

Hispanics, Health Insurance, and the Pact between the Generations

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Introduction

Historians often view the decades of the 1950s and 1960s as a period of widespread economic prosperity and optimism for most Americans. But the prosperity was not equally shared by all. During this period, poverty, racism, and economic inequality coexisted with abundance and prosperity as the result of the widening gap between the “haves” and the “have-nots.” In addition to “declaring an unconditional war on poverty” in the Economic Opportunity Act (EOA) of 1964, President Lyndon Johnson outlawed discrimination based on race after passage of the landmark Civil Rights Act of 1964 (Dallek, 2004). When Johnson proposed the latter legislation together with a set of anti-poverty programs, he intended to end racial inequalities in public accommodations, in schools, and at work. In his eyes this meant protecting the freedoms of all Americans and fighting for a commitment to equal opportunity. Advocacy organizations such as the National Association for the Advancement of Colored People (NAACP) helped in defining his agenda and making the moment “right” for this new policy idea. Yet, it was Johnson’s innate ability to work across party lines in Congress that allowed him to achieve such remarkable success with his social policy initiatives (Dallek, 2004). Less than a year later, he persuaded Congress to pass the only civil rights legislation that ensured the natural voting rights long denied to African Americans (Goodwin, 1991).

Although the “War on Poverty” slowed during the early 1970s—many programs were abandoned, and President Gerald Ford dismantled the Office of Economic Opportunity (OEO) in 1975—it was not without long-lasting results. The declaration by President Johnson raised the nation’s awareness of fundamental social problems and empowered future generations of leaders (Zarefsky, 1986). Most significantly, the Great Society programs, which were enacted separately from the EOA, continue to be the most politically viable policies, as they are supported by the middle class (Bernstein and Stevens, 1999). In his most enduring set of domestic programs, in which Congress amended the Social Security Act to create Medicare and Medicaid, President Johnson greatly expanded health care entitlements (Jordan and Rostow, 1986). The birth of Medicare, which provided hospital coverage and a provision to cover physician services for the elderly, was the cornerstone on which to build an “inclusive universal program” of health care (Jordan and Rostow, 1986). This included Medicaid, a health care safety net, which provided assistance for acute and long-term care to many of the nation’s poor (Institute of Medicine, 2001). The overall goals of the health insurance programs were admirable. They were designed to protect the elderly and disabled from falling into poverty, through work-based payroll contributions (Medicare), and to provide tax-funded

health insurance for less fortunate people (Medicaid). In the absence of the Great Society programs, the health of an entire nation could have been put at risk. As Wilbur Cohen, the Secretary of Health, Education and Welfare discussed at a dinner on January 13, 1969, in just five brief years President Johnson had more legislative achievements that so profoundly affected people's health and their access to health care and other social services than any other United States president. Never before in our history did a president act on behalf of older Americans with programs to enrich their lives, such as Medicare, the Social Security Act of 1965, 1966, and 1967, the Older Americans Act, and community service projects. The Medicare program gave elderly citizens the dignity and respect they deserved, and also the health security for generations to come.

As we celebrate President Johnson's 100th birthday this year, we can take great pride in knowing that the Great Society's innovative social and economic initiatives both protected and improved the welfare of millions of Americans from all walks of life. At the same time, we must recognize that these insurance programs and safety nets were not originally intended to address the wider and more controversial issue of universal access to health insurance coverage (Johnson, 1998). As health care costs rise, the lack of universal access to health insurance coverage and long-term care increasingly affects the country's most vulnerable—the chronically ill, the near poor, the unemployed, and the mentally and physically disabled (Institute of Medicine, 2001). Beyond this issue is the indisputable fact that the nation as a whole is growing more racially and ethnically diverse (Angel and Angel, 2006). This demographic fact raises many critical policy issues, some of which provide the primary focus of this paper for the LBJ Centennial Celebration.

Undeniably, the growing diversity of the U.S. population constitutes a social force that presents new opportunities as well as challenges in ensuring access to health care for all Americans. Within the next decade, the working-age population that will support the retiring baby boom generation will increasingly become African-American and Hispanic. Of particular concern is the exponential growth in the Hispanic population and the implications of this growth for the health and well-being of more than 36 million people. Today's Hispanics will be tomorrow's majority in many states, and they will make up a large share of the U.S. labor force that supports tomorrow's retirees. If these groups are confined to the low-paying service sector, which in addition to low wages offers poor access to health insurance, yet another disparity based on race and ethnicity will be introduced into our structures of social inequality. The fact that the productive potential of a large segment of the future labor force might be undermined by poor health and low educational levels has profound implications for older, as well as younger, Americans. Everyone's welfare, therefore, depends upon the productivity of minority groups.

In this study we explore how labor force vulnerabilities affect the overall well-being of Hispanics, with a specific focus on health insurance for people of Mexican descent in the United States. Surprisingly, very little research has probed deeply into the ways in which work-related policy mechanisms might explain such vulnerability, even though an abundance of studies document Hispanics' dismal access to health insurance. The neglect in research along these lines is puzzling because it is well known that the

employment-based health insurance system of the United States means that those individuals who are disadvantaged in the labor market are also disadvantaged in terms of health insurance coverage. Hispanics, especially those of Mexican-origin, have historically been disadvantaged in both domains.

