40	2.09	0.93	0.86	0.41	2.11	0.96	0.93	0.43	2.15
Poor	2.06	0.89	0.40	10.61	2.03	0.41	0.37	11.25	2.22	0.34	0.43	11.38

*Significant at the P<=.05

CI=Confidence Interval

OR=Odd Ratio

Data Source: CDC/HRSA, National Survey of Children's Health

Regression Model for Medical Health Services

The Cox and Snell R Square for dependent variable medical services were 0.0810 illustrating that 8.1% of the variance has been accounted in this regression analysis for medical service received in the last 12 months. The Hosmer and Lemeshow Test significance was at 0.000 meaning that the data is not a good fit for the model. In addition, the model found no statistically significant differences among the children of Black immigrant-mothers compared to children of Black native-mothers in the receipt of medical services. The odds ratio (OR) for medical service was (OR) =0.99; 95% confidence interval (CI) =0.62-1.57.

Regression Model for Mental Health Services

The Cox and Snell R Square for dependent variable mental health services were 0.0482 illustrating that 4.8% of the variance has been accounted in this regression model for mental health services. The Hosmer and Lemeshow Test were significant at 0.1262 for the full model showing a good fit of the data to the model. Table 25 presents the results for regression model for dental service.

The model with parental status found statistically significant differences among the children of black immigrant-mothers compared to children of black native-mothers. Children whose mothers were black immigrants were less likely to receive mental health services. The odds ratio (OR) for mental health service was (OR) =0.36; 95% confidence interval (CI) =0.15-0.89.

Factors associated with the receipt of mental health services were age cohort groups. Children in cohort 8-11 (OR=4.77; CI=2.07-11.00) 4-7 (OR=3.66; CI= 1.58-8.63) and 12-17 (OR=4.49; CI=2.01-10.02) were more likely to receive services than

children in age cohort 0-3; children who were females were less likely to receive mental health services compared to males (OR=0.42; CI=0.30-0.59), children residing in southern regions (OR=0.50; CI=0.30-0.87) were less likely to receive services than children in the Northeast; children with Medicaid were more likely to receive services compared to children who were not insured (OR=2.59; CI=1.30-5.14); children residing in households in which the income level was between 133-150 were less likely to receive services than children whose household incomes were less than 100% FPL (OR=.30; CI=.13-.73) and children's health status reported as good (OR=1.81; CI=1.16-2.82); fair (OR=3.38; CI=1.79-6.38); poor (OR=19.54; CI=5.66-67.48) were more likely to receive services than children whose healthy status was excellent.

Without parental status, the Cox and Snell R Square for the dependent variable mental health services were 0.0388 illustrating that 3.9% of the variance has been accounted. The Hosmer and Lemeshow Test for the model reported a good fit of the data. The Hosmer significance was at 0.2108.

Without parental status factors associated with the receipt of mental health services were children's gender (OR=0.43; CI=0.31-0.61); children residing in the South (OR=0.54; CI of 0.33-0.90); Medicaid and the State Children's Health Insurance Program (OR=2.51; CI=1.25-5.02), residing in households in which annual incomes were 133-150 FPL (OR=0.30; CI=0.12-0.71) and children's health status reported as good (OR=1.95; CI=1.25-3.06); fair (OR=3.62; CI=1.87-7.02); poor (OR=18.23; CI=5.42-61.37).

The third model without regular source of care found statistically significant differences among the children of black foreign-born mothers compared to children of native mothers. The (OR) is 0.36; (CI) of 0.14-0.88.

The Cox and Snell R Square for dependent variable mental health service without the regular source of care variable were 0.04788 illustrating that 4.9% of the variance has been accounted. The Hosmer was significant at 0.8084.

Factors associated with the receipt of mental health services were children's age groups, children in cohort 8-11 (OR=4.75; CI=2.06-10.93); children in age cohorts 4-7 (OR=3.68; CI= 1.57-8.59) and 12-17 (OR=4.41; CI=1.98-9.86) were more likely to receive mental health services than children in age cohort 0-3; children who were female (OR=0.42; CI=0.41-0.59) were less likely to receive mental health services than males; residing in southern regions (OR=0.50; CI=0.30-0.85); having Medicaid (OR=2.72; CI=1.40-5.30); income level between 133-150 FPL (OR=0.31; CI=0.13-0.74) and children's health status reported as good (OR=1.81; CI=1.16-2.83); fair (OR=3.42; CI=1.80-6.50); poor (OR=20.60; CI=5.87-72.24).

TABLE--25 Logistic Regression Analysis for Mental Services for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need	Parental Status				Without Parental Status				Regular source of care			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI
Predisposing Factor												
Parental Status												
Black Natives (Ref)	1.00								1.00			
Black Immigrants	0.36	0.03*	0.15	0.89					0.36	0.03*	0.14	0.88
Children's Age												
0-3 (Ref)	1.00								1.00			
4-7	3.66	0.00*	1.58	8.63					3.68	.000*	1.57	8.59
8-11	4.77	0.00*	2.07	11.00					4.75	.000*	2.06	10.93
12-17	4.49	0.00*	2.01	10.02					4.41	.000*	1.98	9.86
Household Education												
Less than HS (Ref)	1.00				1.00				1.00			
High School	0.85	0.64	0.43	1.69	0.89	0.73	0.44	1.77	0.86	0.66	0.43	1.70
More than HS	0.82	0.58	0.40	1.67	0.84	0.62	0.41	1.72	0.84	0.63	0.41	1.73
Children's Gender												
Male (Ref)	1.00				1.00				1.00			
Female	0.42	.000*	0.30	0.59	0.43	.000*	0.31	0.61	0.42	.000*	0.41	0.59
Household Language												
English (Ref)	1.00				1.00				1.00			
Spanish	1.15	0.12	0.13	10.09	0.46	0.46	0.06	3.54	1.17	0.89	0.13	10.28
Regions												
Northeast (Ref)	1.00				1.00				1.00			
Midwest	0.75	0.34	0.41	1.37	0.84	0.56	0.47	1.50	0.75	0.34	0.41	1.36
South	0.50	0.01*	0.30	0.86	0.54	0.02*	0.33	0.90	0.50	0.01*	0.30	0.85
West	0.87	0.73	0.39	1.95	0.86	0.71	0.39	1.88	0.86	0.72	0.39	1.93

