

Immigrants' Access to Quality Health Care

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Immigrants' Access to Quality Health Care

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September 2004



The Council of
State Governments

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Executive Summary

As the number of immigrants grows and the demographic makeup of these immigrants changes, states must address issues related both to population growth as well as social, economic and cultural diversity. While immigration affects every facet of state government, certain policy areas are particularly impacted. Health care is one such policy area.

As the population of the United States becomes more diverse due in large part to the influx of immigrants, the health care system must adapt to changing conditions. Immigration influences racial and ethnic health disparities and raises cultural and health literacy issues. In addition, some immigrants don't have health insurance, which can limit their access to quality health care.

State policy-makers may want to consider a number of options for increasing immigrants' access to health care and ensuring that immigrants receive linguistically and appropriate health care services. Policy options include:

- creating incentives for employers to provide health insurance benefits;
- expanding access to public health programs;
- encouraging or mandating access to medical translation and interpretation services; and
- promoting foreign language skills and cultural competency in college health care curricula and professional education programs.

The first section of this *TrendsAlert* looks at immigration's impact on the health care system in the states. And the second section outlines possible policy options and highlights examples of state policies and programs to provide immigrants and their children with quality health care.

1. Immigration and the Health Care System

Access to health care and health care quality are two prominent policy concerns at the state level. This is true for both the native and foreign-born populations. More specifically, the nation's health care system must adapt to a number of changing conditions related to immigration. Those conditions include:

- racial and ethnic health disparities that may influence health care research and costs;
- cultural competency and health literacy that can affect the quality of health care; and
- the lack of health insurance among many immigrants.

Racial and Ethnic Health Disparities

A large body of research has documented substantial variation in access to care, quality of care and health outcomes among racial and ethnic groups in the United States. Minorities frequently have less access to care, receive lower quality care and have poorer health status than non-Hispanic whites. This can lead to health disparities among racial and ethnic groups. Asians, for example, have higher rates of stomach and liver cancers.¹ Hispanics have higher rates of cervical, esophageal, gallbladder and stomach cancer, and a disproportionate share of Hispanics die from cancer.² There are also differences among racial and ethnic groups when it comes to preventive medicine. Compared with non-Hispanic white women, for instance, Hispanic women are less likely to get mammograms,³ and Asian and Hispanic women are less likely to get Pap smears.⁴

Hispanics suffer from certain chronic illnesses at higher rates than non-Whites. Hispanics are more likely to suffer from diabetes and have higher death rates from diabetes.⁵ In contrast, Asians are less likely to be hospitalized for diabetes.⁶ Hispanics have higher AIDS incidence rates than whites.⁷ In addition, AIDS-related death rates are higher among Hispanics.⁸

These racial and ethnic health disparities are also present in immigrant populations. As the immigrant population grows and the country becomes more racially and ethnically diverse, health issues that are more prevalent among immigrants will likely gain more attention. For instance, there may be more demand for research funds devoted to diseases that affect the immigrant population disproportionately. Consequently, there may be a greater emphasis on prevention and treatment of these diseases, which is intertwined with the problems of cultural competency and health literacy as well as access to health insurance.

