Health

Section VII of the

2006-2007 Travis County Immigrant Assessment

Conducted by

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Research and Planning Division

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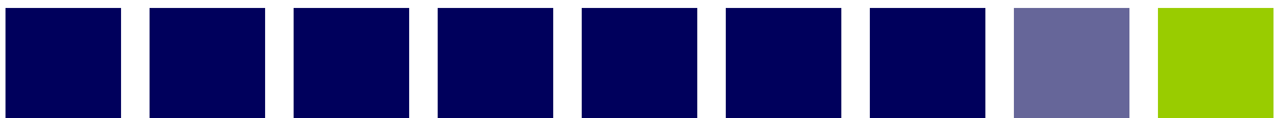


Health Overview

Community Goal

The community's goal for health in Travis County is reflected in the following statement:

> **[To] promote the health and wellness of the residents of our community, especially the uninsured and underinsured, by working together to ensure access to a full range of coordinated healthcare services.**
>
> (Travis County Healthcare District Board of Managers, 2007)[36]

Healthy residents can be full participants in their communities, schools, and places of work, thus contributing to the prosperity of Travis County as a whole.

Highlights

- Immigrants are subject to the same constraints and challenges endemic to the U.S. healthcare system as the population at large.
- Immigrants are more likely than the native born to lack health insurance. In Texas, the share of the foreign born that lack health insurance (48%) is more than twice that of the native born (20%). In particular, non-citizens lack health insurance at almost three times the rate of the native born (55% are uninsured). These disparities in coverage are largely due to employment trends and to policies governing immigrants' access to public health insurance.
- Due to their lower rates of health insurance coverage, immigrants tend to be more reliant on healthcare safety net providers.
- Immigrants are disproportionately low users of healthcare services and account for a relatively small share of total and per capita U.S. healthcare costs.
- First-generation immigrants to the U.S. tend to be healthier than the native born population, despite their socio-economic risk factors and limited access to care. However, their health tends to decline with acculturation.
- Language barriers, cultural differences, and providers' levels of cultural competency can affect immigrants' access to care, quality of care received, and ability to navigate the healthcare system.

[36] The use of the Travis County Healthcare District's mission statement does not imply their endorsement of content.

Healthcare Access

Access to care is the first link in a chain of factors that impact individuals' health outcomes. Health insurance coverage is the primary predictor of one's access to healthcare. The availability of health insurance is governed by policies at federal, state and local levels, as well as individuals' socioeconomic and employment characteristics. Particularly for those without health insurance, access to healthcare is dependent upon the capacity of local "safety net" healthcare providers to meet service demands.

Immigrants' Access to Public Health Insurance: Key Laws and Policies

In the 1970s and 1980s, U.S. immigration policy followed largely liberalizing trends. During this period, the Supreme Court determined that unlike the states, the federal government *did* have authority to make eligibility distinctions on the basis of nativity and citizenship in public benefit programs; but the federal government did not do so. Policies thus reflected more or less similar treatment of legal immigrants and citizens concerning their daily life in U.S. society, with some rights extended to undocumented individuals as well, and widened access to legal entry into the U.S. (Fix & Zimmermann, 1999)

The 1990s marked the onset of a more restrictive era in immigration-related policies, one which more narrowly defined immigrants' membership in U.S. society. The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (also known as the Welfare Reform Act or the 1996 welfare law) restricted legal immigrants' eligibility for public health insurance, including Medicaid, and later the State Children's Health Insurance Program (SCHIP) when it was implemented as a supplement to Medicaid in 1997. In general, legal immigrants entering the U.S. after the passage of the 1996 legislation cannot receive Medicaid for five years, after which coverage becomes a state option. Some exceptions are made on the five year ban, including refugees[37] and asylees, victims of human trafficking, veterans, and members of the military on active duty and their spouses and unmarried dependent children. Undocumented immigrants, as well as temporary residents (individuals with time-limited work, study or travel visas), were not eligible for Medicaid or SCHIP benefits prior to the 1996 welfare law and remained ineligible after its passage. All immigrants, regardless of their status, retained eligibility for emergency Medicaid services and emergency medical services provided by state governments. (Siskin, 2004; Staiti, Hurley & Katz, 2006; Nielson, 2004; for a more detailed discussion of immigrants' access to public benefits, including public insurance, refer to the Economic Safety Net section of this report.)

These stricter eligibility requirements produced significant declines in the number of legal immigrants receiving Medicaid coverage, particularly among low-income immigrants and their citizen children (Ku & Freilich, 2001; Ku, Fremstad & Broaddus, 2003; *Health Coverage for Immigrants*, 2004). The policy changes also increased coverage gaps between immigrants and

[37] Refugee eligibility is complex and may vary from state to state. For more information, refer to the website of the Office of Refugee Resettlement (www. http://www.acf.hhs.gov/programs/orr/).

U.S. citizens (particularly among low-income persons), and amplified inter-state disparities in coverage for immigrants (Fremstad & Cox, 2004).

To address these gaps, twenty-three states, including Texas, responded to the 1996 welfare law by (1) creating or expanding state-funded healthcare coverage programs for legal immigrants, and/or (2) engaging in outreach efforts to enroll eligible immigrants in public insurance programs and maintain their insurance coverage. States defined eligibility criteria for immigrants with the intent to provide either more encompassing or more limited coverage for specific populations. Almost all states opted to provide coverage to children and pregnant women, and most extended coverage to parents, the elderly, and people with disabilities. A few states, including Texas, defined eligibility more narrowly: In Texas, healthcare coverage *is* provided to all children who are qualified immigrants[38] through the SCHIP program, but coverage is *not* offered to legal immigrants who are pregnant, parents, elderly, or disabled. (Fremstad & Cox, 2004)

Nationwide, these state-funded programs have increased insured rates among immigrants, but without federal funding, state health programs are vulnerable to local fiscal pressures, and places an undue burden of care on states in which higher numbers of immigrants reside (Kaiser Family Foundation, 2004; Carrasquillo et al, 2003). This is particularly relevant in the state of Texas, which is home to approximately 10% of the country's foreign born and 12% of its non-citizens (American Community Survey, 2005).

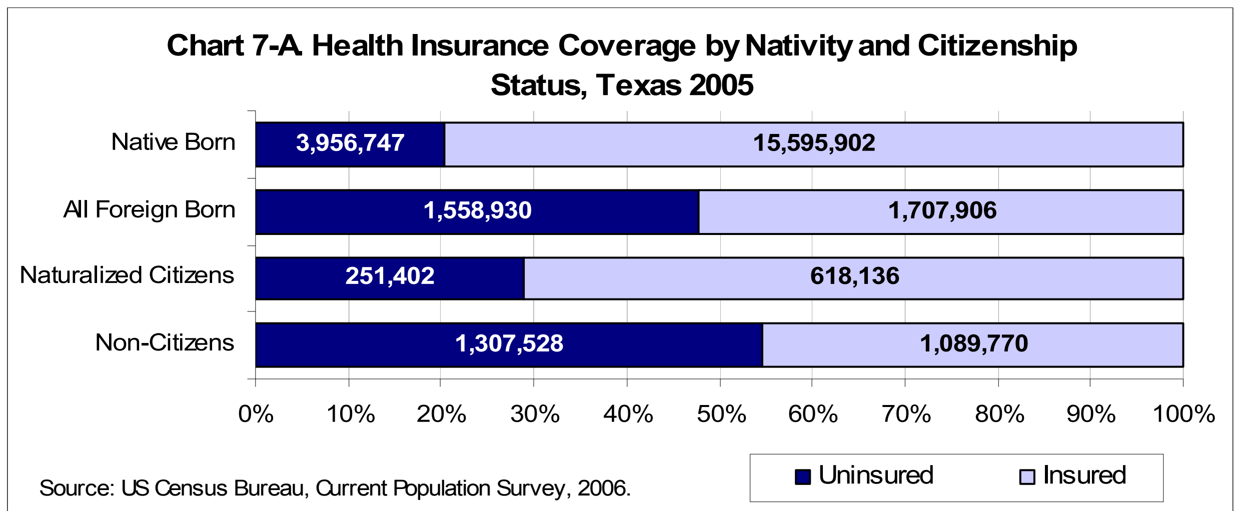
Health Insurance Coverage for Immigrant Populations