TABLE--25 Logistic Regression Analysis for Mental Services for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need	Parental Status				Without Parental Status				Regular source of care			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI
Enabling Factors												
Insurance Type												
Uninsured	1.00				1.00				1.00			
Private	1.21	0.59	0.60	2.45	1.22	0.58	0.60	2.48	1.28	0.48	0.64	2.56
Medicaid/CHIP	2.59	0.01*	1.30	5.14	2.51	0.01*	1.25	5.02	2.72	0.00*	1.40	5.30
Poverty												
Less than 100% (Ref)	1.00				1.00				1.00			
100-133	0.67	0.14	0.40	1.14	0.74	0.25	0.44	1.24	0.67	0.14	0.40	1.13
133-150	0.30	0.01*	0.13	0.73	0.30	0.01*	0.12	0.71	0.31	0.01*	0.13	0.74
150-185	1.09	0.82	0.54	2.19	1.09	0.80	0.54	2.20	1.09	0.08	0.54	2.20
185-200	0.60	0.43	0.17	2.12	0.59	0.41	0.17	2.05	0.60	0.43	0.17	2.13
200-300	0.69	0.19	0.39	1.20	0.72	0.25	0.42	1.25	0.69	0.20	0.40	1.22
300-400	1.19	0.61	0.61	2.33	1.24	0.53	0.64	2.39	1.22	0.56	0.63	2.39
400% and over	0.82	0.54	0.44	1.53	0.78	0.43	0.41	1.46	0.84	0.59	0.45	1.57
Regular source of care												
No source of care (Ref)	1.00											
Yes source of care	1.22	0.39	0.77	1.92	1.19	0.47	0.75	1.88				
Need Factor												
Children's Health Status												
Excellent (Ref)	1.00				1.00				1.00			
Very Good	1.25	0.28	0.83	1.88	1.30	0.21	0.86	1.95	1.26	0.27	0.84	1.89
Good	1.81	0.01*	1.16	2.82	1.95	0.00*	1.25	3.06	1.81	0.01*	1.16	2.83
Fair	3.38	0.00*	1.79	6.38	3.62	0.00*	1.87	7.02	3.42	0.00*	1.80	6.50
Poor	19.54	0.00*	5.66	67.48	18.23	0.00*	5.42	61.37	20.60	0.00*	5.87	72.24

*Significant at the P<=.05

CI=Confidence Interval

OR=Odd Ratio

Data Source: CDC/HRSA, National Survey of Children's Health

SUMMARY OF ANALYSIS

In developing responses to the first regression question, twelve regression models were developed. Of those, four included mothers' immigrant status, four were without race and four included mothers immigrant status but, the independent variable, regular source of care was removed.

The analysis for the first regression question that looked at services utilization of dental, medical, and mental health services demonstrated that there are no differences in the receipt of dental services among the US population of black children. The model developed for medical services Hosmer Test was not significant. However, the model developed for receipt of mental health services demonstrates statistically significant differences among this population of US children. For all dependent variables utilized, analyses exemplified the significant role of Medicaid as a vehicle for age appropriate health care services for black children in the US.

MEDICAID ASSOCIATION AND WELFARE REFORM

This second regression question investigated the association between Medicaid and service utilization. Unlike the first question in which dependent variables were dental, medical and mental health services, in this analysis, Medicaid was used as dependent variable. For this analysis, three regression models were developed. Like the first question, models were developed with parental status, without parental status, and with the parental status variable but without regular source of care. In this model, only age groups 8-11 and 12-17 were in this regression model. The reference group was age cohort 8-11. All other reference groups remained similar to the first regression model. The question under investigation was as follows:

Was the Medicaid provision in the PRWORA associated with service utilization of dental, medical and mental services of children between the age cohorts of 8-11 and 12-17 whose mothers identified as black foreign-born as compared to children with mothers identified as native-born black?

The Null Hypothesis and the Alternative hypothesis were:

Null Hypothesis

(H₀): The Medicaid provision in PRWORA is not associated with the receipt of dental, medical and of mental health services among children whose mother identified as black foreign-born and black native-born?

Alternative Hypothesis

(H_i): The Medicaid provision in PRWORA is associated with the receipt of dental, medical and of mental health services among children whose mother's self identified as Black foreign-born and Black native-born?

Regression Model for Medicaid Association

The Cox and Snell R Square for dependent variable insurance type Medicaid were 0.3579 illustrating that 3.6% of the variance has been accounted in this regression model. The Hosmer and Lemeshow Test were significant at 0.0314. Table 26 presents the results for regression model for mental health services.

The model with parental status found no statistically significant differences among the children of black immigrant-mothers compared to children of black native-mothers in having Medicaid. The odds ratio (OR) for Medicaid was (OR) =0.60; 95% confidence interval (CI) =0.35-1.05. The age group of the children in age group 12-17 had no statistically significant differences compared to the children in age cohort 8-11.

