Immigrants and Health Care: Sources Of Vulnerability

More opportunities for immigrants to obtain legal residency and citizenship may be the best route to expanded access to care.

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ABSTRACT: Immigrants have been identified as a vulnerable population, but there is heterogeneity in the degree to which they are vulnerable to inadequate health care. Here we examine the factors that affect immigrants’ vulnerability, including socioeconomic background; immigration status; limited English proficiency; federal, state, and local policies on access to publicly funded health care; residential location; and stigma and marginalization. We find that, overall, immigrants have lower rates of health insurance, use less health care, and receive lower quality of care than U.S.-born populations; however, there are differences among subgroups. We conclude with policy options for addressing immigrants’ vulnerabilities. [Health Affairs 26, no. 5 (2007): 1258–1268; 10.1377/hlthaff.26.5.1258]

Immigrants are often identified as a “vulnerable population”—that is, a group at increased risk for poor physical, psychological, and social health outcomes and inadequate health care. Vulnerability is shaped by many factors, including political and social marginalization and a lack of socioeconomic and societal resources. Addressing the health care needs of immigrant populations is challenging both because of the heterogeneity of this group and because recent federal and state policies have restricted some immigrants’ access to health care. These policies have exacerbated existing differences in access (for example, legal residents versus undocumented and long-term residents versus recent arrivals). The stigma associated with some forms of immigration status (for example, undocumented versus refugee) can also contribute to vulnerability.

Size and makeup of U.S. immigrant population. Immigrants to the United States represent a sizable and rapidly growing group that totaled approximately thirty-six million people, or 12 percent of the U.S. population, in 2005. This percentage has doubled since 1970 and shows no signs of decreasing. The influx of immigrants over the past two decades is having a profound effect on a growing number of communities, as immigrants settle in nontraditional destinations: Twenty-two...
states that had relatively low percentages of immigrants saw these populations grow by more than 90 percent between 1990 and 2000. In 2003, 53 percent of all foreign-born people in the United States were from Latin America, 25 percent were from Asia, 14 percent were from Europe, and 8 percent were from other regions. Recent immigrants are largely from Latin America, and more of them are undocumented than was true of earlier cohorts. Of the estimated twelve million undocumented immigrants living in the United States in 2004, 81 percent were from Latin America, and 86 percent were thought to have arrived since 1990.

- **Legal-status groups.** Approximately a third of immigrants are now in each of the three principal legal-status groups (naturalized citizens, legal permanent residents, and undocumented immigrants). However, because current immigration policy places more restrictions and delays than in the past on immigrants’ ability to adjust their status following illegal immigration, the number of undocumented immigrants is likely to continue to grow.

- **Eligibility for public programs.** The immigrant provisions of the 1996 welfare reform act, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), have made most legal immigrants ineligible for publicly funded services such as Medicaid for the first five years of residence (undocumented immigrants were already ineligible), although states can preserve eligibility by fully funding these services themselves. PRWORA also extends the period of time that sponsors' income can be deemed available to immigrants and therefore counted as income for means-tested programs such as Medicaid. Finally, the law requires that state or local governments providing benefits to undocumented immigrants must pass a law to affirmatively establish their eligibility. These restrictions, aimed to discourage immigrants likely to seek public benefits from entering the United States, shift responsibility away from the government onto newcomers’ sponsors and realize a large stream of new cost savings.

With this policy context in mind, we now discuss the factors that influence immigrants' vulnerability in obtaining adequate health care.

**Factors That Influence Immigrants’ Vulnerability**

Much of the research on immigrants and health or health care has focused on the largest immigrant group, Latin Americans, and to some degree on the second-largest group, Asians, although these pan-ethnic terms obscure much within-group variation. More recent studies have focused on health care access and quality for black immigrants.