Within the U.S. healthcare system, health insurance coverage greatly impacts both health outcomes of individuals and the financial well-being of families. More specifically, the presence and extensiveness of health insurance affects whether care is accessed, the frequency with which care is accessed, and the quality and affordability of the care received. These findings have notable implications for immigrants, who are significantly more likely to be uninsured than native-born citizens, both nationally and at the state level.

Nationally, in the year 2004, the proportion of the foreign-born population without health insurance (34%) was about two-and-a-half times that of the native-born population (13%). Among foreign-born persons, non-citizens were more likely than naturalized citizens to lack coverage (44% and 17%, respectively) (DeNavas-Walt, Proctor & Lee, 2005). Undocumented immigrants are the most likely group to be uninsured, accounting for up to one-third of the growth in the uninsured population in the United States over the past two decades (Rand Corporation, 2005a).

[38] "Qualified immigrants" is defined in the federal welfare law as: lawful permanent residents, refugees, asylees, persons granted withholding of deportation, persons paroled into the United States for at least one year, persons granted conditional entry (prior to April 1, 1980), certain battered spouses and children, Cuban/Haitian entrants, and victims of a severe form of trafficking (Nielson, 2004).

These proportions look very similar for the state of Texas, although the uninsured rates for all populations are slightly higher than they are nationally. Of the state's total population, 24% are uninsured. The foreign born in Texas comprise a disproportionate number of those without health insurance coverage: In 2005, the foreign born comprised only about 14% of the total population of the state, but 28% of the state's uninsured. Chart 7-A shows the number and percent uninsured for Texas' native-born and foreign-born populations. Compared to the native born, of whom 20% lack health insurance, the foreign born are uninsured at more than twice that rate (48%). Among non-citizens in Texas, 55% lack health insurance. (Current Population Survey, 2006)



According the U.S. Census Bureau's Small Area Health Insurance Estimates Program, Travis County's rate of uninsured is lower than both the Texas and national figures. It is estimated, at a 90% level of certainty, that Travis County's uninsured number between approximately 99,700 and 132,700 persons (or 12.1% or 16.1% of the total population).[39]

Reasons for High Uninsurance Rates among Immigrants

The coverage gap between immigrants and their native-born counterparts is attributable primarily to three factors:

- Workforce trends,
- Eligibility for government (public) insurance, and
- Personal characteristics that affect coverage (Mohanty, 2006; Grieco, 2004; Capps et al, 2002).

Workforce Trends: Immigrants, and in particular undocumented immigrants, are more likely to hold jobs without employment-based coverage, such as part-time or seasonal positions, jobs in industries such as service or construction, and/or jobs with small employers (Grieco, 2004; Ku &

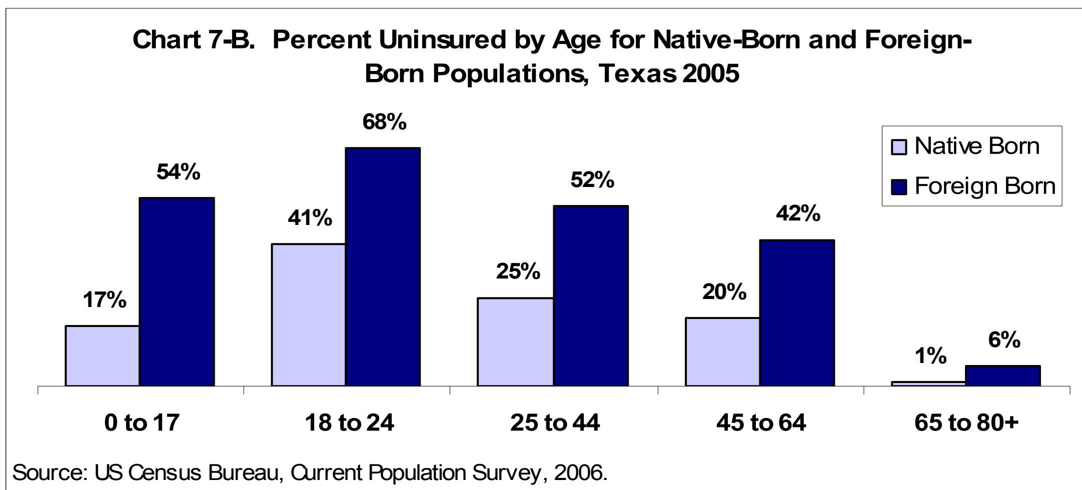
[39] These proportions are 3-year averages of county-level observations from the Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS). The confidence interval represents uncertainty from both sampling and modeling, for each estimate. For more information on methodology, refer to the following page of the U.S. Census Bureau's website: http://www.census.gov/hhes/www/sahie/methods/methods.html

Waidman, 2003; Stiati et al, 2006). This is particularly true for non-citizen immigrants, who tend to be younger and less educated, and thus work less-skilled jobs (Mohanty, 2006; Rand Corporation, 2005a). Even when their employers offer insurance, immigrants in low-income households commonly decline coverage because they cannot afford it (Burgos, Schetzina, Dixon & Mendoza, 2005). This has far-reaching effects, given that healthcare coverage in the U.S. is so closely tied to the workforce and economy. As a result, only about 36% of foreign-born persons in Texas have employment-based health insurance, compared to 55% of the state's native born (Current Population Survey, 2006).

Eligibility for Public Insurance: Immigrants have low rates of public insurance coverage (Staiti et al, 2006). In Texas, only 15% of foreign-born persons have government insurance, compared to 27% of the state's native born (Current Population Survey, 2006). Undocumented immigrants are typically ineligible for government-issued insurance, and due to the 1996 welfare law, so are many legal immigrants. While legal immigrants have greater access to government-based coverage, in most cases, five years of residency is required (Grieco, 2004). Some immigrants, namely refugees, have Medicaid coverage temporarily after entry into the U.S., but typically lose coverage after eight months ("History of Time," 2002). Immigrants who maintain eligibility or become eligible for Medicaid coverage may be deterred from enrollment by the difficulty of navigating the program, or by the fear that it would constitute a "public charge" and thus have damaging effects on immigration status (Ku & Freilich, 2001; Ku & Waidmann, 2003). All these factors render immigrants less likely to have a form of government insurance. (For more information on this topic, refer to the Economic Safety Net section of this report.)