Despite a century of impressive innovations in medical science and clear improvements in public health, poverty continues to undermine the physical and emotional health of a large number of Hispanics (Institute of Medicine, 2001). Members of low-income families have inadequate health care coverage, and poverty undermines the health and well-being of entire Hispanic communities (Institute of Medicine, 2002b). Johnson was particularly sympathetic to the plight of Mexican Americans during his presidency (Gonzales, 1999), in part because he had previously taught at a predominantly “Mexican” school in Cotulla, Texas. He also designated September 15th as National Hispanic Heritage Week in 1968 in recognition of the contributions of Hispanics, and in 1988, Congress extended the observance to a full month. Notwithstanding the ideals of the Great Society and Johnson’s strong efforts on behalf of the welfare of Hispanics and the poor, serious racial-based disparities in health care persist today. Before the enactment of Medicare and Medicaid legislation in 1966, 47 million Americans were uninsured. By the mid-1970s, the number of people without coverage had dropped by more than one half to 21 million (Woolhandler and Himmelstein, 2007). However, approximately 46 million Americans (15.3 percent of the population) went without any health insurance in 2007, and many others have only episodic or inadequate coverage (U.S. Census Bureau, 2008). The failure of the U.S. health care system to cover everyone has serious implications for the most vulnerable, including minority Americans, the poor, and children.

Although the lack of health insurance among the poor represents a clear inequity in the system, that inequity is exacerbated by differential racial and ethnic vulnerabilities. What stands out starkly and consistently in the large body of health care services research that has appeared in the last two decades is the extreme vulnerability of the Mexican-origin population. At all ages, individuals of Mexican-origin have higher rates of inadequate or no health insurance coverage than other groups, including African Americans and other minority group members (Amey, Seccombe, and Duncan, 1995; Angel, Angel, and Lein, 2008; Valdez et al., 1993; Santos and Seitz, 2000). Many explanations for these low rates of coverage have been offered, including employment in jobs that do not offer coverage, the high cost of family coverage, bureaucratic barriers to accessing public coverage, language difficulties, and more (Doty, 2003). The most immediate source of the vulnerability of the Mexican-origin population relates to this population’s position in the labor force (Perry and Kannel, 2000).

The most basic question we must ask, then, is whether health insurance disadvantages among minority Americans, and particularly among those of Mexican-origin, are the direct and almost complete result of their type of employment and its correlates, which include poverty, cultural and environmental factors, and behavioral influences. Toward that end, we examine the place of minorities in the labor market, paying particular attention to the consequences of the employment-based benefits system. We begin with a

general discussion of the social welfare safety net in the United States and how race and ethnicity have determined the place of specific groups in the system of social and economic stratification. The analyses focus on the situations of working-age men and women to arrive at an understanding of the causes of the low rates of health insurance coverage among Mexican-origin families. The paper concludes with a discussion of the politics of reform and policy options for addressing these problems and for overcoming the major barriers to adequate health care coverage for Mexican-origin families and other poor Americans.

Employment-Related Determinants of Low Levels of Coverage among Hispanic Workers

In the United States, work is the key to economic success as well as the major source of health care coverage and retirement security. While Europeans look to the state for the basics of a dignified life, Americans for the most part do not. In the United States, adequate retirement income and health insurance coverage depend on one's place in the labor market. Although retired workers receive Social Security and Medicare, a private retirement plan and supplementary Medigap health insurance are necessary to ensure a healthy and financially secure old age. This system of employment-based benefits, which reflects basic American values related to self-sufficiency, means that those individuals who are disadvantaged in the labor market are also disadvantaged in terms of retirement security and health insurance coverage. One's place in the labor force clearly reflects individual factors such as ambition and initiative, but it also reflects historical and structural factors that determine the opportunities available. Given the well-documented fact that race and Hispanic ethnicity have historically determined the opportunity structures that specific subgroups encounter, the playing field is not yet level.

But perhaps the most immediate source of the vulnerability of the Mexican-origin population relates to its position in the labor force. Minority Americans, particularly the Mexican-origin population, are more likely than majority Americans to be employed in occupations that do not offer health care coverage (Hall, Collins, and Glied, 1999; Angel and Angel, 2007). The overrepresentation of African Americans and Hispanics in low-wage service-sector jobs has serious implications for the social and economic capital of these groups as a whole and for the opportunities of future generations to achieve social and economic mobility. Although minimum-wage work may prevent a person and his or her dependents from starving, for millions of Americans work does not provide the benefits (or the income to purchase them) that have come to define minimal citizenship rights in most of the developed world.

The health care coverage disadvantage among employed Hispanics is clear when one compares overall rates of coverage even without disaggregating the Hispanic population into its constituent groups. In 1999 only 69 percent of full-time Hispanic workers were offered employer-sponsored health care coverage, compared to almost 87 percent of full-time non-Hispanic white workers (Schur and Feldman, 2001). Part of this difference can be explained by the fact that Hispanics are more likely than non-Hispanic whites to be employed in agriculture, construction, forestry, fishing, and retail trade industrial sectors

in which health benefits are less likely to be offered (U.S. Census Bureau, 2000). In order to gain some insight into this Hispanic vulnerability, we begin with a general overview of the characteristics of firms and employees that influence the likelihood that a worker will be covered and relate these to the characteristics of the Mexican-origin population. We also document the general decline in employer-based coverage that has occurred during the last two decades and speculate on its potential impact on coverage for groups, including Hispanics, for whom coverage is already incomplete.

When offered coverage, the majority of full-time employees participate. In 2005, 72 percent of full-time private- and public-sector workers participated in employer-sponsored health plans, compared to only 13 percent of part-time, part-year workers (U.S. Government Accountability Office, 2007). The majority of uninsured workers are either not eligible or decline coverage because of cost (Fronstin, 2005).