Factors associated with Medicaid were that children residing in the Midwest (OR=0.55; CI=0.33-0.90) were less likely to have Medicaid than children in the Northeast; children living in household 100-133 FPL (OR=0.43; CI=0.28-0.68); 133-150 FPL (OR=0.24; CI=0.14-0.42); 150-185 FPL (OR=0.16; CI=0.1-0.25); 185-200 FPL (OR=0.06; CI=0.04-0.10); 200-300 FPL (OR=0.03; CI=0.02-0.05) and 400 and over FPL

(OR=0.01; CI=0.01-0.02) were less likely to have Medicaid than children with household incomes less than 100% of the FPL. Children with Medicaid were more likely to have medical (OR=1.51; CI=1.07-2.15); and mental services (OR=2.27; CI=1.25-4.11) compared to uninsured children.

The second model in which the parental status variable was removed had a Cox and Snell R Square for dependent variable Medicaid were 0.3565 for illustrating that 3.6% of the variance has been accounted. The Hosmer and Lemeshow Test for the model suggested a good fit of the data. The Hosmer was significant at 0.2108.

Factors associated with Medicaid were similar to the odds ratio, confidence levels and significance levels was all poverty levels that was found by the inclusion of the race variable. Children with Medicaid were more likely to have medical, and mental health services than children who were uninsured reporting (Medical (OR=1.51; CI=1.07-2.15); Mental health (OR=2.30; CI=1.27-4.16).

The third model without regular source of care found no statistically significant differences among the children of black foreign-born mothers compared to children of native-born mothers. The (OR) is 0.60; (CI) of 0.36-1.05.

The Cox and Snell R Square for dependent variable Medicaid without the regular source of care variable were 0.357224 for the third model illustrating that 3.5% of the variance has been accounted. The Hosmer was significant at 0.0120.

Factors associated with Medicaid were similar to results presented in the model with race. Having Medicaid as a type of insurance was associated with household incomes, children's health status reported as being poor and the receipt of medical, and mental health services. Unlike the first and second model, this model revealed that

children with Medicaid were more likely to receive dental services (OR=1.49; CI=1.00-2.21) compared to children who were uninsured.

SUMMARY OF ANALYSIS

This analysis was completed to determine the role of Medicaid in the receipt of health care services post welfare reform among the US population of black children. The Northeast continues to be significant in providing health care coverage to black children living in the US by developed Medicaid Programs. With the removal of the variable regular source of care, Medicaid contributed to the utilization of dental, medical and mental health services

Medicaid, a critical health and social policy program developed in 1965 continues to be a pertinent public health care financing program in addressing the health care needs of the US population of black children. Whether a child was reared by a foreign versus native born mother, residing in household with variations in educational levels, languages spoken, gender of enrolled child and children having a regular source of care or without a source of care; Medicaid emerging forty-six years ago continues to be a significant public policy program for children.

TABLE--26 Logistic Regression Analysis for Medicaid Post PRWORA for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need Factors	Parental Status				Without Parental Status				Source of care			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95%CI	95% CI
Predisposing Factors												
Parental Status												
Black Natives (Ref)	1.00								1.00			
Black Immigrants	0.60	0.07	0.35	1.05					0.60	0.07	0.35	1.05
Children's Age												
8-11 (Ref)	1.00				1.00				1.00			
12-17	1.10	0.49	0.84	1.45	1.12	0.43	0.85	1.46	0.60	0.48	0.35	1.05
Household Education												
Less than HS (Ref)	1.00				1.00							
High School	0.92	0.82	0.47	1.83	0.93	0.83	0.47	1.84	0.92	0.80	0.46	1.82
More than HS	0.57	0.11	0.29	1.14	0.57	0.10	0.29	1.12	0.58	0.11	0.29	1.15
Children's Gender												
Male (Ref)	1.00				1.00				1.00			
Female	0.92	0.50	0.70	1.19	0.92	0.51	0.71	1.19	0.91	0.48	0.70	1.18
Household Language												
English (Ref)	1.00				1.00							
Spanish	2.73	0.16	0.68	11.00	1.87	0.36	0.48	7.23	2.73	0.16	0.68	11.01
Regions												
Northeast (Ref)	1.00				1.00				1.00			
Midwest	0.55	0.02*	0.33	0.90	0.60	0.36	0.37	0.97	0.55	0.02*	0.34	0.9
South	0.85	0.41	0.57	1.26	0.91	0.62	0.61	1.34	0.84	0.39	0.56	1.25
West	0.79	0.54	0.37	1.68	0.85	0.68	0.40	1.81	0.78	0.53	0.37	1.66
Enabling Factors												
Poverty												
Less than 100% (Ref)	1.00				1.00							
100-133	0.43	0.00*	0.28	0.68	0.43	.000*	0.28	0.68	0.42	0.00*	0.27	0.66
133-150	0.24	0.00*	0.14	0.42	0.24	.000*	0.14	0.40	0.24	0.00*	0.14	0.41

TABLE--26 Logistic Regression Analysis for Medicaid Post PRWORA for Children from the National Survey of Children's Health, 2003-2004