Personal Characteristics that Affect Coverage: A combination of other personal factors contributes to an immigrant's likelihood of being uninsured, including their world region of origin, age, naturalization status, and socio-economic status.

- **Age:** For all age groups in Texas, uninsurance is more common among immigrants than the native born (see Chart 7-B). Among the foreign born, the 18-to-24 age group experiences the highest rate of uninsurance (68%). However, the coverage gap between native-born and foreign-born is highest among children (under age 18) and the elderly (age 65 and older).



The uninsured rate for foreign-born children in Texas (54%) is more than three times that of the state's native-born children (Current Population Survey, 2006). Immigrant children experience high levels of uninsurance for many of the same reasons their parents lack coverage. Their parents are likely to lack employer-based coverage, so the children of immigrants are less likely to be covered under an employer health plan (Capps, Fix, Henderson and Reardon-Anderson, 2005). In mixed status families with citizen children and non-citizen parents, many eligible children are not enrolled in public insurance programs because their parents are not aware that their children are eligible, or they fear that doing so will compromise their legal status or future citizenship (Capps et al, 2005b).

Foreign-born elderly persons, although they have extremely low rates of uninsurance (6%), are six times more likely to lack health insurance than their native-born counterparts (Current Population Survey 2006). This disparity in coverage may be due to differences in Medicare coverage for the foreign born (elderly non-citizens' ineligibility for Medicare, and the possibility that legal immigrants may not have been employed for a sufficient number of qualifying quarters to be eligible for Medicare).

- **Naturalization Status:** When foreign-born persons become naturalized citizens, their likelihood of being uninsured drops significantly, but remains higher than that of the native born. In Texas, uninsurance among the naturalized immigrant population is 47% lower than that of the non-citizen immigrant population. This decrease in uninsurance for naturalized persons is consistently observable across age groups, but by varying degrees: Citizenship status has the greatest effect on the elderly population (a 53% lower rate of uninsurance), and it has the least effect on the 18 to 24 year old age group (a 23% lower rate of uninsurance). (Current Population Survey 2006)

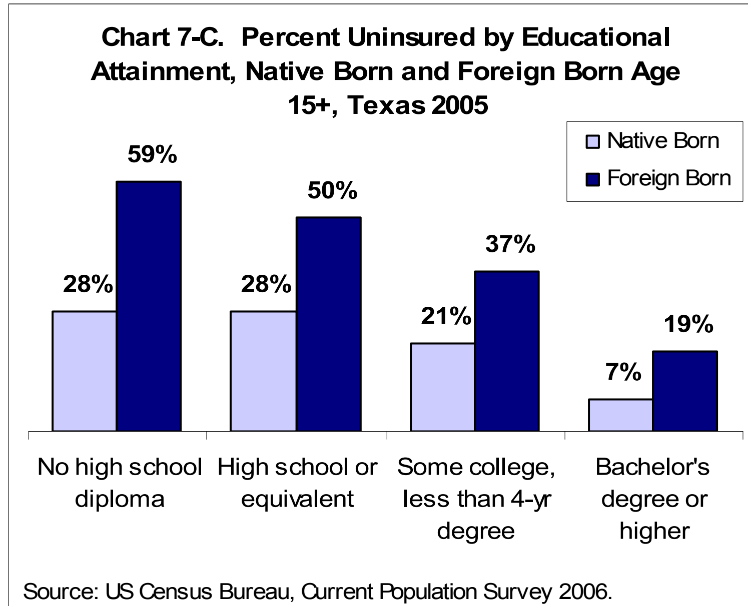
- **World Region of Origin:** Uninsurance affects groups from some regions of origin more than others (see Table 7-A). In Texas, immigrants from Central America have both the highest numbers of uninsured and the highest rates of uninsurance. Notably, although Asians have lower rates of uninsurance, they still have the second highest number of uninsured in the state, due to their larger population size in Texas.

Table 7-A. Number and Percent Uninsured by World Region of Origin
Foreign-Born Individuals, Texas 2005

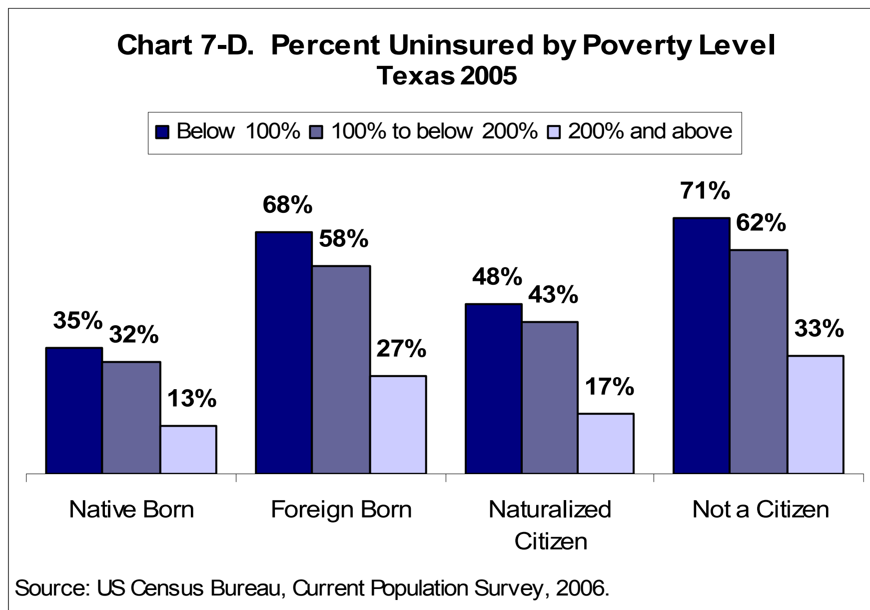
Region of Origin	Number Uninsured	Percent Uninsured
Europe	6,757	6%
Caribbean	7,189	18%
South America	24,072	40%
Other Areas	41,737	28%
Asia	128,093	20%
Central America & Mexico	1,351,082	56%

Source: U.S. Census Bureau, Current Population Survey 2006

- **Socio-economic Factors:** Across all groups, socio-economic factors—in particular, income and education—strongly influence health insurance coverage rates. For both the foreign-born and the native-born populations in Texas, higher educational attainment levels correlate to lower uninsurance rates, but the correlation is much greater for foreign-born persons at every level (see Chart 7-C).



Similarly, for all populations, the likelihood of uninsurance decreases as people move out of poverty (see Chart 7-D). It is noteworthy that as people move further out of poverty, the likelihood of uninsurance decreases more or less by similar ratios for all groups. However, a consistently greater proportion of foreign-born persons are uninsured compared to the native born.



Personal socio-economic characteristics, while they are factors in uninsurance overall, do not explain away the disparities in coverage between immigrants and the native-born population.

Travis County's Healthcare Safety Net

Immigrants are subject to the same constraints and challenges endemic to the U.S. healthcare system as the population at large. Their use of care is likewise dependent on common mitigating factors, including income and health insurance coverage. Given immigrants' higher rates of uninsurance, the role of "safety net" providers[40] is particularly important in serving this population (Staiti et al, 2006). In Travis County, as in other communities across the U.S., safety net providers are often called on to serve those who slip through the cracks of federal and state programs.