In addition to industry, firm size stands out as a major predictor of the availability of group coverage. In general, smaller firms are less likely to offer coverage than are larger firms. In 2006 only 48 percent of firms with three to nine employees offered coverage, whereas 73 percent of firms with 10 to 24 employees, 87 percent of firms with 25 to 49 employees, and over 90 percent of firms with 50 or more workers offered coverage (Kaiser Family Foundation, 2006). As is the case for other groups, uninsured Hispanics are more likely than insured Hispanics to be employed in small firms (Monheit and Vistnes, 2000).

Yet firm size does not appear to account for the difference in coverage between Hispanics and other groups. One study found that in 1997 only 38 percent of Hispanics in firms with fewer than 100 employees had health insurance, compared to 47 percent of African Americans and 63 percent of non-Hispanic whites (Hall et al., 1999). Hispanics employed in very small businesses (20 or fewer employees) have far less access to coverage (55 percent) than do those who work for firms with 500 or more employees (92 percent) (Santos and Seitz, 2000). Data from the 2006 Employer Health Benefits Annual Survey show that health care coverage is also affected by other firm and worker characteristics. Non-unionized firms are less likely to offer coverage than are unionized firms, and low-wage and part-time workers are less likely to be offered coverage than are salaried or full-time workers (Kaiser Family Foundation, 2006). According to Monheit and Vistnes (2000), decreases in labor union membership resulted in a drop in coverage among Hispanic men between 1987 and 1996 (from 24.1 percent to 12.8 percent, respectively).

In addition to working in smaller firms, Hispanics are concentrated in occupational sectors in which coverage is less likely to be offered by employers. In 2000 only 16 percent of Hispanics were employed in professional occupations, compared to 34 percent of non-Hispanic white and 42 percent of Asian workers (Kochhar, 2005). From 1990 to 2000, the proportion of Hispanic men in executive, management, and professional occupations declined by close to 2 percent (1.8 percent), whereas non-Hispanic white men enjoyed a 2.3 percent increase (Kochhar, 2005). Hispanics are overrepresented in production, construction, and farming, occupations in which health care coverage is less

common (Hall et al., 1999; Monheit and Vistnes, 2000). In addition, although Hispanics made up only 12 percent of the labor force in 2000, they represented 40 percent of agricultural workers (Kochhar, 2005).

For working adults without employment-based coverage, few options exist. If a person is employed in a job that does not provide a group plan, he or she is unlikely to be earning enough to pay for an individual or family plan in the private insurance market. Even if a group plan is offered, the cost of family or even individual coverage can be prohibitive for many low-wage workers. The result is that in the absence of the universal, publicly funded system of health care that is typical of other developed nations, health care vulnerability falls heaviest on the poor and minorities in the United States.

The employment-based system of health care coverage thrived after World War II largely because it addressed the needs of the most politically and economically powerful segments of the economy. Most of the middle class was covered by tax-subsidized employer-sponsored plans, and two of the potential political weak spots in the system were addressed by Medicaid and Medicare, which provided universal coverage to those over 65 years old and health care access for the disabled and poor children. Those who remained outside of the safety net, largely working-age adults with low earning capacities (who were disproportionately minority), possessed little political clout and had few powerful advocates. As a result, rather than providing the universal health care coverage that is typical of other developed nations, the United States tolerates a huge population of uninsured who must rely on charitable care and emergency rooms, or who simply go without needed care—particularly preventive care. Although the existence of a huge uninsured population will probably never serve as motivation for basic health care system reform, other trends that are affecting the middle class may. In recent years the growth in health care costs has meant that an increasing proportion of employers are dropping their group plans, and they are shifting a greater portion of the cost to employees. As the economic burden of insurance coverage and unmet medical expenditures grows, the middle class may demand reform.

Many other explanations for minorities' low rates of coverage have been offered, including the high cost of family coverage, bureaucratic barriers to accessing public coverage, language difficulties, and more (Mechanic, Rogut, Colby, and Knickman, 2005; Quadagno, 2005). Factors such as immigration history, citizenship status, and language proficiency interact with structural factors to further block opportunities for upward mobility. As among the rest of the Mexican-origin population, low levels of education have been well documented among Mexican-origin women. The average educational attainment for Mexican-origin women is just 9.2 years among foreign-born and 11.1 years among native-born women, compared with 12.9 years for African-American and 13.7 years for non-Hispanic white women (Everett, Rogers, Krueger et al., 2007). Foreign-born Mexican-origin women experience multiple education-related disadvantages. Not only do they have the lowest educational attainment among all major ethnic groups, but their returns to education are attenuated because U.S. employers tend to place less value on education obtained abroad (Duncan, Hotz, and Trejo, 2005). Multiple barriers, including low levels of education, minimal English proficiency, and a

lack of legal documentation, severely constrain the employment opportunities of these foreign-born women.

Disparities in earnings are primarily accounted for by low educational attainment and low employment status, combined with a lack of English language proficiency—factors that also decrease access to health insurance coverage (Duncan, Hotz, and Trejo, 2005). Earnings among employed non-Hispanic white women are marginally higher than among African-American women and considerably higher than among Mexican-origin women. The annual earnings of African-American women are 95 percent of the earnings of non-Hispanic white women which is in contrast to 60 percent for Mexican-origin women (Duncan, Hotz, and Trejo, 2005). The proportion is 0.84 for native-born and 0.37 for foreign-born women as a percent of non-Hispanic white women.