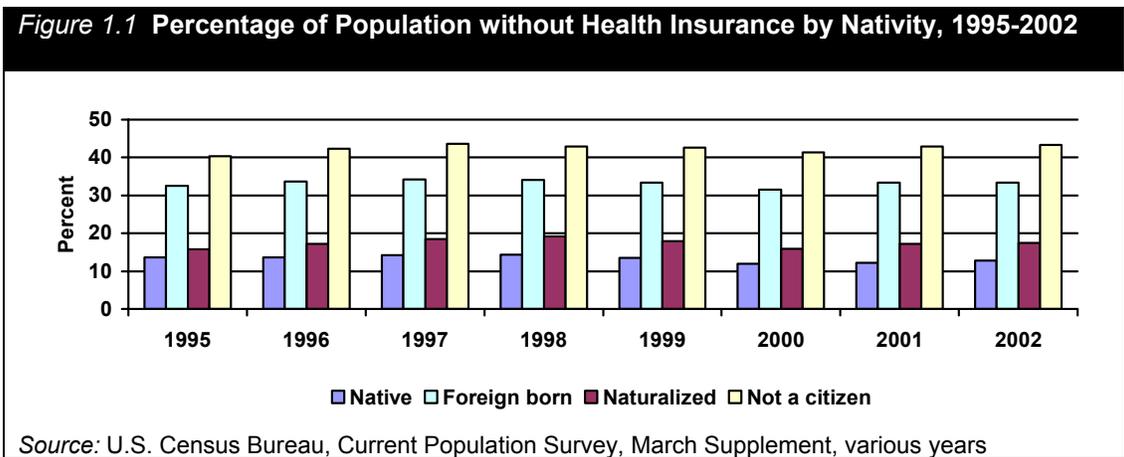
Cultural Competency and Health Literacy

Cultural considerations and health literacy levels can play a large role in how well a patient understands health care information and makes appropriate health care decisions. The medical community must increasingly take these realities into consideration. People from different parts of the world view disease and illness in different ways. People from different cultures may shy away from certain treatments, and some cultures may prefer homeopathic or nontraditional treatment over mainstream medical treatments. Moreover, health literacy, which is the ability to read, understand and act on health information,⁹ will become an even more important issue. Health literacy is low among poorly educated people and non-English speakers. Immigrants' health depends on their ability to process medical information, so health care professionals will need to find ways to communicate more effectively with these groups.

Inability to speak English well can serve as a barrier to health care access. For instance, patients who do not speak English are less likely to see primary care physicians and use preventive care services and more likely to receive emergency room treatment.¹⁰ In addition, patients with chronic illnesses, such as asthma, are less likely to go to follow-up appointments and follow their medication regimen if there are language barriers between them and their doctors.¹¹

Uninsured Immigrants

There are substantial health insurance coverage gaps among citizens and non-citizens. This coverage gap is illustrated in Figure 1.1.



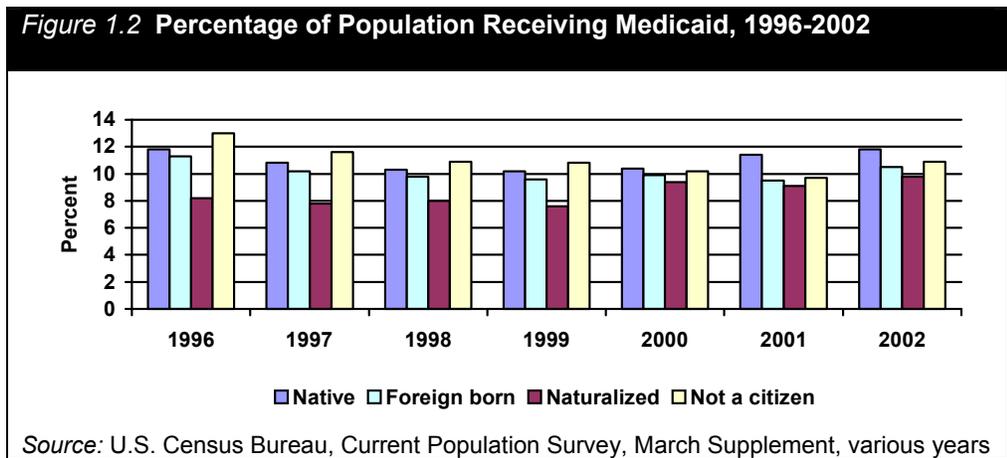
The foreign-born population is more than twice as likely as natives to be uninsured. In 2002, for example, 12.8 percent of the native population did not have health insurance but 33.4 percent of the foreign-born population was uninsured. Most of this gap, however, can be explained by differences among two subgroups of the foreign-born population – naturalized citizens and noncitizens, who include undocumented as well as resident aliens. While 43.3 percent of noncitizens were uninsured in 2002, the percentage of naturalized citizens who were uninsured was 17.5 percent, which is slightly more than the percentage of natives without health insurance.

Some studies have looked at health insurance issues for immigrants. One study found several barriers to obtaining health insurance for Hispanic workers.¹² Cost can be an issue as can lack of employer coverage particularly if a job is low-wage or temporary. Hispanics may have previously been covered by either private insurance or Medicaid and were dissatisfied with coverage. Some, who are young and healthy, may not see the need for insurance. Language barriers and immigration concerns among illegals also form barriers to access.

Although being uninsured is linked to lower use of health care services, uninsured immigrants and their children still have health care needs and may access free clinics, emergency rooms and other public health care facilities for care.