Travis County's healthcare safety net consists of multiple providers offering primary[41] and specialty care, including Brackenridge Hospital, the 15 Austin/Travis County Community Health Centers, and other primary care clinics (Health Management Associates, 2006). All of these safety net options are available to immigrant populations, although, in some settings, immigrants may be subject to different eligibility criteria dependent upon citizenship status (for a detailed discussion of immigration-related statuses, refer to the Immigration Policy, Process, and Legal Rights section). The following provides an overview of the Travis County healthcare safety net and immigrants' access to local safety net services.

Primary Care: The 15 Community Health Centers (CHCs) provide primary care to over 50,000 low-income adults and children in Travis County. CHC services include outpatient primary healthcare, dental care, behavioral health services, and HIV/AIDS treatment services. They serve individuals who are residents of Travis County, have incomes up to 200% of federal poverty income guidelines, and lack private health insurance. As Federally Qualified Health Centers[42] (FQHCs), the Travis County Healthcare District CHCs serve predominantly uninsured or medically underserved populations, and they provide services to all eligible persons regardless of their ability to pay. The CHCs serve as the primary provider for more than 50,000 children and adults in Travis County, and comprise approximately half of the safety net capacity within the boundaries of Travis County. (Community Care Services Department, 2006; *Community health centers*, n.d; Travis County Healthcare District, 2007b; C. Garbe and T. Young, personal communication, April 17, 2007)

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[40] "Safety net" providers are the healthcare facilities that are open to all patients, including those who are low-income and uninsured. They may include hospitals, community health centers, free clinics, community-based organizations, and in some cases local health departments. (Staiti et al, 2006)

[41] Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care. (American Academy of Family Physicians, 2007)

[42] The Federally Qualified Health Center status is a federal designation from the Bureau of Primary Healthcare and the Center for Medicare and Medicaid Services that is assigned to private nonprofit or public healthcare organizations that serve predominantly uninsured or medically underserved populations, and are located in or serving a Federally designated Medically Underserved Area/Population.

The CHCs serve as the primary care provider system for enrollees in the Medical Assistance Program (MAP). The Medical Assistance Program is a healthcare program of the Travis County Healthcare District, for which the District provides funding and sets policy. MAP provides access to a network of established providers located in Travis County (*Medical assistance program,* n.d.). In fiscal year 2006, MAP had an average monthly enrollment of approximately 10,000 people, and in fiscal year 2007, average monthly enrollment is projected to be approximately 10,100 (C. Konecny, personal communication, March 23, 2007). Travis County residents who have family incomes at or below 100% of the federal poverty income guidelines, meet asset guidelines, and have no other healthcare coverage are eligible for MAP. Unlike federal and state public health insurance programs, non-citizens can participate in MAP. However, individuals without proof of citizenship or legal residency status[43] must have incomes less than 21% of federal poverty income guidelines[44] to be eligible for MAP.

For those who do not qualify for MAP, don't have another form of insurance, and have incomes up to 200% of federal poverty income guidelines, the Community Health Centers provide medical, prescription and limited dental services on a sliding fee scale, based on family size and income (*Medical assistance program,* n.d.). The same sliding fee scale is applied to all populations served by a given FQHC. For families and individuals up to 100% of the federal poverty income guidelines, clients pay 0% of fees for CHC services (Travis County Healthcare District, 2007a).

Many private, nonprofit and community-based providers of primary and preventative care in Travis County serve a key function in our community. Private nonprofit clinics such as People's Community Clinic, the Seton Community Clinics, the Volunteer Health Clinic, Planned Parenthood of the Texas Capitol Region, and the smaller community-based providers like Manos de Cristo and El Buen Samaritano, are alternative sources of affordable primary care, in some cases subsidized by public funding. Some of these providers also offer appointments outside of the traditional work day, thus helping to alleviate one of the access barriers for working clients (Travis County Focus Groups, 2006). Additionally, community-based and nonprofit organizations often play a role in advocating for immigrant groups and bridging cultural gaps, especially for those with language barriers (Staiti et al, 2006).

[43] Legal status validation for MAP is voluntary, through one's own admission and procurement of valid identification; INS is not consulted.

[44] These eligibility guidelines (21% of federal poverty income guidelines) are specified under the Texas Indigent Health Care and Treatment Act. (Texas Health and Safety Code Ann. Ch. 61)

Specialty Care: Brackenridge Hospital is home to a specialty clinic addressing 27 areas of medicine and sub-specialties on a rotating basis. The specialty clinic's daily average of 75 to 100 clients are mostly uninsured, underinsured, or have government-issued insurance (Health Management Associates, 2006). Due to the limited availability of specialists and lack of capacity for expansion, the Brackenridge Specialty Care Clinic frequently has long wait periods, depending on the specialty type (see Table 7-B). A lack of affordable specialty care for the uninsured poses a barrier to caring for vulnerable populations in Travis County (E. Carroll & L. Glenn, personal communication, October 3, 2006; Gilliam, Starkey & Johnson, 2006).

Table 7-B. Wait Period in Days (from 6/5/2006) for Selected Brackenridge Specialty Care Services

Specialty Type	Wait Period
OB Diabetic	7
Asthma	9
Ultrasound	16
Renal Hypertension	58
Surgery	59
Pulmonary	60
Urology	72
Neurology	143
Orthopedics	183
Rheumatology	244
ENT	311
Eye	361

Source: Gilliam, Starkey & Johnson, 2006.

Mental Health Services: Mental health services are available through safety net providers, but only on a very limited basis. Austin Travis County MHMR provides mental health services to individuals with priority diagnoses[45] regardless of nativity, citizenship, or immigration status. (For more detailed discussion of these statuses, refer to the Immigration Policy, Process and Legal Rights section.) As part of primary care services, the federally qualified Community Health Centers provide limited mental health services under the umbrella of behavioral health[46] services (E. Carroll & L. Glenn, personal communication, October 3, 2006).

Emergency Care: Immigrants, including undocumented persons, are eligible for all the same hospital-based emergency services as the general population. While some immigrants are not eligible for public health insurance, they are eligible for emergency medical care provided by state governments and for emergency Medicaid services (Siskin, 2004). In general, hospitals in areas with large immigrant populations experience higher growth in the uninsured patient load and face greater problems with uncompensated care (Ku & Freilich, 2001). Brackenridge Hospital is the historically public hospital for the Austin area; over half (53%) of its patients have some kind of government-issued healthcare coverage (Health Management Associates, 2006).