Data and Methods

In this study, we employ the Annual Social and Economic (ASEC) March Supplement to the 2004-06 Current Population Survey (CPS) to focus on access to health insurance for adults ages 18 to 64. Every March, the sample and the survey are expanded as part of the ASEC to capture an oversample of special populations, including Hispanic persons. Having multiple waves of data provides a total sample of 421,803 respondents that represents all American households. Pooling effectively doubles the sample size of Mexican-origin, African-American, and non-Hispanic white individuals and reduces the standard error of each estimate of insurance coverage. The CPS is one of the best sources of data with which to estimate health insurance coverage and associated factors. The survey includes a variety of information concerning health coverage of each household member for the previous calendar year plus an individual's, age, education, marital status, work experience, family structure, income, and migration history.

Again, we focus on both men and women but treat them separately in the analyses because of important differences between the main predictor variables of interest. Although employment is the primary method of obtaining coverage for men, marital status is also a key indicator of coverage for women. The final sample for this study included 80,827 male and 81,822 female individuals.

Measurement

In the CPS, a series of question are used to ascertain access to health insurance. We create a dichotomous measure based on whether the individual has health insurance coverage through his or her current or former employer or union. This measure meets our objective of assessing a person's likelihood of coverage as a direct result of being employed within certain job sectors and occupations. In essence, our measure of coverage for men assesses whether a man is offered an employer plan *and* whether it is better than the alternatives, which may include another plan or no plan at all. For women, our dependent variable has three categories indicating whether a woman had (1) private health insurance, (2) public health insurance only, or (3) no health insurance of any kind during the previous calendar year. Private insurance includes employment-based, privately purchased, and military health insurance such as TRICARE/CHAMPUS

and CHAMPVA. Public insurance includes Medicaid, Medicare, and other state programs for low-income adults. We do not distinguish between policyholder and dependent statuses among the privately insured. Because the focus of our analysis is how the combination of roles corresponds with coverage, we select one aggregate measure that captures any source of private insurance gained from the accumulation of those roles.

Job sector consists of four categories created from the 14 job sector descriptions in the CPS. These categories are professional (e.g., financial, scientific, information, educational, health), service (e.g., wholesale and retail trade, entertainment, food services), construction (e.g., construction, forestry, fishing, mining), and manufacturing. *Occupation* consists of four categories created from the 11 categories in the CPS. These are professional and managerial, service and sales, maintenance and production, and construction and farming occupations.

Information about race and ethnicity are self-reported in the ASEC. Prior to self-reporting race, individuals are asked whether they are Spanish, Hispanic, or Latino. Those who respond affirmatively are shown a flash card listing five origins (Mexican, Puerto Rican, Cuban, Central/South American, and Other Spanish) and asked to select one. We identify women as being of Mexican origin if they selected a Mexican origin, regardless of race or nativity. Thus, an individual's *race/ethnicity* consists of one of three categories: non-Hispanic white, African American, and Mexican American. *Education* indicates the highest level of schooling attained and consists of four categories: less than high school, high school, some college or associate's degree, and bachelor's degree or higher. *Marital status* consists of never married, married, and either divorced, separated, or widowed. *Age* in years is included as a continuous measure. *Family size* is a continuous measure that includes the individual, his or her spouse if married, and all the individual's never-married children younger than 18 years.

Using logistic regression, we estimate odds ratios to indicate the impact of several occupations and sectors on the odds of having employer or union health insurance coverage for men stratified by race/ethnicity. Because a woman's access to health insurance coverage is determined not only by her employment but also by her marital status, we include controls for the interactive effects of marital and work roles. To do this, we create a typology of all combinations of the three races/ethnicities, three work statuses, and three marital statuses. We analyze these categories using 27 dummy variables (omitted reference is non-Hispanic white, full-time employed, and married women). In this model, then, we include both family and work predictors to determine how these factors in conjunction with the control variables affect access to insurance coverage for women. The data are weighted to adjust for the sampling design.

Results

We begin the analysis with a description of the sample characteristics. Table 1 reveals that Mexican-origin men are far less likely than either non-Hispanic white or African-American men to have insurance, regardless of their employment status. Non-Hispanic white males who are employed full-time have the highest rates of coverage, and although

full-time employed African-American men have lower rates than non-Hispanic white men they are far more likely to have coverage than are full-time employed Mexican-origin males, nearly half of whom are not covered. Both Mexican-origin men and African-American men are less likely than non-Hispanic white men to be self-employed. In terms of sectors, Mexican-origin males are far less likely than either non-Hispanic white or African-American males to be employed in the professional sector, and they are far more likely to be employed in construction or agriculture. Within specific occupational groupings, Mexican-origin males are concentrated in construction and extraction, production, transportation and materials moving, food service, and building and grounds cleaning jobs. These statistics clearly show that Mexican-origin men are less likely than employed men from the other two groups to be professionals, to work for government, or to be self-employed.

In terms of other risk factors of being uninsured, Table 1 shows that Mexican-origin men are younger than the other two groups and are far more likely to have very low levels of education. They are far more likely to be foreign born, and fewer than half are U.S. citizens. The final row indicates that they are far more likely than either employed non-Hispanic white or African-American males to live in households with incomes below the poverty level. This demographic profile, in conjunction with the occupational profile, underscores the clear labor force and health insurance vulnerabilities specific to the Mexican-origin working population.