Predisposing/Enabling/Need Factors	Parental Status				Without Parental Status				Source of care			
	OR	P	95% CI	95% CI	OR	P	95% CI	95% CI	OR	P	95%CI	95% CI
150-185	0.16	0.00*	0.1	0.25	0.15	.000*	0.10	0.25	0.15	0.00*	0.10	0.25
185-200	0.14	0.00*	0.08	0.25	0.14	.000*	0.08	0.25	0.14	0.00*	0.08	0.24
200-300	0.06	0.00*	0.04	0.10	0.06	.000*	0.04	0.09	0.06	0.00*	0.04	0.10
300-400	0.03	0.00*	0.02	0.05	0.03	.000*	0.02	0.05	0.03	0.00*	0.02	0.05
400% and over	0.01	0.00*	0.01	0.02	0.01	.000*	0.01	0.02	0.01	0.00*	0.01	0.02
Regular source of care												
No source of care (Ref)	1.00											
Yes source of care	1.03	0.86	0.73	1.45	1.05	0.79	0.75	1.47				
Need Factors												
Children's Health Status												
Excellent (Ref)	1.00				1.00							
Very Good	0.94	0.70	0.70	1.27	0.96	0.79	0.71	1.29	0.95	0.72	0.70	1.27
Good	1.14	0.49	0.78	1.66	1.16	0.44	0.80	1.69	1.12	0.55	0.77	1.63
Fair	1.40	0.39	0.65	3.03	1.44	0.36	0.66	3.14	1.46	0.33	0.68	3.15
Poor	4.28	0.05*	1.02	18.05	3.74	0.11	0.75	18.51	4.25	0.05*	1.00	17.98
Dental Services												
No Dental Services	1.00											
Yes Dental Services	1.45	0.07	0.98	2.16	1.45	0.07	0.97	2.16	1.49	0.05*	1.00	2.21
Medical Services												
No Medical Services	1.00											
Yes Medical Services	1.51	0.02*	1.06	2.14	1.51	0.02*	1.07	2.15	1.50	0.02*	1.06	2.13
Mental Health Services												
No Mental Services	1.00											
Yes Mental Services	2.27	0.01*	1.25	4.11	2.30	0.01*	1.27	4.16	2.25	0.01*	1.25	4.07

*Significant at the P<=.05

CI=Confidence Interval

OR=Odd Ratio-- Data Source: CDC/HRSA, NSCH

CHAPTER FIVE

DISCUSSION

**“Access to health care services, particularly for children, is essential to ensure that preventative services are provided as recommended, acute and chronic conditions are diagnosed and treated in a timely manner, and health and development are adequately monitored so that minor health problems do not escalate into serious and costly medical emergencies.” (Hernandez 1999:5; Brown et al. 1999:126)
Institute of Medicine (IOM) Report, *Children of Immigrants***

Each March, the US Census Bureau releases data on the economical, political and social characteristics of the US population. Like previous reports, the year 2010 illustrated the continued diversity throughout the various states. Since the passage of the Immigrant Act of 1965, there has been an increase in the foreign-born population, making America, not only a diverse country, but a country of immigrants. Given the high influx of immigrants, over 22 percent of the children being born in America are children of immigrants (Acevedo-Garcia and Stone 2008). Immigrants and their children contribute substantially to the diversity throughout all fifty states and territories.

Leading academic researchers on the well-being of the children of immigrants have argued that these children are lower users of age appropriate services and do not have a regular source of care compared to native-born children. Research examining health care access and utilization has focused on children born to Asian and Hispanic parents. This investigation differs from previous examinations because the black population of children born to women identifying as Black natives and Black foreigners were the primary focus of this investigation. The stratification of the US black population of children into two distinct categories and four age cohorts lends itself to some startling findings and conclusions. Due to the on-going increase in the black immigrant adult community, it is of significance that we investigate their children’s welfare.

SECTION I---STUDY INTERPRETATIONS

To accomplish the goals and purposes of this study, the following questions were explored: (1) demographic characteristics of blacks, Hispanics, multi-racial and whites children from zero to seventeen whose mothers identified as foreign-born and native-born from the NSCH; (2) differences in socio-demographics, health status, dental, medical and mental health services among children from zero to seventeen from the NCHS among native-born and foreign-born mothers; (3) differences in the receipt of any service, dental, medical and mental health services among children whose mothers self identified as being black foreign-born as compared to children with black native-born mothers; and (4) whether the Medicaid provision in the PRWORA was associated with differential access and service utilization of dental, medical and mental services of children between the ages of 8-11 and 12-17 whose mothers identified as black foreign-born.

The research question to ascertain whether differences exist in the receipt of dental, medical and mental health services found no statistically significant differences in the receipt of dental, medical and any of the services among the US population of black children. Regression models in which the parental status variable remained in the analysis had similar but lower odds ratios and confidence intervals as the regression models developed without parental status and without regular source of care. Models looking at differences in the receipt of mental health services found that the children of black foreign-born mothers are less likely to receive mental health services compared to the children of native-born mothers.

Dental Services Similarities

Although the research hypothesis stated that there will be no differences between the children of native-born and the children of black foreign- mothers in the receipt of dental, mental health and medical services; one must ascertain why similarities were fundamental in receipt of significant medical and dental services among the black population of children. To the investigator's knowledge, this is one of the first comparative studies utilizing the NSCH examining services received by children of native and foreign-born black mothers. To determine the similarities in services received among the US black population of children, a critical argument is the environment and the communities in which black foreigners resides. Gresenz et al. 2009 have found that immigrant Hispanics who live in areas more heavily populated by Spanish immigrants form social networks that enable them to better navigate the US health care system leading to similarities in health care access and utilization.

