



LONG ISLAND'S IMMIGRANTS: Health Status and Health Care Access

2008



VITAL SIGNS

Measuring Long Island's Social Health

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Data for this report come from the *Long Island Health Care Survey*.

We would like to thank the Vital Signs Advisory Board for their assistance and our LIHCS partners for their generous support:

Nassau University Medical Center

North Shore-Long Island Jewish Health System's Office of Strategic Planning

CITATION REFERENCE

Eichberg, S. & Michael, S. (2008). Long Island's Immigrants: Health Status and Health Care Access. Garden City: Adelphi University

WEBSITE

www.adelphi.edu/vitalsigns

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INTRODUCTION

Health care access plays an important role in determining health status and health outcomes. In the United States, immigrants experience more barriers to health care than native-born Americans. These disparities in service use and health insurance coverage also exist on Long Island. Overall, immigrants on Long Island report poorer health status, less insurance coverage, greater barriers to services and more difficulty paying for medical bills and prescription drugs than U.S. born residents. These challenges are vital issues for policymakers and planners to address as they develop programs and strategies to expand health insurance coverage and reduce health care disparities.

This fact booklet explores differences in health care access between Long Island adults born in the United States and those born in other countries through an analysis of data from the Long Island Health Care Survey (LIHCS). The LIHCS was funded, designed and analyzed by Vital Signs, Nassau University Medical Center and North Shore-LIJ's Office for Strategic Planning. Conducted in 2007 by Princeton Survey Research Associates, Inc., the LIHCS was a random digit dial telephone survey, with interviews in Spanish and English. The survey included a sample of 1,561 adults ages 18 and older living in Nassau and Suffolk Counties. In order to allow for more meaningful subpopulation analysis, Hispanic and black Long Islanders were purposefully oversampled. Special weighting adjustments were later used to restore the overall representativeness of the sample. Statistically significant findings are described in the report. The margin of sampling error for the complete set of weighted data is $\pm 3.6\%$.

IMMIGRANTS ON LONG ISLAND

Suburban areas across the United States are experiencing the fast growth of foreign-born residents. Over the past two decades, Long Island's economy has attracted immigrants from around the world to both Nassau and Suffolk counties. As a result, Long Island's foreign-born population increased 45% between 1990 and 2000.¹ In 2006, there were approximately 465,217 foreign-born Long Island residents, making up about 16.8% of the total population.²

Immigrants on Long Island are a diverse group, having come to the region from different countries, by various routes and for different reasons. Latin America is the world region contributing the greatest percentage of immigrants to Long Island: 46% of foreign-born residents in Nassau are from Latin America and 54% of foreign-born residents in Suffolk are from Latin America.

TEN LARGEST SOURCE NATIONS FOR THE FOREIGN-BORN (2000)

	NASSAU COUNTY		SUFFOLK COUNTY
Total Population	1,334,544	Total Population	1,419,369
Total Foreign-Born	238,414	Total Foreign-Born	158,525
% Population	17.9	% Population	11.2
El Salvador	25,568	El Salvador	18,499
Italy	18,241	Italy	10,771
India	13,667	Dominican Republic	8,041
Jamaica	12,861	Columbia	7,125
Haiti	11,793	China	6,681
China	9,396	Germany	6,124
Dominican Republic	8,844	Ecuador	6,092
Columbia	7,576	India	5,885
Korea	6,933	Poland	5,746
Iran	6,817	Jamaica	5,371

Sources: US Census; New York City Department of City Planning

LONG ISLAND HEALTH CARE SURVEY SOCIO-DEMOGRAPHICS

The LIHCS interviewed 343 foreign-born residents, comprising 15% of the total (weighted) sample. More than half (55%) of foreign-born respondents were naturalized citizens. Immigrant respondents were not asked their legal status or whether they had children who were U.S. citizens living in their households.

Approximately 31% of foreign-born residents were white, 12% were black, 39% were Hispanic, and 16% were Other (including Asians).

The vast majority of foreign-born respondents (76.7%) reported that they had lived in the United States for more than 10 years.