Medicaid

Without health insurance, some qualified immigrants rely on Medicaid. As Medicaid costs continue to spiral upward, this issue has major fiscal impacts for the states. Figure 1.2 highlights the percentage of the native and foreign-born populations that receive Medicaid. The number of immigrant households participating in the Medicaid program has increased since 1996, but this increase is due to an increase in



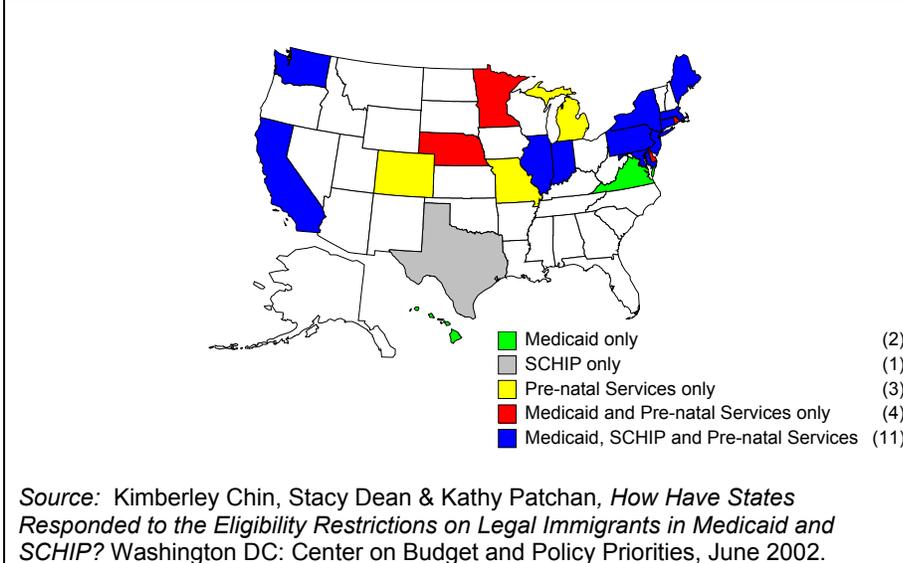
the number of U.S. citizen children living in immigrant households.¹³

Welfare reform passed in 1996 established new barriers to providing coverage for legal immigrants under Medicaid. As illustrated in Figure 1.3, many states,

however, chose to cover immigrants without reimbursement from the federal government. In 2003, 18 states provided Medicaid coverage and 12 states provide State Children's Health Insurance Program (SCHIP) to some legal immigrants without federal reimbursement.¹⁴

In addition, 19 states provide pre-natal services for pregnant immigrant women who were excluded from federal coverage when welfare reform passed. Because of the recent fiscal crises, however, some states

Figure 1.3 States Providing Health Coverage without Federal Reimbursement, 2003



are re-examining this process. For instance, New Jersey and Massachusetts eliminated coverage for legal immigrants in 2004.

Low-income noncitizen children are less likely to have health insurance than low-income citizen children.¹⁵ Between 1996 and 2001, the percentage of citizen children with health insurance increased while the percentage of low-income noncitizen children with health insurance decreased. The increase in health insurance among citizen children is due to SCHIP

and expanded Medicaid services. In 2001, while more than 50 percent of low-income noncitizen children were uninsured, only 16 percent of citizen children were uninsured.¹⁶ That year, nearly 47 percent of the insured low-income citizen children, including citizen children born to immigrant parents, were covered by either Medicaid or SCHIP while only 24 percent of low-income noncitizen children were covered.¹⁷

In tight fiscal times, states are finding it difficult to address the health needs of undocumented immigrants. Washington state in 2002, for instance, eliminated its Medically Indigent Fund, which was used in part to help cover medical costs of illegal immigrants. But this may cost the state more in the long run. An article in *The Seattle Post-Intelligencer* told the story of an illegal immigrant suffering from kidney failure. A kidney transplant would have cost about \$100,000 plus an annual cost of \$11,000 for medication. The immigrant is receiving dialysis, with an annual cost of \$45,000, because it is covered by Medicaid as life-saving whereas a transplant is not.¹⁸ In the past, the cost of transplants and drugs not covered by Medicaid would be paid for with money from the Medically Indigent Fund. Without these government funds, demand for charity care at nonprofit clinics and hospitals is rising. Since undocumented immigrants are entitled to emergency care, there is a chance that there will be no cost savings from eliminating health services for them if their ailments go untreated until becoming bad enough to seek treatment in emergency rooms.

2. Policy Options

Racial and ethnic disparities can be heightened due to lack of access to health care coverage, inadequate cultural competency, lack of appropriate training of health care professionals and the insufficient attention to the risk for low health literacy among immigrants.