- **Socioeconomic background.** Educational attainment, type of occupation, and earnings directly and indirectly influence immigrants' access to health care resources. Overall, immigrants are less likely than U.S.-born populations to have graduated from high school and are more likely to work in service occupations and live in poverty, although important variations exist. For example, among Asian and African immigrants, the percentage of high school graduates equals the percentage for U.S.-
born populations (87 percent), whereas the percentage is much lower (38 percent) among immigrants from Mexico and Central America. The proportion of foreign-born workers in management and professional occupations is highest among those from Asia (47 percent) and lowest among those from Latin America (13 percent), compared to 36 percent for the U.S.-born. Finally, the proportion of Asian immigrants living below the federal poverty level is similar to that for U.S.-born populations (11 percent), whereas the proportion of Latin American immigrants is twice as high (22 percent).8 Within immigrant subgroups, there are also large variations based on country of origin, perhaps greatest among Asian immigrants. For example, educational attainment is much higher among immigrants from India (89 percent high school graduates) than among those from Laos (46 percent).9

**Immigration status.** Legal status is another major determinant of immigrants’ access to social services and jobs with benefits. Immigrants have consistently lower rates of health insurance coverage than U.S.-born populations, although there are differences among immigrants based on immigration status, time in the United States, and country of origin. Nearly half (45 percent) of noncitizen immigrants living in the United States lack health insurance, whereas noncoverage for naturalized citizens generally approximates that of the U.S.-born (15–20 percent). However, 65 percent of undocumented immigrants lack health insurance, compared with 32 percent of permanent residents. The percentage of uninsured immigrants varies widely depending on country of origin: for example, from 7 percent for immigrants from Germany to 58 percent for immigrants from Guatemala.10 The higher risk of being uninsured among immigrants remains after adjusting for socioeconomic factors.11

These disparities in insurance extend to immigrants’ children: U.S.-born children with noncitizen or naturalized parents also have lower rates of health insurance (both public and private) than U.S.-born children with U.S.-born parents.12 The disparities are manifest in other measures of access as well, such as not having a regular source of care, not having a physician or dental visit in the past year, or having fewer visits, even after adjusting for health insurance and health status.13

**Limited English proficiency.** Although disparities in insurance and access to care for immigrants are attributable in part to socioeconomic status, sector of employment, and legal status, nonfinancial barriers, especially limited English proficiency, also play a major role. This is largely not an issue for immigrants from countries where English predominates (such as many Caribbean and African nations).14 Adults with limited English proficiency and their children are much less likely to have insurance and a usual source of care, have fewer physician visits, and receive less preventive care than those who only speak English.15 When groups with limited English proficiency are broken down by language subgroups, however, there are differences. For example, Spanish speakers in California were more likely than English speakers were to receive a Pap test in the past three years, whereas women who spoke Vietnamese, Cantonese, Mandarin, and Korean were all less likely.16

Limited English proficiency is also likely to affect the quality of care immigrants
receive; for instance, immigrants with limited proficiency report lower satisfaction with care and lower understanding of their medical situation. Those who need an interpreter but do not receive one fare the worst, followed by those who receive an interpreter and those who have a language-concordant provider or speak English well enough to communicate with the provider. The quality of interpretation is also important, but professional, trained interpreters are rare in many settings, and much interpretation is provided by ad hoc interpreters (family members, janitorial staff, and other patients) and is suboptimal.

Not surprisingly, limited English proficiency also affects patient safety, increasing the probability of an adverse medication reaction resulting from problems in understanding instructions. Providing written instructions in patients’ native language is not always an effective solution, given that some immigrants—particularly those who are older and have less formal education—have limited literacy in their native languages as well.

Although Title VI of the Civil Rights Act of 1964 has been interpreted to mean that federally funded health facilities must provide interpretation for all patients who request it, implementation is uneven. Many patients are not aware of the law, and there are few financing mechanisms to support it (for example, only ten states require Medicaid to cover access to an interpreter). Further, although the supply of Spanish-speaking physicians in places such as California may appear to be ample, the number of Spanish-speaking physicians willing to care for uninsured or Medicaid patients is inadequate. The supply of physicians speaking other languages, although largely unstudied, is probably even lower.

Efforts to address the effects of limited English proficiency have increased; for example, in 2000, the U.S. Department of Health and Human Services Office of Minority Health issued national standards for culturally and linguistically appropriate services (CLAS) directed at health care organizations. Federal law requires state Medicaid agencies and providers to overcome language barriers, a provision that is increasingly required by Medicaid managed care contracts as well. Under California’s managed care contract, plans are required to collect data on the language needs of their Medicaid patients, provide access to interpretation and translation services, and create consumer advisory committees with representatives of immigrant communities to help develop policies on language access. Further, the California Department of Managed Health Care recently implemented regulations that require all California health plans to develop and implement language assistance programs for enrollees whose languages represent some minimal threshold of members.