The argument made by Gresenz et al. can be extrapolated to the black foreign-born community. Individuals from the Caribbean have a tendency to reside in Florida, Massachusetts, New York, and New Jersey. On the other hand, Black Africans typical places of residence are California, Georgia, Maryland, and Texas. In conjunction with the CDC, the EPSDT Program under both Medicaid and SCHIP and professional medical organizations, such as, the American Academy of Pediatrics have developed standards in the care and treatment for America's children from zero to seventeen years. These states aforementioned continues to develop robust outreach programs, reduces Medicaid and SCHIP confusion by simplifying eligibility, instituted presumptive eligibility for

enrollment, and have educational initiatives to ensure the accessibility and the availability of children's health services.

Upon arrival to the US, one can argue that black immigrants reside in similar environments, attend similar schools, and seek analogous venues for the receipt of health care services. It is in these similar environments where Black natives live that they acquire the awareness of local programs. These immigrants from African nations and Caribbean Islands receive education from fellow residents to understand community resources available for their children leading to the development of social networks for the well-being of their children to receive health care services in the US.

Mental Health Services Differences

Policy makers in various academic disciplines continue to debate the need to eliminate racial and ethnic disparities among America's population groups. Racial and ethnic disparities in access to mental health care, like access to medical services pose an equitable challenge (Jackson et al. 2007). Much of the research on mental health services and receipt on immigrant blacks have been completed in the United Kingdom. American researchers looking to recognize the mental health service usage of black immigrants are becoming aware of previous studies and current investigations not only in the UK, but countries, such as Canada and other European countries.

There is a growing awareness about the importance of good mental health for the economic well-being of the nation (Williams 1997). Little is known on the access and utilization of mental health services among the children of black immigrant mothers. This current investigation by the utilization of the NSCH is a substantial new contribution to research on the children of black immigrants. The children of black immigrant mothers

are less likely to receive mental health services compared with children of black native-born. This research highlights grave disparities within America's black children in the receipt of mental health services. Taking this research to another level, one must determine the rationale for this difference.

Investigations on the mental health needs of the black immigrant community have been mixed. Academicians have argued that there is a Black-White paradox in the US. One study has revealed that Blacks are mentally resilient in the face of greater social inequality and exposure to discrimination (Keyes 2009). Miranda et al (2005) have found that among US Blacks with access to health care, Caribbean-born women with low socioeconomic status (SES) had a lower risk of depression compared with US born women. Another study found that blacks of Caribbean ancestry had higher levels of psychological stress compared with US-born Blacks (Williams 2000). Jackson et al (2007) found no notable differences between Caribbean Blacks and African Americans in the utilization of formal mental health services, satisfaction with services and the perceived helpfulness of professionals. Mental health differences tend to emerge due to generational status, arriving at a younger age, and years since immigration. Third generation Caribbean Blacks use of mental health services exceeded those of African Americans and immigrating at a younger age were linked to the utilization of mental health services. It was argued that socialization and access to mental health services are critical in the utilization of these services (Williams 2007).

Research on mental health has focused on the black immigrant adult of Caribbean decent and not specifically the black immigrant of African decent. Research findings on the adult population will be utilized to comprehend the variations in the utilization of

mental health services among America's black population of children. Investigations on children's mental health have focused on the role of poverty and family structure as contributors to the problem. In September 2010, the Census Bureau reported that 41% of the US black population lives in poverty. Poverty increases the likelihood that parents, especially mothers, are depressed, impose harsh discipline, and do not respond emotionally to children's needs (Milkie and Warner 2011). Given the mental health paradox and poverty and the rise in poverty among blacks, what lends itself to reduced access to mental health services and utilization among children of black immigrant mothers?

In all communities, substantial stigma is attached to one's mental illness (Corrigan 2004). The label of mental illness in families is disruptive for the family equilibrium. For parents, a diagnosis of mental illness, means that their children will require special needs programs, might not develop the skills sets to care for themselves in the community, and might not have the resources to provide the interventions required. The literature on labeling theory has argued that people's reaction to mental health symptoms are socially influenced (Thoits 2011:4). Although associated with a high degree of stigma, seeking mental health interventions is influenced by social ties and social networks. Albert et al (1998) has shown that persons who are low in support are more likely to enter mental health services.

The prevalence of mental illness, such as attention deficit disorder, attention deficit disorder with hyperactivity, behavioral problems, mild, moderate, and severe mental retardation, learning disabilities and other childhood mental illness in the black immigrant children community have not been substantially investigated. Given the

paucity of research on mental health and immigrant children, this investigator experienced difficulties drawing similarities or disproving previous studies on this subject. Nonetheless, using research from the adult black immigrant community and information on the general black community, one anticipates that with socialization by black immigrant mothers, when their children are in need of this resource, the fear of stigmatization, self-labeling and community labeling will not deter their children from mental health services. The investment in mental health program improvements by the integration of this service in the primary care setting and in school based health centers may curtail this underutilize service in all of America's children. Furthermore, through investment, the sizeable differences in service utilization across all racial and ethnic groups can be reduced (Cummings and Druss 2011).

PRWORA, Medicaid and the US Black Children

Extensive review of the literature on immigrant children vehemently argues that the passage of the PRWORA on August 22, 1996 and critical amendments have negatively impacted eligibility for immigrants to receive Medicaid (Beck and Schur 2000; Borjas 2003; Kullgren 2003; Kaushal & Kaestner 2004). The implementation of PRWORA created unintended consequences for the children born in America to undocumented mothers, and mothers not residing permanently in America for five years especially children of Hispanic/Latino decent.

This research did not mirror other research on the children of immigrants and their Medicaid accessibility and utilization upon the implementation of PRWORA. Using age cohort 8-11 as a reference group post PRWORA and 12-17 as the comparison group, no differences were noted in having Medicaid among the US black population as

deterrence in the receipt of health care services. Medicaid's role is critical in the receipt of medical and mental health services among the black population of children. With the removal of regular source of care, the significance of Medicaid could not be underscored. The receipt of all outcome variables used in this investigation which were dental, medical and mental health services increased for the black population of children.