[45] For children and adolescents under the age of 18, a priority diagnosis includes diagnosis of mental illness and exhibition of severe emotional or social disabilities which are life-threatening or require prolonged intervention. For adults, a priority diagnosis includes severe and persistent mental illnesses such as schizophrenia, major depression, manic depressive disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment. (Austin Travis County MHMR, 2002)

[46] Within the CHC system, behavioral health services are provided by E-Merge Program, which aims to help individuals realize improved health outcomes by concurrently addressing their behavioral health needs. The program targets patients with acute, recurrent or chronic conditions such as diabetes, chronic pain and/or mood disorders, but also serves an increasing number of individuals with more complex mental health needs including psychotropic medications. (Coe-Simmons & Guariguata, 2006; T. Young, personal communication, April 17, 2007)

Local Findings: Access to Care

Focus group discussions with immigrants revealed general concerns about the cost of healthcare in the U.S. Many participants stated that they found medical care, even from their local providers and clinics, to be prohibitively expensive. Several discussed the costliness of insurance coverage. Of those focus group participants who had sought medical care, most expressed concern over paying their medical bills. One person commented that a simple medical visit could be catastrophic on their family income, particularly because time spent receiving care is less time working and less money earned.

Participants also commented on their limited access to prescription drugs, largely due to financial constraints and lack of insurance coverage for medications:

- "I have difficulty getting all of the prescriptions that I need. Without being eligible for Medicaid I cannot get all the medication that I need. I have to take six different prescriptions. The clinic has written a prescription that I cannot pay for."
- "I have a child with asthma, which requires much medication. The insurance I have now [Medicaid] doesn't cover everything."
- "I couldn't believe how ridiculous the system is here. The cost of prescription drugs especially."

Several focus group participants said they acquired their medications, either personally or through friends from Mexico, because they were available without prescriptions and at lower costs. Some participants wished the US healthcare system was more similar to that of their home countries. For example, one person said "It's better in my country. It's difficult to get pharmaceuticals [in the US]. I don't understand why they're separate [from the provision of medical services]."

During the Travis County Immigrant Assessment Provider Forum, providers repeatedly mentioned reducing barriers to healthcare access as a top need of immigrants. Several immigrant focus group attendees mentioned the pivotal role played by private, nonprofit, and community-based organizations, including the Seton clinics in providing affordable care, and staff from other agencies in helping immigrants to navigate the healthcare system.

Limited Capacity and Other Strains on the Safety Net

Research on community responses to immigrant health needs suggests that communities with well-developed safety net provider networks are generally better prepared to serve immigrants (Staiti et al, 2006). Having become increasingly diverse over the past few decades, Travis County has developed an extensive network of community health centers and other private, nonprofit or community-based organizations that provide "safety net" healthcare. Travis County is poised to apply its knowledge and experience to serving the immigrant population. As this population grows, service capacity may prove to be a limiting factor.

Travis County's emergency care, Community Health Centers, and small private providers have a limited ability to address the ever-widening gaps in the healthcare system. Safety net providers also face increasing financial pressures, as they are often dependent on public funding and care for a growing number of uninsured persons (Staiti et al, 2006). A recent local report found that Travis County's safety net providers are experiencing higher demand for services: Between 2001 and 2005, the number of patients receiving care at Travis County primary care clinics increased by 10%, the number of patient encounters increased by 33%, and the average number of visits per person has also increased steadily (Indigent Care Collaboration, 2007). A lack of affordable specialty care for the uninsured poses another challenge in caring for Travis County's vulnerable populations (E. Carroll & L. Glenn, personal communication, October 3, 2006; Gilliam et al, 2006).

Recently, the Community Health Centers have faced a new challenge brought about by the gentrification of historically low-income areas and the subsequent changes in affordability in the local housing market. When originally built, the CHCs were strategically placed in areas of need. Building clinics in close proximity to their low-income consumers helped to minimize transportation barriers for clients. In recent years, changes in the local housing market have spurred a shift in the demographics of those neighborhoods. Increases in the cost of housing inside city limits and gentrification of traditionally ethnic Austin neighborhoods have pushed low-income persons away from the areas in which the clinics are located. In more outlying areas, housing is more affordable, but transportation to clinic locations (and to emergency hospital facilities) becomes a much bigger barrier. (E. Carroll & L. Glenn, personal communication, October 3, 2006; Gilliam et al, 2006)

Local Findings: “Safety Net” Health Services

Immigrant focus group participants shared first-hand experiences of the limited capacity of safety net providers. Many commented on long wait times and limited appointments:

- “In my clinic, when I’m sick, I can never get an appointment. I have a MAP card, but I never go because by the time I am able to schedule and appointment, my … illness has already gone away.”
- “One time I was waiting in line at the clinic to check in. I waited forty minutes.”
- They’ll give you an appointment for six months after you’re received your [MAP] card. By the time your appointment date comes up, your card has expired.”
- “It takes two or three weeks to get an appointment at the clinic.”
- “Sometimes you feel sick and you don’t go to the clinics because then you can’t go to work that day—they see people only during working hours.”

Focus group results indicate that misunderstandings are present in the immigrant community regarding the policies of the Medical Assistance Program (MAP) and the services available to persons without MAP at the Community Health Centers:

- “MAP can’t see you if you’re an immigrant.”
- “To me, MAP is for people with no income.”
- “I’ve heard about MAP but I don’t have any deadly or chronic illnesses.”
- “If you don’t have a MAP card they won’t see you at the clinic.”

Lastly, transportation was cited by several focus group participants as a challenge in accessing needed medical services. One participant noted that “The [clinic] locations are far away.” One person reported that without a car, scheduling appointments at the CHCs requires coordination with public transportation: “Sometimes there are only appointments available at 8am and I can’t get there on time no matter how early I leave for the appointment, because the buses are always running late that early in the morning.” Other participants discussed juggling family and work commitments with time for medical appointments. Lastly, some participants alluded to the fragmented provision of services, and the difficulty of seeking care from multiple sources.

In spite of capacity and transportation challenges, some participants expressed general satisfaction with the quality of care provided at the Community Health Centers. One person said, “It takes time at the clinic, but when we go in, they do treat us well.” Another reported, “I’m happy with the services I’ve received.”

Healthcare Utilization

Disparities exist in the types of healthcare that immigrants use and the frequency with which they use heat care. As a result, healthcare costs for immigrants are disproportionately low.

Type and Frequency of Care Utilized

Immigrants are disproportionately low users of medical services. Compared to the native born, immigrants are less likely to be hospitalized, have a regular source of care, visit a doctor, or obtain preventive care (Goldman, Smith & Sood, 2006; *Health Coverage for Immigrants*, 2004). They are also more likely to avoid treatment and/or delay care (Ku & Freilich, 2001). According to one study, a large share of the foreign born in the US have almost no contact with the formal healthcare system. Approximately one quarter of the foreign born have never had a medical checkup, and one in nine have never visited a doctor; among the undocumented, the rates of utilization are even lower (Goldman et al, 2006). Undocumented immigrants face a unique barrier to utilizing services: Fear of reporting and deportation may prevent them from seeking care from public providers of safety net healthcare (Ku & Freilich, 2004). For people with limited English proficiency, language barriers also exacerbate access problems and result in less connection with the healthcare system (Ku & Waidmann, 2003).

Immigrants do not use emergency rooms as often as the native born, but because many immigrants lack access to preventative healthcare, they often delay care and seek health services when they are sickest (and when the cost of care becomes more expensive) (Mohanty, 2006). Some immigrants may also seek out lower cost alternative or underground sources of care, such as unlicensed providers and folk medicine providers (Ku & Freilich, 2004).