While 46% of immigrants reported household incomes over \$100,000 per year, foreign-born respondents were significantly more likely than U.S. born respondents to report household incomes under \$40,000 per year.

WEIGHTED SAMPLE DEMOGRAPHICS

	LIHCS TOTAL	BORN U.S.	BORN ANOTHER COUNTRY	U.S. CITIZEN	NON- CITIZEN
Sample Size	N=1,561	N=1,206	N=343	N=1,389	N=155
Sex					
Male	46%	46%	47%	46%	48%
Female	54%	54%	53%	54%	52%
Race/Ethnicity					
White	76%	85%	31%	81%	20%
Black	7%	6%	12%	7%	10%
Hispanic	9%	4%	39%	5%	59%
Some Other	5%	3%	16%	5%	7%
Age					
18-29	13%	12%	15%	12%	20%
30-49	41%	40%	43%	40%	56%
50-64	24%	23%	27%	24%	19%
65+	20%	22%	11%	22%	3%
Household Income					
Less than \$20,000	8%	7%	16%	7%	25%
\$20,000-\$39,999	11%	10%	19%	11%	16%
\$40,000-\$59,999	9%	8%	11%	9%	14%
\$60,000-\$99,999	18%	20%	8%	20%	4%
\$100,000+	23%	24%	19%	24%	17%
County of Residence					
Nassau	45%	43%	57%	45%	52%
Suffolk	47%	50%	32%	48%	33%

*Percentages or numbers may not total 100% due to rounding and/or because undesignated, don't know and/or refused answers are not included.

HEALTH STATUS AND HEALTH CARE ACCESS FINDINGS

Background: Disparities

Health status and health care access are determined by multiple factors internal and external to the individual as well as the health care system, such as genetics, psychology and behavior, social status, culture, economic resources, and physical environment. Some of the reasons for health disparities among immigrants include: economic disadvantage, occupation, language barriers, cultural differences, immigration status and government policies.

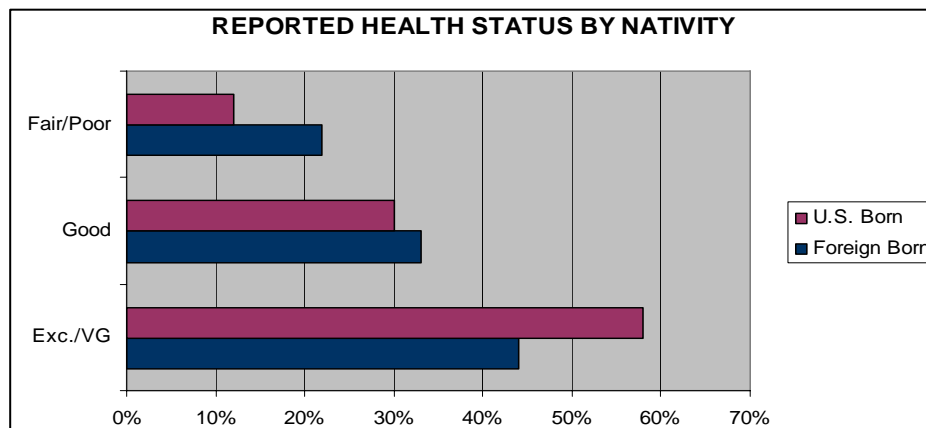
Many immigrants, particularly non-citizens, encounter the same financial barriers to care as other low-income Americans. Immigrants are also disproportionately employed in low-wage service work, where employers are less likely to provide health plans. In addition, policy changes, particularly the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, have restricted immigrant access to government-sponsored social welfare programs, such as food stamps and Medicaid.³

Fear and uncertainty about the effects of enrollment on immigration status may also deter immigrants who are eligible from seeking government-sponsored health insurance.⁴ Other impediments to health care include language and limited availability of interpreter services in medical facilities, lack of health literacy, and race/ethnic bias, both within and without of the health care system.