SECTION II---STUDY LIMITATIONS

The present study has several limitations warranting comments. First, this study did not look at various barriers to health care services for the US Black population of children. Other studies on the children of immigrants have focused on the barriers resulting in low access and utilization of services. The only barrier that this study investigated was whether Medicaid had any influence on the utilization of critical services under the EPSDT program that was developed in 1967. In selected services, such as, dental, medical and mental, Medicaid was not a barrier for this population of children.

Second, the study looked at only foreign-born mothers and not the foreign-born fathers. This vehicle was selected because literature on the well-being of children of immigrants has argued that mothers ensure that their children are beneficiaries of an array of health care and social services (Winters 2008). The NSCH has a question to determine whether the sample child father was born in the US. Frequency distribution completed illustrated that 3,735 of the children had fathers who were foreign-born.

Cross tabulations revealed that of that number, in the black population of children, only 126 of the children had a foreign-born father. If both mothers and fathers were utilized, the study sample size would be larger making it potentially more generalizable

to the children of black-foreign-born parents. Nonetheless, given the sample size of 651 children born to black foreign-born mothers, the inclusion of black foreign-born fathers might not have any significant influence on the current investigation. Given the sample size of 651, the results of this study is potentially generalizable to the overall population of children born to black foreign-born women.

Third, this study did not investigate the quality of the services that children are receiving in the Medicaid Program. The life cycle model, federal entities and various private organizations have developed age specific quality standards to monitor preventative services required for children from zero to seventeen years. For example, there are a series of immunizations that children must receive by the age of three. In addition, the American Academy of Pediatric Dentistry recommends semi-annual clinical oral examinations beginning at the age of 6-12 months (Kennedy et al. 2011). The study looked at whether the children can access the services, whether services were utilized and not the frequency of the services received. Although viewed as a limitation, not looking at the quality provided to Black children should not deflect from the overall usefulness of this investigation. The re-authorization of the Children's Health Insurance Program by President Obama in March 2009 calls for the development of intense monitoring standards to ensure that every child residing in the US are beneficiaries of effective health services which are quality driven. A future study can examine the quality of services children are receiving post CHIPRA.

Fourth, the investigation was a quantitative study and not a qualitative study. Conducting a multi-method study in which the information in the quantitative section is used to develop a qualitative study could yield to interesting results. Potentially useful is

the development of a focus group with mothers from various African nations and Commonwealth Caribbean countries to hear their opinions on the US health care system and the health care received by their children. With this study, the influence of one's culture and one's language proficiency was not determined. With the inclusion of a qualitative approach, acculturation factors could be examined to determine whether these factors have any impact on health care utilization among children of black immigrants.

Fifth, the survey that was utilized for this investigation does not stratify the foreign-born black population by country of origin, and length of time in the US. The population of blacks residing in America is not a homogeneous group and the black population continues to be 12.8% of the US population. The increase in this group is attributed to the growing numbers of black immigrants. The NSCH purpose is to address the well-being of America's children, but, the lack of stratification of the foreign-born population questions the credibility of the survey to generalize findings to the children of the black immigrant community. Although language is sometimes utilized as a proxy, the black immigrant community tends to migrate from English speaking countries. By the incorporation of additional questions to the NSCH, studies could emerge addressing the needs of this sub-population of black children by parental nativity. By examining the mothers' length of time, one can determine whether the healthy immigrant paradox that is found among other immigrant groups reflective among children of black immigrants.

Finally, the survey instrument utilizes self-reported information of the person responding to the survey to gage the well-being of children. Self-reports are viewed as a limitation to this cross-sectional survey because respondents might not understand survey questions. Lack of question comprehension can lead to parents acquiescing to provide

answers that they believe that interviewers anticipate. Self report is a limitation, but, surveys are commonly developed by engaging the self reports of respondents. The NSCH developed and designed by the DHHS is commonly used by academic researchers and is a valid and reliable instrument investigating the well-being of America's children.

SECTION III---STUDY STRENGTHS

In the previous decade, there have been numerous studies examining the state of children residing in the US. Research has documented the grave disparities within both the adult (Singh, 2008) and children (Ku, 2009) of minority population groups. With the growing rise of the immigrant population that began with the 1990 Census, a new focus of research began. Researchers began to investigate health care access, health care utilization, educational performances, child welfare services and other investigations focusing on the immigrant community. As compelling as previous research, there exists a vast paucity of specific research on the health and well-being of children born to black foreign-born mothers.

The strengths of this investigation are the following: First, this study highlights the need to collect data by race and ethnicity by stratifying population groups into sub-groups. For years, America has been categorized as a melting pot; a country of diversity. After the 1990 Census, to determine variations in America's diverse communities, a decision was made by the DHHS, Office of Management and Budget to collect data based on race and ethnicity. Among the Asian and Latino groups, data is collected stratifying the country of origination in most survey instruments developed by the federal government. For the black population, data collection continues to be limited. The need to collect data specific to the sub-population of the black population is critical. This study

has provided fundamental evidence that health care utilization do differ. Only by understanding differences among the US diverse population can services be tailored for positive outcomes thereby enriching the US as a whole.