Local Findings: Emergency Care

In local immigrant focus group discussions, emergency room use was common. While some had gone for emergencies, several participants said they had visited an emergency room for routine care, such as poison ivy and flu. One participant said, "I take my kids to the hospital ... when they are sick." Such use of emergency rooms may suggest a lack of relationships with what are considered in this country to be regular sources of care and/or primary care providers.

Healthcare Costs

Immigrants account for a relatively small share of total U.S. healthcare costs, and have a low impact on national healthcare spending relative to their representation in the population. In 1998, immigrant healthcare spending was about $39.5 billion—only 8% of national healthcare costs, despite the fact that immigrants comprised 10% of the U.S. population. Per capita expenditures for immigrants are, on

7-C. Healthcare Per Capita Expenditures, U.S. 1998

Race/ Ethnicity	Per Capita Expenditures	
	Foreign Born	Native Born
Latino	$962	$1,870
Black	$1,030	$2,524
White	$1,747	$3,117
All U.S.	**$1,139**	**$2,546**

Source: Mohanty, 2006

average, 55% lower than those of the native born. For example, immigrants have lower expenditures for emergency room visits, doctor's office visits, outpatient hospital visits, inpatient hospital visits, and prescription drugs. This disparity between immigrants and the native born persists across racial/ethnic groups as well (see Table 7-C). (Mohanty, 2006)

Two sub-groups that have disproportionately low healthcare expenditures are undocumented immigrants and immigrant children. In the year 2000, undocumented immigrants comprised 3.2% of the population but only 1.5% of total U.S. healthcare costs (Goldman et al, 2006). In 1998, per capita healthcare spending was 74% lower for immigrant children than for native born children (Mohanty, 2006).

Most of immigrants' healthcare costs are paid for by private insurers, and compared to the native born, immigrants are more likely to pay a higher fraction of costs out-of-pocket. In terms of tax-payer burden, in 2000, the per-household tax for immigrant care was only $56, compared to $843 for native born households. (Goldman et al, 2006; Mohanty 2006)

Quality of Care

Research at the national level finds that the quality of care an immigrant patient receives can be compromised by language barriers, cultural differences, and a provider's level of cultural competence and multicultural knowledge (Kamath et al, 2003).

Effects on Patients

By preventing clear communication, language barriers can negatively affect the quality of care received. Language barriers can impact the practitioner's ability to solicit the information necessary to make appropriate diagnoses, and the patient's ability to understand the diagnosis, treatment options, and prescribed regimens (Ku & Freilich, 2001; Morse, 2002). People with limited English proficiency are more likely to report problems communicating with their healthcare providers (Ku & Waidmann, 2003), however even those with some comfort with the English language may be unfamiliar with medical terminology. In Travis County, approximately 81,000 foreign-born persons over age five speak English "less than very well" (American Community Survey, 2005).

Providing qualified translation services can be a particular challenge in areas where translation services are limited, unavailable or costly—for example, in smaller communities, in organizations working above capacity, in specialty care settings, or for less widely spoken languages. If qualified translation services are limited or unavailable, non-English speakers may experience longer wait times for care. If unqualified interpreters are used, such as a patient's family member, both confidentiality and informed consent are compromised and the patient may not openly discuss his or her symptoms. (Morse, 2002)

Translation can also be mediated by gender or cultural norms (E. Carroll & L. Glenn, personal communication, October 3, 2006). For example, a female patient may edit what she tells a practitioner through a male interpreter depending upon her cultural background. Effective and culturally appropriate communication in health care settings requires more than language fluency. In one study, non-Spanish speaking immigrants had the greatest challenge with interpretation and translation services, however even Spanish-speaking immigrants often had trouble communicating with providers despite the frequent presence of bilingual practitioners (Ku & Freilich, 2001).

Cultural differences can also make it difficult for immigrants to accept recommendations from American healthcare providers, particularly if they are unfamiliar with the paradigm of Western medicine. For example, immigrants whose home countries have government-administered health systems may be unfamiliar with the components of the American healthcare system, such as buying insurance, and may have difficulty navigating the system. (Connolly, 2005)

Effects on Providers and the Provider-Patient Relationship

Language and cultural barriers can also undermine the provider-patient relationship. According to the 2005 National Healthcare Disparities Report, issued by the U.S. Department of Health and Human Services, individuals who speak a foreign language at home are more likely to have health providers who sometimes or never listened carefully, explained things, showed respect, or spent enough time with them. These negative experiences may prevent people with limited English abilities from developing a relationship with a primary care provider. (U.S. Department of Health and Human Services, 2005)

Providers, too, can experience the negative effects of these barriers in their clinical encounters with immigrant patients. One study found that physicians are generally less satisfied with their healthcare encounters with immigrant patients compared with native born white patients, particularly around the understanding of prevention and management of chronic disease (Kamath et al, 2003).

Local Findings: Language and Cultural Barriers

Language and cultural barriers, sometimes in combination with racial or ethnic minority status, can contribute to a real or perceived difference in how immigrants are treated by healthcare practitioners. In several focus groups, participants said they experienced longer wait times at hospital emergency rooms and local clinics because they did not speak English. One participant stated, "If you don't speak English, you're seen last." Another person commented that, "When you only know Spanish, you suffer. For example, at the bank or at the clinic, the lines are longer for Spanish speakers." One woman reported that language barriers had consistently kept her and her children "at the end of the line" even though she had health insurance. Some participants attributed their experiences to discrimination.

Other focus group participants spoke to the logistical challenges of accessing care without proficiency in English. Regarding the MAP program and CHC services, one person said, "It requires that you speak good English to get an appointment." Lack of English proficiency also affected participants' quality of care. This topic was discussed in detail in one of the Asian focus groups, where a participant reported that a family member who received dialysis three times weekly could not always understand the doctor. This group also noted that both the elderly and the newly arrived immigrants in their community (of Asian origin) seem to have greater difficulty understanding their physicians. Lastly, participants in this focus group commented on the need for interpreter services in Asian languages and dialects, as well as the need for referral services to bilingual providers who speak Asian languages.

Cultural differences between the U.S. healthcare system and those of immigrants' home countries surfaced in focus group discussions. In particular, participants commented on the long wait times in U.S. emergency rooms, and expressed shock over the higher cost of this care and the hurried interactions with physicians in this setting. For example, one person said, "When there's an emergency I've gone to Brackenridge Hospital. Two and a half hours of waiting only to be seen for less than 15 minutes. We got a bill for $3,000." Another participant stated, "We went to the ER and we waited for two hours .... In my country, we get served right away. I think in hospitals [in the U.S.], all service is bad, regardless of your background." These results suggest that immigrants may bring expectations based on the healthcare systems of their home countries.

Health Outcomes

The Impact of Race and Ethnicity

A large body of research examines the relationship between health status and race and ethnicity, most of which points to the health disparities experienced by racial and ethnic minorities in the United States. For example, with the exception of Asians, racial/ethnic minorities in the U.S. tend to rate their overall health worse than non-Hispanic whites, and generally report higher rates of specific health problems, such as diabetes, overweight and obesity. African-Americans in particular have higher infant mortality rates, and experience higher rates of death from heart disease and cancer, than do other groups. These kinds of racial and ethnic health disparities persist across all income levels. (James, Thomas, Lillie-Blanton, & Garfield, 2007)

In the available literature, only a select few studies explore race and ethnicity separate from nativity status and place of origin vis-à-vis health and wellness. Rather, immigrant health is frequently subsumed under the broader category of minority health. This approach masks the

unique differences experienced by immigrants within minority populations, and overlooks those immigrants whose race or ethnicity excludes them from groups traditionally defined as minorities. Moreover, it fails to distinguish between foreign-born or "first generation" immigrants and their U.S.-born children and subsequent generations. It is more meaningful to examine immigrant populations as distinct groups—a fairly new area of research that warrants further exploration.