■ Welfare reform. Federal law has also affected immigrants’ access to and use of health care. Nationally, PRWORA has been associated with an increase in uninsurance among foreign-born, less educated single women and among children of foreign-born women. However, state programs to preserve eligibility have ameliorated some of the negative effects of PRWORA. Further, it appears that expanded
coverage and outreach under the State Children’s Health Insurance Program (SCHIP) and the federal guidance clarifying that use of publicly funded health insurance will not jeopardize citizenship applications have been effective in maintaining Medicaid/SCHIP coverage among immigrant children and their families post-PRWORA. By contrast, Medicaid/SCHIP participation has decreased among legal permanent resident and refugee adults at a rate that is three and seven times, respectively, that for U.S. citizens.25

■ Residential location. Immigrants’ vulnerability can also be influenced by whether an immigrant’s U.S. residence is in a traditional or new destination for immigrants. New destinations are less likely than established destinations to have well-developed safety nets, culturally competent providers, and immigrant advocacy or community-based organizations. Latinos in areas with relatively small Latino populations rely more on emergency departments (EDs) for their care than do Latinos in areas with relatively large Latino populations, and physicians in communities with small Latino populations report more language barriers and problems communicating with patients compared to physicians in major Latino centers.26 Little is known about how immigrants from other regions fare, although some studies have noted a tendency among groups such as Somali refugees to rely on EDs.27

Immigrants in new destinations probably have a different set of social networks than those in traditional destinations. Recent immigrants in new destinations are likely to know relatively fewer immigrants who are long-term residents to whom they can turn for assistance and knowledge about the health care system. This may cause newer immigrants to delay care until the problem becomes unbearable, or they and their providers might encounter frustration when they do attempt to seek care. On the other hand, immigrants and native-born residents in smaller gateway communities (which are more likely to be newer destinations) tend to interact more frequently, impeding social isolation of new immigrants and facilitating intergroup interactions.28 The ability to serve new immigrant populations seems to be related to the capacity of a locality’s safety net.29

■ Stigma and marginalization. Immigrants’ vulnerability can also be influenced by factors related to stigma and marginalization. A variety of factors can contribute to this: differences in appearance (for example, wearing traditional dress), cultural and religious practices, language barriers, speaking with an accent (even among immigrants who speak English), and skin tone.

Stigmatization of immigrant populations can be exacerbated by community concerns regarding the effects of immigration on community resources. A common theme in newspaper articles and opinion pieces of late is that immigrants, especially the undocumented, overburden the safety net and take away from “deserving” families, even though research suggests that immigrants in general and the undocumented in particular use relatively little health care.30

Being part of a stigmatized group can make immigrants reluctant to seek care because of concerns about poor treatment. If providers do not have adequate re-
sources to serve immigrant groups, longer waits and frustration affect both patients and providers. As noted earlier, immigrants and those with limited English proficiency are generally less satisfied with their care than U.S.-born or English-speaking populations. Further, immigrants are more likely than U.S.-born populations to report discrimination in health care.\(^{31}\) Perceptions of being discriminated against can reinforce feelings of stigmatization and lead to decreased use of health services in the future.

PRWORA has contributed to the stigmatization of certain immigrant groups and their resultant social stress. In essence, this law created two categories of immigrants—the “deserving” and the “undeserving”—and exacerbated differences between undocumented and legal immigrants; among different types of legal immigrants; and between legal immigrants and naturalized citizens. Although Congress later restored some benefits to elderly and disabled immigrants and legal immigrant children either already receiving these benefits or in the country at the time of PRWORA’s enactment, this action might have contributed to the idea that some immigrant subgroups are more deserving than others.