- Incentives to employers to provide health insurance benefits and expanding access to public health programs are two ways to address access to care issues.
- Policy-makers can encourage linguistically appropriate and culturally competent health care through measures such as encouraging or mandating access to medical translation and interpretation services and promoting foreign language skills and cultural competency in college health care curricula and professional education programs.

Employer Incentives to Provide Health Insurance Benefits

Immigrants may lack health insurance for a variety of reasons. Hispanics, for instance, are more likely to work for employers in low-wage industries that do not provide health benefits. Private health insurance

Example 2.1 Selected Recommendations of the Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care

The Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, part of the National Academies' Institute of Medicine, was asked by Congress to address the disparity issue. The committee formulated recommendations, many of which deal with linguistic and cultural barriers, to increase health care access and quality in the United States.

General Recommendations

- Increase general public's and health care providers' awareness of racial and ethnic disparities

Legal, Regulatory and Policy Interventions

- Promote sustained relationships among providers and patients which affects patient satisfaction, improves access to care and helps alleviate mistrust of health care providers
- Increase the proportion of racial and ethnic minorities among health professionals

Health Systems Interventions

- Provide financial incentives for practices that reduce cultural and language barriers
- Encourage broader use of linguistic interpretation services
- Support use of community health workers
- Support use of multidisciplinary teams of health care professionals, which have been shown to improve minority health outcomes

Patient Education and Empowerment

- Implement patient education programs, including books, pamphlets, in-person instruction and Web sites

Cross-Cultural Education in Health Professions

- Implement curricula focused on attitudes, knowledge and skills to address cultural barriers and help health care professional better communicate with patients

Source: Brian D. Smedley, Adrienne Y. Stith and Alan R. Nelson, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, D.C: The National Academies Press, 2002.

that is not provided or subsidized by employers can be cost prohibitive. State officials could target small employers and employers in industries which employ many immigrants for incentives for providing insurance.¹⁹ A program in New York state, called Healthy NY, provides publicly funded insurance and incentives for employers to provide coverage. Health NY encourages small employers to provide health insurance by creating state-sponsored benefit packages through HMOs. In addition, the working uninsured can purchase state-sponsored health insurance. Eligibility varies but is typically based on income.

Expansion of Publicly Funded Health Programs

Rather than creating incentives for employers to provide health insurance, states can also use the public health system to increase health care coverage. One way to do that is to aggressively market SCHIP to children in immigrant families. Currently, 12 states provide SCHIP coverage to legal immigrants without federal reimbursement. However, there are many U.S. citizen children born to immigrants who are eligible for SCHIP but do not

receive it. By marketing the program to these families, more children could receive health insurance coverage.

There are other ways states can improve access to health care. The Illinois Department of Human Services Bureau of Refugee and Immigrant Services provides funding for three suburban health clinics in areas with large immigrant populations in order to improve services. These health clinics provide services for all impoverished immigrants whether they are legal or illegal. In addition to primary medical care, mental health services are available.²⁰ Family Health Plus, funded by New York state, covers adults who have low incomes but do not qualify for Medicaid. Health care is provided through managed care plans at no cost to the individual. The citizenship requirements for this program are the same as under Medicaid.

Cultural and Language Barriers

Federal health care programs require linguistically appropriate services. Managed care organizations with Medicaid, SCHIP or Medicare patients must provide access to language services. States often require that materials related to these managed care plans be translated into several languages. In some states, these managed care organizations are required to provide care that also takes cultural differences into consideration. Figure 2.1 displays the states requiring these organizations to provide materials in other languages, provide services for people not speaking English as their primary language and meet cultural competence standards which include skills enabling staff to understand and be sensitive to cultural differences and how they influence relationships between patients and providers.²¹

Most states already address language barriers in the public health care system. Currently, 40 states have laws dealing with language barriers in health care.²² The laws vary widely in their mandates. California and New York, for example, go into a great deal of detail on how health care providers should break down language barriers while other states leave a great deal to the discretion of health care providers.

The Washington State Department of Social and Health Services provides certification of interpreters and contracts with interpretation service agencies through a competitive bidding process. On the positive side, health care providers have access to interpretation services at a fixed cost over the period of the government contract. On the downside, less than half of the interpreters who have taken the certification test since 1995 have passed and the state fiscal crisis has led to a cut in funding for the program.