Table 1. Demographic Characteristics of Employed Men 18–64 Years Old by Race / Mexican-American Ethnicity^a

Characteristic	Non-Hispanic White	Mexican American	African American
Employment-Based Coverage			
Employed part-time	70.5	41.9	57.2
Employed full-time ^b	87.2	52.6	79.5
Age (mean years)	41.7	35.4	39.6
Education (%)			
Less than high school	6.1	45.5	10.4
High school diploma	31.4	30.6	40.2
Some college or associate's degree	27.6	16.5	28.7
Bachelor's degree or higher	34.9	7.3	20.7
Marital Status (%)			
Married	65.7	59.5	47.9
Divorced, separated, widowed	11.7	7.8	14.9
Never married	22.5	32.7	37.2
Family Size (mean)	2.4	2.7	2.1
Foreign-Born (%)	4.4	63.2	12.5
U.S. Citizen (%)	97.8	48.1	93.5
Occupation/Industry			
Professional	18.5	5.2	13.8
Service	9.1	20.3	20.0
Sales	11.9	6.6	7.2
Office and administrative support	5.4	5.3	9.3
Farming, fishing, and forestry	0.6	3.4	0.5

Characteristic	Non-Hispanic White	Mexican American	African American
Construction and extraction	10.7	23.6	7.6
Installation, maintenance, and repair	7.3	6.0	5.1
Production	8.5	12.9	10.9
Transportation and material moving	8.6	11.3	16.7
Living in Families below Poverty Threshold (%)	2.7	12.1	5.4
Total Sample (N)	(63,834)	(9,729)	(7,264)

Source: 2004 and 2006 Annual Social and Economic Supplements, Current Population Survey.

^a Percentages are weighted. Unweighted Ns are in parentheses.

^b Full-time is defined as 35 or more hours per week.

Table 2 presents similar information on access to coverage for risk factors accounting for women's lack of coverage, notably race/ethnicity, immigration, employment, and marital status. The table confirms that Mexican-origin women are less likely than women of other racial/ethnic groups to have private health insurance. Approximately 81 percent of non-Hispanic white women reported private insurance, compared to 65 percent of African-American women, 63 percent of native-born Mexican-origin women, and 35 percent of foreign-born Mexican-origin women. Table 2 also confirms that employment and family roles are directly linked to insurance. Women who are employed full-time are far more likely than unemployed women to have private insurance and less likely to rely on public insurance. This work insurance pattern is evident across all racial/ethnic groups but is most pronounced for African-American women. Employed African-American women are 2.4 (77.2/31.8) times more likely than the not employed to have private insurance, a larger ratio than the 2.1, 1.8, and 1.3 ratios for foreign-born Mexican-origin women, native-born Mexican-origin women, and non-Hispanic white women, respectively. The high ratios for African-American and Mexican-origin women are driven by limited access to spousal coverage, which depresses the ratio's denominator.

In addition, Table 2 illustrates how for each racial/ethnic group, married women are more likely than never-married women to have private insurance and less likely to rely on public insurance. Divorced women are also less likely than married women to have private insurance. Although Table 2 does not reveal this pattern for foreign-born Mexican-origin women, it does hold under a multivariate model that controls for demographic characteristics. Finally, the presence of young children (under 18 years) increases reliance on public insurance for all women. The association of young children with private insurance was inconsistent, however. Having non-adult children increases the likelihood of private insurance among non-Hispanic white women but decreases it among the other groups of women. Clearly, the basic demographic profile of each group of women illustrates the vulnerabilities associated with the lack of private and public coverage.

Table 2. Adult Women with Public Insurance or Private Insurance by Employment and Family Status and by Race and Mexican-Origin^{a,b}

	Non-Hispanic White		Mexican Origin				African American	
	Public (%)	Private (%)	Public (%)	Private (%)	Public (%)	Private (%)	Public (%)	Private (%)
Employment Status								
Full-time employed	1.8	87.7	5.0	73.0	5.9	49.4	5.6	77.2
Not employed	16.8	65.4	23.1	39.8	14.3	23.2	41.3	31.8
Marital Status								
Married	3.5	87.2	7.0	69.8	9.4	38.1	6.4	80.3
Divorced	11.7	71.9	13.4	61.7	16.3	38.8	16.6	65.5
Never married	11.2	67.6	16.6	48.9	13.2	21.0	22.8	50.7
Parental Status								
Children under 18 years	6.5	82.6	11.9	59.9	11.2	34.3	18.2	63.3
No children under 18 years	5.9	80.5	9.3	65.7	9.0	36.8	13.0	66.0
Total Sample (%)	6.1	81.3	10.7	62.5	10.5	35.1	15.4	64.7
N	(61,588)		(3,957)		(4,950)		(11,327)	

Source: 2004 and 2006 Annual Social and Economic Supplements, Current Population Survey.

^a Unweighted Ns are in parentheses.

^b Part-time employed women are excluded from all estimates.