Second, a significant rationale for completing this study was not only to look at ascertaining differences among the children of black natives and the children of black immigrants but to determine whether the Medicaid provision in the Welfare Reform Act of 1996 resulted in variation of access and utilization of dental, medical and mental health services. With the development of regression models, this investigation demonstrated that Medicaid continues to be critical as a measure for health care access and utilization. In 1997, SCHIP emerged as a landmark legislation to address the needs of children whose parents earn too much to be eligible for Medicaid. Within this legislation, states were encouraged and permitted to develop outreach activities to educate parents on the importance of SCHIP in the delivery of effective health care services. With the re-authorization of the SCHIP in March 2009, advocates for the well-being of children were instrumental to maintain mandates from the original SCHIP by securing funds for ongoing outreach and education. In 2010, 10.2 percent of black children were uninsured, given that both Medicaid and CHIPRA are critical child health financing policies, public servants should have strategies in place to locate and educate individuals caring for these children and enroll them into one of these landmark health care financing programs.

Third, the study underscores the importance of having a regular source of care in contributing to the utilization of health care services. The American Association of Pediatrics (AAP) developed the first definition for medical home in 1965 (American Association of Pediatrics 2002). AAP has defined a medical home as having a regular

place to receive an array of primary pediatric medical services that is accessible, continuous, comprehensive, family centered coordinated compassionate and culturally effective. To address the growing trends of being uninsured, the Public Law Number 111-148 known as the Patient Protection and Affordable Care Act of 2010 has placed an emphasis on the development of medical homes. Taking ideas from the AAP, it has been argued that medical homes will lead to each individual having a regular source to receive needed health services thereby leading to care coordination, greater quality and the potential reduction in health care cost. Using the 2007-2008 NSCH, large racial and ethnic disparities were reported among the US population of children in medical home attainment. Non-Hispanic white children had the highest attainment rate and Hispanic children had the lowest. Non-Hispanic black children fared only modestly better than Hispanic children (Strickland et al. 2011). This new investigation is yet another research highlighting the importance of medical homes in contributing to the receipt of health access and health utilization of standard health care services for children.

Finally, although the study instrument does not stratify the black foreign-born by variations in countries of origins, the researcher believes that the findings of this investigation are generalizable to both the US population of children being reared by black immigrant and native mothers. Time and time again, research has shown that the US population of black children is insured. In addition, research continues to show variation in care coordination among the US black population of children and the low utilization of mental health services. Given what is known in the literature on service utilization, this investigation is another study providing additional evidence on the growing disparities in the receipt of services for minority children.

SECTION IV--PUBLIC ADMINISTRATION SIGNIFICANCE

It has been argued that implementation is where the rubber hits the road (Pressman & Wildavsky 1984). Each year, the US Congress, states and local governments authorizes and appropriates funds to implement various programs to benefit America's constituents. Public servants working in various governmental agencies are responsible to implement those programs materializing from government officials. In their classic book, *Implementation*, Paul A. Sabatier and Daniel A. Mazmanian (1981) developed an implementation framework. The authors defined implementation as:

The process for the carrying out of a basic policy decision, usually incorporated in a statute but which can also take the form of important executive orders or court decisions. That decision identifies the problem(s) to be addressed, stipulates the objective(s) to be pursued, and in a variety of ways, structures the implementation process.....pgs 20-21

The authors argued that the crucial role of implementation analysis is the identification of variables affecting the achievement of the objectives of the program authorized. As public servants, it is critical that we comprehend both the positive and negative impacts on mandated polices. To identify those impacts, one must listen to workers on the frontline who daily interacts with the policy target population. *In Street-Level Bureaucracy*, Michael Lipsky argues that public service workers occupy a critical position in the US society. These individuals may not be the person who conceptualized the policy and advocated for the policy for its authorization, but this person is required by their agency to implement the requirements. Fundamentally, it is these individuals who are in positions to determine both the negative and positive outcomes of policies to be implemented on constituents. These workers who interact directly with citizens in the

course of employment potentially having substantial discretion in the executive of policies are called street-level bureaucrats (Lipsky, 1980).

Researchers have argued that the PRWORA have contributed to a significant public health crisis in the immigrant community. Contributing factors stems from cultural barriers, fear of deportation, eligibility confusion, federal, state and local policies, language, parental isolation, parental inabilities to navigate the health care system, stigma, the undocumented status of some parents, and widespread poverty. Historically, PRWORA has been implemented for fifteen years and states have comprehended some of the rationale for some of the unintended consequences implementing this federal policy and have corrected some hurdles impacting the children of immigrant' access to age appropriate medical and social service interventions (Zambrana and Carter-Pokras 2004). One can postulate that the awareness of the unintended consequences of PRWORA can be traced back to street-level bureaucrats working in the field and having the humanist desire to implement programs grounded in social justice principles. Also, it can be asserted that street-level bureaucrats with their identification of PRWORA became connected with various advocacy groups leading to the changes in the 2009 reauthorization of CHIPRA.

This new investigation is critical to public administrators because it highlights (1) disparities within the black sub-population of children in the receipt of mental health services; (2) the importance of having a regular source of care; (3) the need to collect specific data on the black sub-population group at the federal, state, and local levels; (4) the significance of Medicaid at influencing health care access and service utilization; (5) the need to ascertain care takers behavioral patterns leading to health care utilization

among black children; (6) the need to develop structural interventions in communities to encourage age appropriate services; and (7) the critical role that a culturally sensitive workforce can ignite in surmounting health care differences among our nation's children.

Grouping together the black population misses important variation within this population (Reed, Emerson and Tarlov 2005). The recent release of the DHHS's Action Plan to Reduce Racial and Ethnic Health Disparities recommends that major payors, such as Medicaid, Medicare, and private insurance plans contracting with the federal, state, local, counties and the business community begin to collect data on health and other related services not only by race but country of origin. By working with non-traditional partners to address health care inequities and by continued advocacy for data stratification, public administrators who are committed to social justice can acquire new knowledge to enhance the health and wellbeing of America's children.