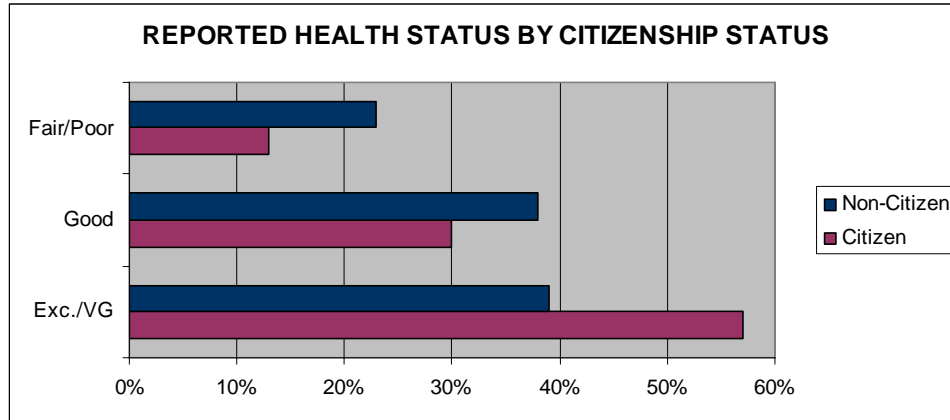
Self-Reported Health

When immigrants are asked to evaluate their health on national surveys, Asian and Hispanic immigrants tend to report poorer health status than U.S. born adults. Black immigrants tend to report better health status than U.S. born adults. Despite poorer self-reported health for some immigrant subpopulations, on a range of actual ailments, including hypertension and cardiovascular diseases, immigrant adults tend to have lower rates of morbidity than U.S. born adults.⁵ This is often referred to as the “immigrant advantage” or “healthy immigrant effect.”⁶

On Long Island, self-reported health status for immigrants matches national trends. Foreign-born respondents asked to rate their health were significantly more likely to report their health as fair/poor compared to others their age than U.S. born respondents. 22% of immigrants reported fair/poor health compared to 12% of those who were born in the U.S.



Non-citizens reported significantly poorer health status than citizens. 57% of citizens said their health was excellent/very good compared to 39% of non-citizens; 13% of citizens reported fair/poor health compared to 23% of non-citizens.



These findings suggest that there may be greater rates of morbidity, including undiagnosed medical conditions, among the foreign-born population on Long Island. On the other hand, poorer self-reported health status may reflect varying perceptions of health rather than actual or measurable differences.

Chronic Health Problems

When respondents were asked whether they were being monitored for specific health problems, including hypertension, asthma, HIV/AIDS and diabetes, foreign-born adults and U.S. born adults reported relatively similar rates. 46% of foreign-born respondents and 41% of U.S. born respondents said that they had at least one of the specific health problems mentioned. Rates for each specific health problem were also similar. For example, while 23% of U.S. born adults said that they were monitored for hypertension, 20% of foreign-born respondents said they were monitored.

While these findings suggest that immigrants on Long Island may enjoy a small “immigrant advantage” with regard to chronic health problems, it is also possible that they report fewer specific health problems because they have not yet been diagnosed.

Health Insurance

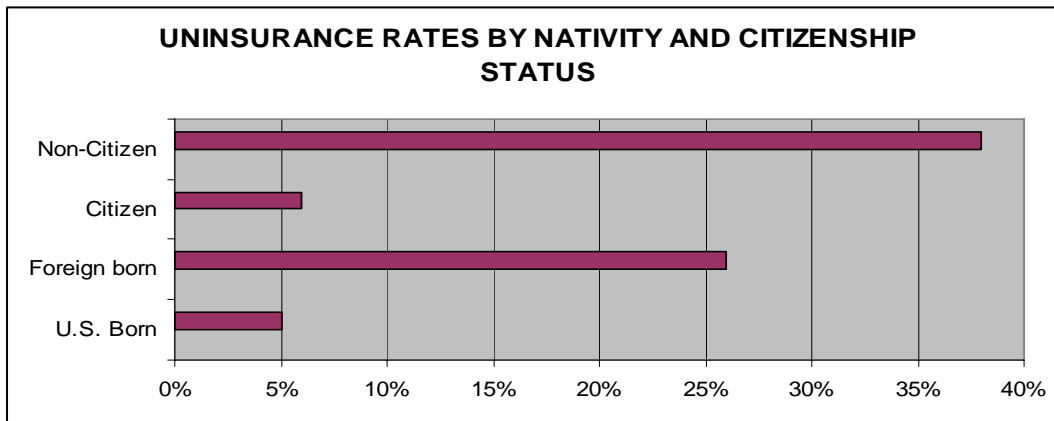
Health insurance is an important determinant of access to non-emergent primary and specialty health care. Uninsured adults are less likely to have a usual source of care or have access to primary and preventive services. The uninsured also tend to enter the health care system when they are sicker and require more acute services. As a result, uninsured adults tend to report poorer health status and poorer health outcomes.⁷