Multivariate Analyses: Men

We next turn to the multivariate analyses and explore the effect of factors, such as sector, occupational category, other employment characteristics, and demographics on coverage for males. We should note that the variables used in this study and detailed results are reported in our previous research (Angel, Angel, and Montez, 2009 and Montez, Angel, and Angel, 2009). The logic underlying the multivariate analyses for men is the following: if occupational distribution is not the sole or even the major explanation of low rates of coverage, then we are left with the question of what is? In order to have coverage, at least two conditions must hold: (1) one must be offered a plan and (2) one must buy into it. If an employer does not offer a plan, the game is over. If a plan is offered but it is too expensive, the individual may choose not to buy into it. Since family plans are more expensive than individual plans, a worker may be able to cover only himself or herself. Since children in families with incomes even well above the poverty level can receive Medicaid or CHIP, the family can potentially piece together fairly complete coverage. The picture that emerges, though, suggests that the Mexican-origin male disadvantage may result both from a lower likelihood of being employed in a job with a high probability of coverage (as a police officer, for example) and from a lower probability of having insurance (compared to other racial/ethnic groups) within the same occupational grouping.

Table 3 presents the results of logistic regressions in which we control for occupational category, occupational sector, other employment characteristics, and demographics. The

table presents five models in which each block of variables is introduced to determine the extent to which each explains the lower level of coverage among Mexican-origin workers revealed in Model 1. Again, we should note that the occupation and health insurance variables are both for the previous year.

Model 1, the baseline model, controls only for race and Mexican-origin and once again reveals the health insurance disadvantage among Mexican-origin workers. In this model, African-American working males are 87 percent, and Mexican-origin working males 37 percent, as likely as non-Hispanic white male workers to have coverage through their employer or union.

In Model 2, which introduces the occupational categories, the probability of *not having* coverage increases somewhat for African-American men and even more so for Mexican-origin men. Within the group of occupations, professionals, office and administrative support, and production occupations are associated with higher probabilities of coverage than are the management occupations (the reference category), while the other categories are associated with lower probabilities. Farming, fishing, and forestry, as well as construction and extraction, in which Mexican-origin workers are disproportionately employed, have very low probabilities of coverage. This model suggests, then, that the low general rate of coverage among Mexican-origin male workers is to some extent a reflection of their disproportionate representation in occupational categories with low overall coverage rates.

Model 3 introduces job sectors, with the professional sector serving as the reference group. This block of dichotomies has no substantive impact on the probability of coverage for either African-American or Mexican-origin men. The block itself indicates that manufacturing workers are more likely than other groups to have coverage and that those in construction and agriculture, in which a large proportion of Mexican-origin men work, are much less likely to have coverage.

Model 4 introduces other employment characteristics that reduce the probability of coverage for African-American and Mexican-origin workers. In this model, full-time employment greatly increases the probability of coverage, as does public-sector employment. Self-employed individuals are far less likely than private-sector workers to have coverage. Again, the model suggests that the distribution of African-American and Mexican-origin men in terms of hours worked and public employment represents a health insurance risk for both groups.

Finally, Model 5 introduces demographic characteristics and greatly increases the probability of coverage for African-American and Mexican-origin men. This block of variables corroborates the descriptive findings and clearly reflects the elevated risk associated with low levels of education and a family income below poverty level. It also illustrates the improved chances of having health insurance benefits that are associated with marriage (including terminated marriages), older age, U.S. citizenship, higher family income, and larger family size. As the descriptive tables revealed, Mexican-origin males have very low levels of education and are very likely to be noncitizens. The model indicates that even after controlling for occupation and sector, individual-level

demographic factors represent a clear health insurance risk for Mexican-origin male workers.

Table 3. Odds Ratios for Employer/Union Coverage

Risk Factors^a	Model 1	Model 2	Model 3	Model 4	Model 5
Race/Ethnicity (Non-Hispanic White)					
African American	0.87*	0.91*	0.88*	0.78*	0.93*
Mexican-Origin	0.37*	0.48*	0.49*	0.42*	0.82*
Occupation (Management)					
Architecture and engineering		2.51*	1.95*	1.26*	1.19*
Healthcare practitioner and technical		1.24*	1.02	1.16*	1.06
Computer and mathematical sciences		1.77*	1.40*	1.01	1.01
Life, physical, and social sciences		1.84*	1.50*	0.96	0.95
Office and administrative support		1.14*	1.03	0.67*	0.88*
Legal		1.05	0.86*	0.99	0.85*
Installation, maintenance and repair		0.95	0.92*	0.64*	0.84*
Production		1.26*	0.78*	0.56*	0.83*
Public Safety, protective service		2.21*	1.84*	0.65*	0.83*
Business and financial operations		1.17*	0.99	0.87*	0.83*
Sales		0.75*	0.72*	0.67*	0.77*
Education, training and library		1.91*	1.56*	0.71*	0.73*
Transportation and material moving		0.71*	0.69*	0.51*	0.72*
Arts, design, entertainment, sports, media		0.61*	0.52*	0.60*	0.67*
Healthcare support		0.60*	0.50*	0.42*	0.64*
Construction and extraction		0.40*	0.69*	0.45*	0.64*
Community and social service		1.10	1.01	0.58*	0.59*
Building and grounds cleaning, maintenance		0.49*	0.42*	0.33*	0.58*
Personal care and service		0.36*	0.37*	0.38*	0.52*
Farming, fishing and forestry		0.24*	0.41*	0.25*	0.43*
Food preparation and serving		0.24*	0.24*	0.20*	0.38*
Job Sector (Professional)					
Manufacturing			1.66*	1.66*	1.71*
Services			0.78*	0.87*	0.94*
Construction and Agriculture			0.41*	0.60*	0.69*
<i>Other Employment Characteristics</i>					
Full-time Employment (Part-time)				5.02*	3.96*
Employment Sector (Private)					
Public				2.84*	2.41*
Self-Employed				0.20*	0.18*
<i>Demographic Characteristics</i>					
Education (High School)					
Less than high school					0.71*
Some college or associates degree					1.19*
Bachelors or higher					1.48*
Marital Status (Never Married)					
Married					1.13*
Divorced, separated, widowed					1.50*
Age (18-35 years)					
36 – 47 years					1.29*
48 – 64 years					1.42*

Risk Factors ^a	Model 1	Model 2	Model 3	Model 4	Model 5
U.S. Citizen (not a citizen)					1.69*
Family Size					1.08*
Family Income to Poverty Ratio (<1.00)					
1.00 to 1.99					1.95*
2.00 to 2.99					3.32*
3.00 to 3.99					4.10*
4.00 or greater					4.23*
Divorced, separated, widowed					1.50*

Source: 2004 and 2006 Annual Social and Economic Supplements, *Current Population Survey*.