SECTION V---FUTURE STUDIES

According to data from the Migration Policy Center, most of the 1.3 million children in black immigrant families in America have parents from Africa and the Caribbean. Black immigrants have been called the invisible immigrants. This terminology has been given because limited research is published on the well-being of this sub-population of blacks living in America. As the following state mapping demonstrates the black immigrant population group is growing. Therefore, research scholars must begin to focus on the growing needs of this sub-population within the US black community. Current research addressing disparities in health, educational attainment, employment performances, and the justice system continues to relate research findings to the overall black population and not by specific stratification of blacks.

Lately, there has been resurgence in educational research on the school performances of the children of black immigrants (Thomas 2009).

The Migration Policy Center views investigating the children of black immigrants along various indicators, such as, education, environment, and health as fundamental to the eradication of societal disparities and has commissioned investigations.

Figure 6---US States and Black Immigrants



Source: The Migration Policy Center, Black Immigrant State Profile

Given the overall findings of this investigation, future investigations should address the following: (1) Community level research to determine low levels of mental health service utilization by children of black immigrant mothers; (2) Implementing CHIPRA mandates on mental health parity to determine the impact of this legislative requirements; and (3) Developing investigations on developed health care performance standards for children between 0-17 stratified by sub-population and age groups.

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law No. 111-148) became law. With its passage, there is an emphasis on

medical homes, expanding school based community health centers, expanding community health centers in marginalized communities, emphasizing prevention services from birth through the elderly, developing special outreach initiatives to educate Americans on various aspects of health and increasing America's workforce to ensure the health and well-being of Americans. Given the foundation of the ACA, the utilization of age specific services for children could potentially increase; thereby, increasing health care efficiency, quality of services render, the reduction in health care expenditures and developing partnerships with non-traditional health partners to address health care inequities.

SECTION VI---PUBLIC POLICY IMPLICATIONS

The PRWORA of 1996 and subsequent research provided substantial evidence for the on-going debate for children reared by Asian and Hispanics (Capps and Fortuny 2006; Flores and Tomany-Korman 2008). Using the NSCH, the completion of descriptive, bivariate and multivariate analysis revealed that the children of black natives and black immigrants do have access to health care in America. This study contributes to the growing body of research on health care access, health care utilization, health care disparities, and the substantial need for the Medicaid Program. Most importantly, it calls attention for public administrators to understand why similarities exist for oral health and medical care services. These similarities must be understood due to the continued high prevalence of morbidity and mortality among the black children population. Academic scholars must comprehend the on-going increased because the public and private access of health coverage among the US Black children is high. Like the children of

Hispanic/Latino decent who tend to be the most uninsured, the children of black immigrants are insured.

It has been centuries since published reports in the US sounded the alarm that inequities exist and its continued negative impact on the black population. Communities must move beyond the providers of health care services to address the on-going disparities debate of negative health care outcomes. Looking at health delivery through socio-ecological lenses, public administrators working with federal, state and local officials could advocate for the development of unique programs for all children with an emphasis on not only reducing health care disparities, but its eradication. The socio-ecological framework encourages public servants to understand the culture of consumers and its negative and positive impacts on health seeking behaviors. In addressing problems in black communities, one can argue that the momentum to address substandard results must come from and within the black community, but, poverty which is a precursor for various societal inequities must be addressed by all concern Americans.

SECTION VII---CONCLUSION

In 1965, President Lyndon Johnson's Administration conceptualized and created a massive array of public policy programs for America's vulnerable population groups. A critical public policy program emerging from the Johnson's Administration was the Medicaid Program. Today, Medicaid is the public health insurance program for low-income individuals in specific eligibility categories. Using Medicaid as a channel to increase coverage, President William Clinton's Administration created the Children's Health Insurance Program in 1997. In an attempt to address the mounting growth in the number of Americans lacking health care, President Barack Obama's Administration

authorized the Patient Protection Affordable Care Act (ACA) of 2010. Like many other administration, the Obama Administration in developing the ACA will expand Medicaid coverage to Americans. Not only have various Presidential administrations perceived Medicaid as an instrument for coverage; state governors in the development of Medicaid 1115 Demonstration Waivers have looked to the Medicaid Program as a mechanism to increase access to essential services covered by Medicaid.

Opponents of the Medicaid Program have articulated that this federal and state partnership program is costly to the American people and have proposed various cost cutting measures. One such cost reduction approach is the PRWORA that changed not only the developed public assistance programs in all fifty states, but, developed a provision that limited Medicaid to legal permanent immigrants. This Medicaid limitation was placed in the SCHIP in 1997 and continues to be embedded in the ACA. The SCHIP reauthorization provides states with the flexibility to utilize Medicaid related SCHIP Programs to serve adults and children without the five year permanent status.

In this study, unlike prior research on PRWORA, Medicaid was not a barrier to age appropriate services as defined by the American Academy of Pediatrics and the CMS developed EPSDT service Medicaid mandates for the children of black immigrants. Heart disease, cancer, trauma, pulmonary conditions, and mental disorders are five of the most expensive health care conditions (National Institute for Health Care Management 2011). By finding that the children of immigrants are less likely to be beneficiaries of mental health service, the black immigrant community should receive on-going education to recognize early forms of mental illness among their children. By education, recognition, and treatment, the growing number of black children will live healthy and

productive lives thereby avoiding costly expenditures and contributing positively to the US society.

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