Figure 2.1 State Programs for Linguistically Appropriate and Culturally Competent Health Care

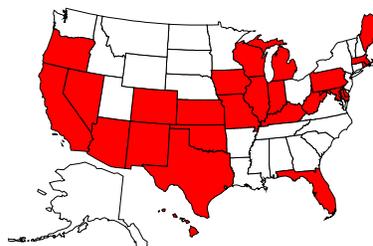
States Requiring Medicaid Managed Care Organizations to Provide Materials in Other Languages



States Requiring Medicaid Managed Care Organizations to Provide Services for People Not Speaking English as a Primary Language



States Requiring Medicaid Managed Care Organizations to be Culturally Competent



Source: Center for Health Services Research and Policy, The George Washington University Medical Center, *Negotiating the New Health System*, http://www.gwu.edu/~chsrp/Fourth_Edition/

Example 2.2 Foreign-Born Medical Professionals

Immigration affects the supply of health care services as well as the demand for such services. Tighter immigration policies following the Sept. 11 attacks have meant a shortage of doctors in underserved areas, because these areas rely disproportionately on foreign medical graduates.

If foreign medical graduates were removed from practice all together, one out of five rural counties that are currently “adequately served” would become underserved.²³ If these doctors could not practice in the United States, rural counties without primary care physicians would increase from 161 to more than 200.²⁴ Realizing the significance of foreign medical graduates to rural health care provision, the U.S. Department of Health and Human Services decided in 2003 to provide visa waivers for physicians willing to practice in rural areas.²⁵

Nurses from countries where English is commonly spoken, such as the Philippines and India, are increasingly being recruited by U.S. hospitals to deal with staffing shortages. A new H-1C visa category created by legislation in 1999 has made it easier for foreign-born nurses to fill positions in areas where there are health professional shortages. The increasing number of nurses from other countries, however, has been controversial with U.S. nursing organizations that favor changes to work place conditions as the way to recruit and retain more nurses.

Minnesota has taken a different approach. The Minnesota Department of Human Services reimburses health care providers for interpretation services. There are several upsides to this approach. There are lower administrative costs than the Washington approach because Minnesota does not contract directly with interpreters nor put interpreters and health care providers in contact with one another nor does it take part in the certification of language service providers. On the other hand, the state has less control over the quality of interpretation services and providers are not always happy to pay for interpretation services and then wait for the state to reimburse them.

Massachusetts state law requires that all acute care hospitals provide interpretation services for non-English speaking patients in emergency rooms. Hospitals are allowed to provide language services via bilingual staff, interpreters on staff or contracted interpreters. Hospitals are also required to monitor their interpretation services. Issues with this law include a potential shortage of interpreters and the potentially high cost of the mandate.

Just speaking another language is not enough. There can be variations in dialect, sociocultural differences and problems with understanding medical terminology. There are several approaches states can take to deal with these constraints.

One approach is to promote foreign languages in college health care curricula and cultural competency in medical and nursing programs and professional education for doctors, nurses and other health care professionals.

Another approach is to concentrate on the patients, rather than the health care providers. Many state

health departments and Medicaid programs prepare multilingual patient education materials to help non-English speakers understand how to use the health care system and deal with certain health care conditions, such as a diabetes asthma and heart disease.

The New Jersey Office of Minority and Multicultural Health, within the Department of Health and Senior Services, is devoted to ensuring access to health programs for the states racial and ethnic minorities. In support of this mission the Office is involved in several activities related to cultural competency. The office helps develop materials and courses in cultural competency in order to address gaps in access to health care. It also provides support and funding to promote community outreach. And it also assists policy-makers in collecting, reporting and analyzing data on minority health and improving health care access for racial and ethnic minorities.²⁶

Washington state also recognizes the need for services and programs designed to overcome cultural barriers. The state sponsors several culturally competent maternal and child health programs. For instance, CHILDP Profile develops education materials in Spanish and English that are mailed to the families of all children born in the state. The Children with Special Health Care Needs Program has a Multicultural Work Group, a Health Disparities Task Force and a Family Summit on Cultural Competence

and Health Disparities. The Healthy Mothers, Healthy Babies Toll-Free Line provides multilingual services and referral information in multiple languages.

Conclusion

Immigrants face some of the same problems that the native population does in terms of finding access to affordable health care. In addition, immigrants face linguistic and cultural barriers that can affect the quality of their health care. As immigration continues to grow, states are expected to focus more efforts on policies and programs aimed at addressing immigrants' access to quality health care services.

Endnotes

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