^a Reference group in parentheses.

* $P \leq 0.05$.

Multivariate Analyses: Women

We now address the likelihood of coverage for women. In Table 4, we stratify the models by race/ethnicity and examine how women's employment and marital roles relate to their health insurance coverage. The data reveal that Mexican-origin women are significantly less likely to have private insurance than non-Hispanic white women within all but two employment-family types. Divorced Mexican-origin women who are employed full-time have similar odds of having private insurance as non-Hispanic white women who are divorced and employed full-time. African-American women are also as likely as non-Hispanic white women to have private insurance (rather than no insurance) within all but two types. Never-married African-American mothers who are employed full-time have *greater* odds of having private insurance than their non-Hispanic white counterparts. African-American women with no employment-family source of insurance (i.e., not employed and not married) are far less likely to have private insurance than are non-Hispanic white women.

Likewise, Mexican-origin women are less likely than non-Hispanic white women to have public insurance (rather than no insurance) for only four of the nine employment-family types. African-American women are also as likely as non-Hispanic white women to have public insurance for all but two types in which they report significantly higher rates. The results underscore the heterogeneity of coverage across women. Full-time employment and marriage significantly increase the odds of private coverage for all women. However, unlike non-Hispanic white women, African-American women increase their odds more through employment than through marriage. What our data also reveal (models are not shown) is that these patterns persist after controlling for other factors known to be associated with the probability of having health insurance including age, education, nativity, family income and self-rated health. It appears, then, that neither employment nor marriage, nor their combination, ensures health insurance for Mexican-origin women.

Table 4: Multinomial Odds Ratios for Having Public or Private Insurance Across Race/Ethnicity-Employment-Family Status Combinations for Women^a

Employment-Family-Race/Ethnicity	Race/Ethnicity	Public	Private
(Full-time, married, children^b)	Non-Hispanic white	1.00	1.00
	African-American	0.90	0.91*
	Mexican-origin	0.77	0.54*
Full-time, married, no children	Non-Hispanic white	0.26*	0.49*
	African-American	0.42*	0.46*
	Mexican-origin	0.24*	0.34*
Full-time, never married, no children	Non-Hispanic white	0.43*	0.35*
	African-American	0.45*	0.32*
	Mexican-origin	0.36*	0.24*
Full-time, never married, children	Non-Hispanic white	1.94*	0.40*
	African-American	2.21*	0.54*
	Mexican-origin	0.96	0.24*
Full-time, divorced, no children	Non-Hispanic white	0.27*	0.39*
	African-American	0.42*	0.41*
	Mexican-origin	0.17*	0.32*
Full-time, divorced, children	Non-Hispanic white	1.05	0.52*
	African-American	1.41	0.59*
	Mexican-origin	0.77	0.43*
Not employed, married, no children	Non-Hispanic white	1.28*	0.31*
	African-American	1.56*	0.30*
	Mexican-origin	0.91	0.18*
Not employed, married, children	Non-Hispanic white	1.79*	0.72*
	African-American	2.60*	0.63*
	Mexican-origin	0.73*	0.29*
Not employed and not married	Non-Hispanic white	3.11*	0.19*
	African-American	3.56*	0.14*
	Mexican-origin	1.52*	0.12*

Source: 2004 and 2006 Annual Social and Economic Supplements, Current Population Survey.

^a Multinomial logistic regression model controlled for age, education, nativity, family income, and self-rated health.

^b Reference group is non-Hispanic white, married, full-time employed women with children.

*P < 0.05.

Discussion

In this paper we employed data from the 2004 and 2006 CPS to examine the role of work and family in explaining differences in rates of health insurance coverage among Mexican-origin, African-American, and non-Hispanic white individuals. These data, as well as most other data, show that the Mexican-origin population faces an extremely high risk of not having health insurance. The results clearly demonstrate that the health insurance vulnerability of the Mexican-origin population entails dismantling multiple road blocks to coverage besides those related to work and, for women, marital status. But, the answer to the question as to why the Mexican-origin population is at such high

risk is more complicated than a simple occupational concentration or gender role explanation would suggest, and our analysis raises other questions concerning the sources of the health insurance coverage risk faced by this population.

The occupational sources of the risk of not having insurance are complex and multilevel. Minority Americans, and Mexican-origin workers without citizenship, are less likely than non-Hispanic whites to be in government jobs or in the private sector, in which coverage rates are higher. Excluded from these good jobs that offer benefits as part of the compensation package, they find themselves having to look for work in sectors in which coverage is not offered. Even when coverage is offered, the employee contribution may be too high for individuals with limited incomes.