In addition, PRWORA’s devolution of federal responsibility for determining eligibility to the state level has led to large variations across state safety nets for noncitizen immigrants; coverage for immigrants tends to be more generous in states with large immigrant populations, strong safety nets, and higher per capita income.\(^{32}\) However, even in states that have preserved eligibility, PRWORA seems to have diminished immigrants’ enrollment in safety-net programs, which suggests confusion, fear, and a “chilling effect” whereby even eligible immigrants are discouraged from applying for or using publicly funded health coverage or services.\(^ {33}\) This fear revolves around concerns over the possibility of deportation for undocumented immigrants and their families, or the possibility that immigrants who seek health care might be putting future security (for example, residency or citizenship applications) at risk. The administration has clarified that receipt of food stamps, Medicaid, or SCHIP will not jeopardize immigrants’ applications for naturalization, but concerns remain.

**Implications For Health**

There is evidence that most immigrants, at least those who are young and come to the United States primarily for work, are relatively healthy and often experience better health outcomes, including lower mortality, than their U.S.-born counterparts.\(^ {34}\) However, immigrants’ health appears to deteriorate over time in the United States and with increasing acculturation, and their health indicators approach those of native-born populations. Several factors may account for this, including adoption of unhealthy habits, living in unhealthy environments, and regression to the mean of a group that had better-than-average health upon arrival to the United States. However, poor access to care is likely to be a risk factor, too. This includes reduced access to both personal medical services and public health...
services and programs (for example, immunizations). Local public health delivery systems, often comprising multiple governmental agencies and private organizations, are known to perform unevenly across communities, with size of the system (measured by the population residing within the jurisdiction) and local health department spending the most important predictors of performance. Public health systems in more rural areas, particularly those facing recent influxes of immigrants, are less well equipped to achieve high levels of performance. Poor access to and the poor performance of the health care and public health systems vis-à-vis immigrants have serious implications for the health of immigrants and their children, and, ultimately, for the health of the nation.

**Implications For Policy**

The factors that render immigrants vulnerable to poor health care can be modified in part through policies that are widely relevant to disadvantaged populations, such as policies related to living wages, access to education, decent housing, and safe jobs. However, health policies targeted specifically to immigrants will also likely be needed. Here we focus on such policies.

- **Policy options to reduce immigrants’ vulnerability.** Expand health insurance coverage. First, given the relatively low rates of health insurance among undocumented and legal immigrants, policies are needed to expand access to health insurance and to community clinics and other care venues. Access can be addressed to a large extent by reauthorizing and increasing funding for programs such as SCHIP, which has been effective in maintaining coverage among immigrant children and their families post-PRWORA. A somewhat harder sell politically is extending eligibility to parents of children eligible for Medicaid and SCHIP, although a number of states have done this and have found that it increases enrollment among children as well. Also useful would be increased funding for community health centers and expanded outreach efforts through trusted sources such as community-based organizations whose culturally competent staff can help immigrants navigate the often overly complex application procedures for Medicaid and SCHIP.

  Policies might also aim to increase employer-based health insurance among immigrants. These are particularly relevant, since immigrants are much less likely than their U.S.-born counterparts to receive such insurance. Policies could include employer mandates that make insurance more affordable for employees, as well as educating those eligible about the value of insurance.

- **Address limited English proficiency.** Second, because issues related to English proficiency remain an important source of vulnerability among immigrants, there is likely a sizable benefit from broader implementation and enforcement of CLAS standards and the expansion of Medicaid benefits to cover interpreter services in the forty states that do not do so. California's regulations provide one example of how implementation can be achieved. Further, researchers and community activists advocate for the use of Medicaid funds for community-based health promoters.
that can reach underserved populations, especially immigrants. Finally, since language-concordant providers are generally preferable to interpreters, long-term solutions include investing in medical education of bilingual people or offering financial incentives such as additional pay for bilingual staff members.

Expand and strengthen the safety net. Third, policies to help build and support the safety-net infrastructure need to take into account the expansion of immigrant populations in many new destinations across the country, including places without the resources typical of large urban centers. Indeed, many of the new destinations for immigrants are in states with more-restrictive Medicaid policies, fewer interpreters and language-concordant providers, and weaker public health systems. Because of these disparities, it has been suggested that additional support is needed to increase the long-term viability of the safety net in these areas. Although private philanthropy has made contributions in some of these destinations, most communities view immigration as a national rather than a local issue. This perspective suggests a federal role in improving services for this population, whether by strengthening the safety net (such as building and staffing more community health centers) and public health systems, by developing health-promoting capabilities and resources within immigrant communities, or by expanding insurance coverage to enable immigrants to make better use of health care services.