Nonetheless, conclusions about health disparities for ethnic and racial minorities are somewhat relevant to immigrants, as the majority of foreign born persons in Texas are of ethnic and racial minority groups. However such inferences must be made with an awareness of their limited application.

The Impact of Socio-Economic Determinants

Socio-economic status is an important moderator of health outcomes and often correlates with race and ethnicity. Populations with the poorest health outcomes are those that have the highest poverty rates and the least education (*Improving children's health*, 2006). In Travis County, nearly a quarter (23%) of immigrants experience poverty, compared to 14% of the county's native born; likewise, 52% of Travis County's immigrants ages 25 and older have a high school degree or less, compared to 26% of the native born (American Community Survey 2005). Thus, in general, Travis County immigrants face slightly higher socio-economic risk factors for poor health compared to the native born.

Local Findings: Living and Working Conditions

Some immigrants must take jobs in the U.S. that pose greater health risks. Several participants from local immigrant focus groups shared concerns about occupational hazards affecting their health:

- "Mexicans come here to kill themselves—to work, they abuse their bodies. The body, in the process, gets worn down physically."
- "The work here is brutal – especially in carpentry. The conditions which we work in are awful. Sometimes, we have no breaks. No water."
- "We … are physically exhausted."

Some participants also revealed public health and safety hazards in their housing, such as sewage problems, pest infestations, and criminal behavior that went unaddressed by their landlords. These individuals expressed a desire to move to healthier conditions, but were either financially limited or felt they lacked the proper documents to do so.

The Immigrant "Epidemiological Paradox"

Despite having lower insured rates, receiving less care, and having higher socio-economic risk factors, immigrants tend to be healthier on average than the native born (Goldman et al, 2006)—a surprising trend sometimes referred to as the "epidemiological paradox" (Burgos et al, 2005, page e322). Immigrants generally experience a lower prevalence of obesity, hypertension, cardiovascular disease, and smoking than their native-born counterparts (Lucas & Day, 2006). This is particularly true of first-generation Hispanic immigrants and non-Hispanic Black immigrants (Lucas & Day, 2006; Ghassemi, 2006).

This trend is likely attributable to *migration selectivity*, which is the likelihood that people who immigrate tend to be healthier than those who do not (Ghassemi, 2006; Goldman et al, 2006; Lucas & Day, 2006). Cultural and behavioral factors may also influence health status, such as the dietary and nutritional habits, levels of physical activity, and prevalence of smoking in the home country (Ghassemi, 2006; Lucas & Day, 2006). Lastly, the youth of the immigrant population in the U.S. may partly explain their relatively better health (Goldman et al, 2006).

Alternate explanations do exist for the "epidemiological paradox." While clinical findings suggest that immigrants are healthier as measured by chronic disease indicators, a body of research suggests that immigrants tend to *rate* their health and the health of their children worse than do the native born (Burgos et al, 2005; Capps et al, 2003; Capps et al, 2005b; Lucas & Day, 2006). This may be due to a number of factors. What appears to be good health may reflect immigrants' lower reporting of need due to their poor access to care (Burgos et al, 2005). Immigrants may also have cultural differences in their reporting habits and in their perception of health and illness (Burgos et al, 2005; Capps et al, 2002).

Intergenerational Changes in Health

The subject of intergenerational health changes for immigrant populations is a very new area of research, and many questions have yet to be explored. However, the current literature suggests that, in general, first-generation immigrants and their children start out as healthy as or healthier than their U.S.-born counterparts, but as they assimilate into American culture, their health tends to decline (Coles & Portner, 1998; Mohanty, 2006). However, acculturation does not appear to affect health outcomes for all immigrants in the same way.

A recent study on immigrants' preventative health behaviors found that Asian immigrants, upon arrival in the U.S., tend to have healthy diets but engage in less physical activity and fewer preventative health behaviors than whites[47]; second- and third-generation Asians develop improved health habits, including more exercise and healthier diets with high fruit and vegetable content. Among Latino immigrants, the trend appears to be reversed. Like Asians, newly-arrived Latino immigrants tend to have healthier diets than whites, but over time, successive generations consume less healthy foods and become less likely to engage in preventative behaviors. (Engel, 2006; Allen et al, 2006)

Latino immigrants' higher risk factors and prevalence of obesity, cardiovascular disease, and hypertension increase directly with length of stay in the U.S. (Dey & Lucas, 2006). Similarly, more recently-arrived black immigrants tend to rate their health higher than do native-born blacks (Dey & Lucas, 2006), but their health status, including lower rates of obesity and chronic diseases, tends to diminish after a few years of residence in the U.S. (Ghassemi, 2006).

[47] In the cited study, the category "whites" was not distinguished by nativity status, therefore the results should be considered provisional.

The declines in immigrant health over time may be due to immigrants adopting the behaviors of native-born persons (Coles & Portner, 1998), as well as to the consequences of obstacles they encounter in accessing care in the U.S., such as language barriers, lack of health insurance, difficulty navigating the U.S. healthcare system, and bias or discrimination by providers (Ghassemi, 2006). Regardless of the health benefits immigrants may bring with them to the U.S. if they have poor access to care and do not receive regular or preventative care, health disparities will persist.

Mental Health

Among immigrant populations as a whole, there is a high risk that mental health problems may go untreated, due to a number of factors:

- Immigrants may not report mental health concerns if their places of origin have cultural norms or stigmas associated with mental health issues.
- Mental health needs of immigrant patients may also be misdiagnosed or undiagnosed by practitioners. Cultures differ in what constitutes mental distress, what information is appropriate to disclose to a practitioner, and how mental distress is culturally expressed. For example, in some cultures mental health concerns are often expressed somatically, as headaches, tiredness, weakness, or "nerves."
- Finally, mental health assessment tools may lack the cultural sensitivity needed to accurately gauge mental health problems among immigrants, who may come from a wide variety of cultural backgrounds.