Furthermore, our results confirm that health insurance remains strongly linked to family and employment status for American women and this is especially true for women of Mexican descent. Employment and marriage generally improve the health insurance situation of all women, although neither one nor the other, nor their combination, equalizes the insurance playing field for Mexican-origin women. These findings have serious implications for the rapidly growing Hispanic population in general, and for women's labor force participation, socioeconomic status, and family status. A dramatic retreat from marriage and fertility, accompanied by the concomitant increase in paid employment among women of all races/ethnicities, will no doubt affect the health and social welfare of women of Mexican origin. Again, the new and compelling evidence clearly points to the extreme vulnerability of stay-at-home Mexican-origin mothers, who are at the highest risk of not having health insurance. For these women, the odds of having coverage only marginally improve with employment. Unlike their grandmothers, younger generations of women, especially the less educated, cannot count on their husbands to guarantee their economic security. Women no longer work simply to supplement the family's income but to build their own retirement nest eggs. In this world, many single women—particularly minority women and those of Mexican ancestry—may find themselves at a serious disadvantage in years to come.

These findings underscore important health consequences of significant demographic changes in the United States, particularly on the burgeoning Hispanic population. They point to the national disparity in access to U.S. employer-sponsored health plans among Mexican-origin adult men and women. Unfortunately, the situation is likely to worsen for the most vulnerable, especially Hispanics, if employer coverage continues to represent the major source of coverage. In 2005, approximately 60 percent of all employers offered health benefits, down from 64 percent in 2000 (Denavas-Walt, Proctor, and Lee, 2006). Although the proportion of large employers who offered health benefits remained fairly constant between 2001 and 2006, at about 98 percent, the share of small employers (with 3-199 employees) offering coverage dropped from 68 percent to 60 percent (U.S. Government Accountability Office, 2007). For smaller employers the cost of coverage has become burdensome, and many choose not to offer it to their employees (Fronstin, 2005). Findings from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits indicate that from 2000 through 2005, coverage declined the

most among low-wage workers, dropping from 57 to 50 percent (Kaiser Family Foundation, 2006).

In the absence of comprehensive national health insurance planning, the only solutions are partial and entail efforts to facilitate the enrollment of eligible individuals in existing state programs. For example, although Medicaid and the new State Children's Health Insurance Program extend coverage to children in more families in or near poverty, many Mexican-origin families with children who qualify still do not participate in this program. Perhaps most important is that working poor families have the information they need about newly created state assistance programs like the Texas Health Opportunity Trust Fund, which provides premium subsidies to make health insurance affordable for low-income uninsured Texans. At this point, the data make it abundantly clear that enrolling more families in health care plans is at least a step in the right direction toward reducing Hispanic disparities in health care coverage. With that said the discussion over which new policy options to carefully consider has just begun in the Obama-Biden administration. The appointment of a new "health czar" to oversee the health care system is promising. Although the bold initiative of providing affordable, accessible coverage to everyone has received widespread public support, the president's plan as it stands will leave about 35 million uninsured, a large proportion of whom are of Hispanic origin.

We end with the observation that policy solutions and health care reform that do not deal adequately with the problems of uninsured workers are likely to be ineffective in guaranteeing the optimal health of the population. We learned this key lesson nearly 50 years ago when President Johnson took office. Even among some of his most vehement critics, most Americans think of Medicare as a basic right (Bernstein and Stevens, 1999). As a result, most of us now marvel at his drive for power with his lofty goals to protect and improve the lives of the American people. Undoubtedly, this public policy was one of the greatest achievements of the Johnson's administration, a legacy of health passed on to millions of Americans today (Goodwin, 1991). These political insights about guaranteeing health care for the uninsured are valuable tools to guide policy. They could ultimately influence governmental priorities and allocations. That is most certain. But it is unknown whether the new Congress will seize the opportunity to tackle the needs of the uninsured and confront the challenge head on in light of the fragile state of the economy.

Even though Medicare played a central role in reducing poverty among elderly Americans, serious racial health disparities still persist. A significant number, some 3.1 million Hispanic and 3.9 of African American elderly Medicare beneficiaries still live below the poverty line. Millions of older minorities in low-income households have inadequate access to health care and prescription drug coverage. Thousands of older Mexican Americans lack any Medicare coverage (Angel and Whitfield, 2007). Unmistakably, the lack of adequate insurance coverage continues to undermine the physical and emotional health of a sizeable number of Mexican-origin people and other minority group members on and beyond the cusp of retirement (Angel and Angel, 2006).

For these reasons, employers and public officials must consider the increasing significance of Hispanic ethnicity in the nation's social policy agenda. Clearly, ethnic differences in risk factors associated with the uninsured and underinsured are amenable to policy interventions. The failure to do so risks introducing a dimension of racial and ethnic strife into the serious age-based conflicts that could arise as the United States begins to face major challenges in financing the retirement and health care needs of future generations. Although addressing such problems will be painful in the short term, ensuring that all minority groups have access to the health care they need in order to be productive members of society will benefit the country as a whole in the long term.

We also need to develop strategies to better gauge how the federal government can reach out effectively to the neediest working families, including ethnic minorities with language barriers, and the limits of what they can do. Given the fact that the United States is the only developed nation without universal health care coverage, understanding the unique vulnerabilities of specific groups like Hispanics is crucial if we are to design health care policy to address the needs of the most at risk groups and their families. Whatever the coming decades hold for increased coverage, in the short term at least it seems clear that the Mexican-origin population will face serious barriers to complete coverage. Understanding these implications represents a new and important policy research agenda for the foreseeable future.

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