Revise PRWORA. Finally, the immigrant provisions of PRWORA, which restrict access to government-sponsored or -subsidized health insurance, should be reconsidered. These policies were put in place to discourage future immigrants from coming to the United States; however, several studies have suggested that this end will not be achieved—that is, the largest driver of immigration and where immigrants settle within the United States is in fact the availability of jobs, not health and social services. Moreover, continuing to restrict immigrants’ access to Medicaid for primary care, while allowing their access to Medicaid for emergency services, creates perverse incentives for providers and patients alike.

Intersection of health and immigration reforms. The United States is in the midst of a heated debate on immigration policy, and a renewed debate on health care reform has also begun in anticipation of the 2008 presidential election. Both of these debates present an important opportunity to revisit health policies affecting immigrants and to craft solutions that are grounded in evidence about the vulnerability of immigrant groups and the potential consequences of lack of access for their health and the health of the nation. To do so, however, will require serious consideration of how various provisions of the immigration and health reform proposals might interact to affect immigrants’ access to health care.

On the immigration reform side, what will temporary work visas and time limits on stays mean for immigrants’ health care access and experiences? What are the implications for immigrants’ health and mental health of provisions barring families from immigrating with a worker? Provisions that expand opportunities for legal residency and citizenship for undocumented immigrants already in the
country may go the farthest in the long run to expand immigrants’ access to health insurance and care. However, when accompanied by steep financial and other costs, these opportunities may be unaffordable for low-income immigrants. Further, unless PRWORA’s immigrant restrictions are repealed, newer immigrants will face the same challenges getting publicly funded health insurance.

On the health reform side, the most concrete proposals have so far emerged at the state rather than the national level. The Massachusetts legislature approved a plan in 2006 that combines elements of an individual mandate and an employer mandate to achieve universal coverage, although state assistance for low-income residents excludes undocumented immigrants. California Gov. Arnold Schwarzenegger has proposed a plan that also stresses an individual mandate but would extend Medi-Cal (California Medicaid) and Healthy Families (California SCHIP) to all uninsured children below 300 percent of poverty, regardless of residency status, and would offer Medi-Cal to legal resident adults with incomes below 100 percent of poverty, regardless of whether they have children (currently, only adults with children are eligible). Individual mandates are likely to be more effective in increasing coverage among the uninsured when they are accompanied by subsidies or low-cost health insurance options for low-income residents. However, when these subsidies are restricted to citizens and only certain types of immigrants (for example, legal permanent residents), they will probably not go very far in covering more immigrants. Employer mandates, although more difficult politically, will likely go much farther, because most immigrants work (and work for employers less likely to offer subsidized health insurance) and because the provisions of PRWORA do not apply to employer-sponsored insurance.

These state-level health reform policies—whether through an individual mandate, an employer mandate, expansion of publicly funded insurance, or a combination of these—provide a type of laboratory for understanding how different policies affect immigrants’ health care experiences and, subsequently, their health status. Tracking these changes and their implications for access, quality, and cost of care for immigrants will be important if we are to make informed policy decisions in the future.

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NOTES
2. R. Capps and J.S. Passel, The New Neighbors: A User’s Guide to Data on Immigrants in U.S. Communities (Washing-

4. Only 9 percent of undocumented immigrants were from Asia, 6 percent from Europe and Canada, and 4 percent from Africa. See J.S. Passel, Unauthorized Migrants: Numbers and Characteristics (Washington: Pew Hispanic Center, 2005).


11. For example, foreign-born non-Hispanic black men have significantly higher rates of uninsurance than U.S.-born black and white men, even after employment status, income, and overall health status are controlled for. See Lucas et al., “Health Status.”


Definitions & Determinants


This threshold ranges from 0.75 percent for plans with more than 1,000,000 members to 5 percent for plans with fewer than 300,000 members. See California Department of Managed Health Care, “Language Assistance Now a Reality for Limited-English Speaking California HMO Members,” Press Release, 1 March 2007, http://www.dmhc.ca.gov/library/reports/news/pr_language_access_regs_3-1-07.pdf (accessed 1 June 2007).


Kaushal and Kaestner, “Welfare Reform and Health Insurance of Immigrants.”