(Burnett & Gebremikael, 2005; Keyes, 2000)

Nonetheless, mental health issues may be a concern for immigrants. Immigrants commonly experience circumstances in their home countries, during migration, and/or after resettling in the U.S. that cause mental distress and contribute to mental health issues. They may leave their country of origin to escape extreme poverty, war, or human rights abuses. For some, the migratory journey itself is a physical and mental hardship. In their new communities, immigrants face challenges adjusting to a new environment. Stressors may include learning a new language, adapting to a new culture, navigating new institutional systems, securing housing and employment, encountering prejudice or discrimination, and mediating their ties with their ethnic community and their acculturation into American life. To survive financially, some immigrants may take jobs in service or labor industries for which they are over-qualified, thus sacrificing the economic status to which they were accustomed in their home countries. Immigrant children may be unaccompanied by family members or living in fragmented families in the U.S. They may also encounter different curricula and teaching styles in the American education system. Families may experience conflict when children acculturate more quickly than their parents or when women assume positions as breadwinners or heads of households. (American Psychological Association, 2006; Burnett & Gebremikael, 2005; Keyes 2000)

The refugee population is at particularly high risk for mental health problems due to the stressors they encounter both before and after they migrate. Frequently displaced by war,

persecution, natural disaster, or forced exile, refugees often endure trauma and experience the sudden loss of family and community. Once resettled, refugees encounter many of the same challenges as other immigrants in adjusting to a new country. These factors increase their risk for post-traumatic stress disorder (PTSD) and other mental health disorders. Approximately 10% of current adult refugees resettled in the United States have PTSD—a rate as much as ten times higher than PTSD is observed in the general U.S. population Other mental health conditions disproportionately observed in the refugee population include major depression (about 5%) and generalized anxiety disorder (about 4%). (Fazel, Wheeler & Danesh, 2005; Keyes, 2000.)

Local Findings: Mental Stressors and Traumas

Immigrants frequently experience traumatic and/or stressful events before, during, and after their migration. Focus group participants shared stories of such experiences:

- "I came here two months ago, to be with my husband. I walked three days and nights. We were a group of 35 people and two young boys fell into the river and drowned. When we were on the other side we stayed at a house where the owner kept threatening the three of us women with rape. Then, when we started out for here, he told the driver to kill the women that couldn't keep up."
- "I am a domestic violence survivor. I was a VOWA applicant, and … I married an American man. I want to improve my English and I want to become a citizen, but I can't because of the system. I feel like a prisoner. I can't move."
- "I was … a political prisoner. The government decided to send me here …. Many of us refugees arrive here and start having problems right away. Social problems. We don't know how we're supposed to behave in this country. We need to know what the social and labor laws are. We end up with problems of domestic abuse, lack of respect. You end up falling in a big pothole that you can't seem to get out of…. Coming here is very difficult—you feel like you just got to the desert and are looking around for a drink of water."
- "The hardest part about being an immigrant is having to leave family behind, and not being able to see them for many years at a time."

Some focus group participants also commented on the strong cultural stigmas attached to mental health concerns and domestic violence, which deter immigrants from seeking help. However, some participants said they had sought out mental health services from local nonprofit and community-based organizations.

Bridging Barriers to Healthcare for Immigrants

To address the health needs of the immigrant population and provide them with better healthcare, steps can be taken to improve immigrants' health insurance coverage, expand service capacity among the providers from which they most often seek care, and overcome language and cultural barriers in healthcare settings.

Expanding Health Insurance Coverage

Lack of insurance is a major barrier to accessing care, and one that affects immigrants disproportionately. With less access to health insurance, immigrants use medical services at lower rates (Goldman et al, 2006). Additionally, policies that restrict immigrants' access to healthcare services lead to the inefficient and costly use of other services, such as emergency

room care (Mohanty, 2006). Expanding eligibility for public health insurance programs and providing entry into employment-based coverage for immigrants would, as it would for all under-insured populations, improve their access to timely care and expand their treatment options. It would also reduce higher-cost emergency expenditures by increasing the use of preventative measures and less costly healthcare services.

As previously discussed, the accessibility of insurance coverage is influenced by many factors, some of which are outside the healthcare arena—most notably, lower rates of employment-based coverage, low-education trends, and policies limiting immigrants' access to public insurance options. Thus, initiatives to expand coverage for immigrants must emerge from these arenas. In Travis County, initiatives could examine the eligibility requirements for local safety net healthcare programs, and explore possibilities for a regional coverage program for the uninsured that would be inclusive of all immigrant groups. The Travis County Healthcare District, in collaboration with other sectors and organizations, is exploring pilot projects to test creative solutions for providing additional health coverage for the uninsured in Travis County.

Expanding Service Capacity among Safety Net Providers

In other U.S. communities, healthcare safety net providers have attempted different approaches to expand capacity to serve immigrants. Some have developed programs and services that target the most populous immigrant groups in their regions, and some have expanded geographically into areas that have experienced significant immigrant population growth (Staiti et al, 2006). Another approach is to make existing programs for the uninsured more inclusive of undocumented persons (Staiti et al, 2006). In Travis County, this would require addressing the overall capacity of providers to serve vulnerable populations, in order to ensure that capacity levels are adequate to serve a greater number of immigrants. Toward this end, the Travis County Healthcare District, the Indigent Care Collaboration and other community partners have worked collaboratively to expand the service capacity of existing safety net providers through operational efficiencies, as resources allow.

Overcoming Language and Cultural Barriers in Healthcare Settings

Quality healthcare requires effective communication between patients and providers, which in turn helps to build a trusting relationship between patient and provider (National Healthcare Disparities Report, 2005). However, language and cultural barriers can preclude both. Addressing systemic solutions in healthcare settings, rather than focusing on individual patient factors, may significantly reduce disparities in care received. Initiatives to bridge these barriers should be community-based as well as hospital- and clinic-based in order to capture the various points of entry for immigrants into the healthcare system (Mohanty, 2006).

To make the healthcare setting more inclusive for immigrants, health literature can be printed in many languages and signs in medical facilities can be multilingual (Ghassemi, 2006; Morse, 2002). Providers can hire multilingual and heterogeneous staff members, and can expand interpreter services. In Travis County, most of the staff and some of the practitioners in the

Community Health Centers speak Spanish (E. Carroll & L. Glenn, personal communication, October 3, 2006). Further enhancements for local providers, modeled after innovative approaches in other communities, could include:

- Creating a community language bank for interpreter recruitment, training and scheduling,
- Providing language classes for practitioners specific to their medical settings, and
- Use of remote interpretation through telephone language lines. (Morse, 2002)

Education for providers of primary, specialty and mental healthcare could also increase efforts to provide culturally competent care—that is, "services that are respectful of and responsive to the cultural and linguistic needs of patients" (Betancourt, Green, Carrillo & Park, 2005, para. 1). This involves not only possessing knowledge about different populations, but also practicing a patient-centered approach rooted in listening and treating patients with respect. These skills can help providers to better understand the customs, beliefs and behaviors of immigrant patients, and thus provide better care. By making care more efficient and effective, cultural competence may also help to control healthcare costs. (Betancourt et al, 2005; Carrasquillo et al, 2003; Kamath et al, 2003)

Additionally, initiatives to educate immigrants on the U.S. healthcare system can better enable immigrants to navigate it and find appropriate sources of care (Kamath et al, 2003). One innovative approach which employs a global perspective on health is the *Ventanilla de Salud* ("Window to Health"). Operated through Mexican consulate offices, the program is a collaboration between government, nonprofit, and private agencies. Its goal is to improve healthcare for low-income and migrant Hispanic families through health education and referral. By nature of a consulate's purpose (processing official documentation, providing information, and protecting the rights and promoting the well-being of nationals while abroad), a consulate is well-situated to capture the program's target population in a neutral, bilingual, and culturally sensitive environment. In Texas, the Ventanilla de Salud program currently operates in Houston, El Paso, McAllen, Dallas, and Austin (with the Mexican Consulate of Austin serving 23 counties, including Travis). (Carrasco, 2006)