As noted previously, immigrants and non-citizens are less likely to have insurance than native-born Americans. According to the U.S. Census, in 2005, 43.6% of non-citizen immigrants were uninsured compared to 13.4% of native-born citizens. Low-income non-citizens, defined as those with household incomes 200% or less of the federal poverty line, were also more likely to lack insurance than low-income citizens.⁸

Uninsurance Rates

The LIHCS asked respondents whether they had any public or private insurance at the point-in-time they were interviewed. 92% of respondents said they had some type of insurance, making the estimated point-in-time uninsurance rate 8% for Long Island adults over age 18.

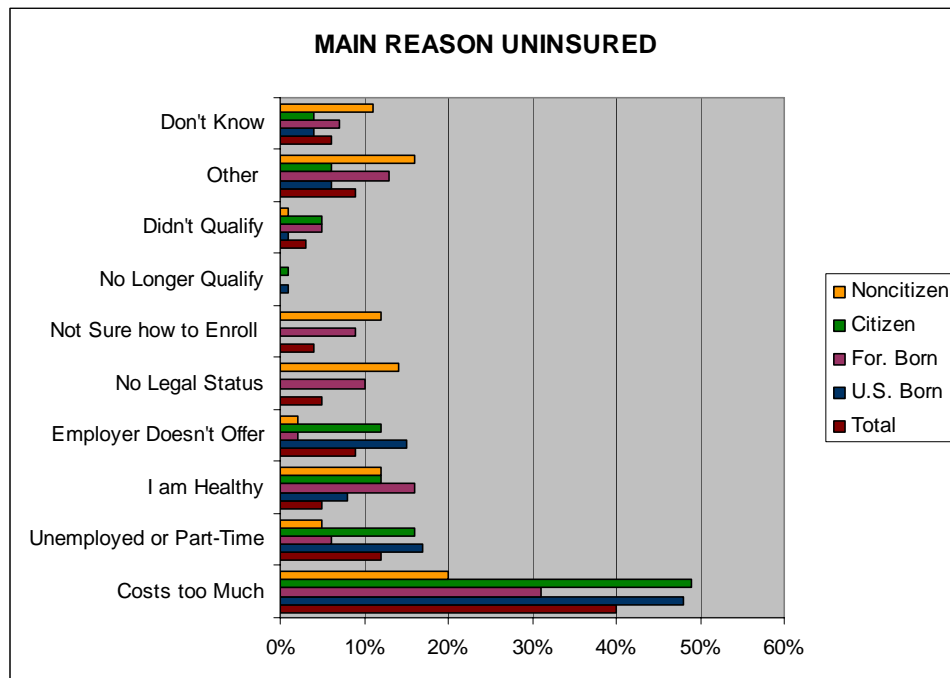
Immigrants and non-citizens had uninsurance rates more than 5 times those for U.S. born and U.S. citizen respondents. For example, 38% of non-citizens lacked health insurance coverage compared to just 6% of U.S. citizens. This is slightly lower than the 43.6% of non-citizens uninsured nationally in 2005.



Reason Why Uninsured

In an effort to understand why some Long Islanders do not have health insurance, the LIHCS asked uninsured respondents the main reason they lacked coverage. The largest proportion of adults reported that cost was the main reason they were uninsured — 40% said that they could not afford health insurance.

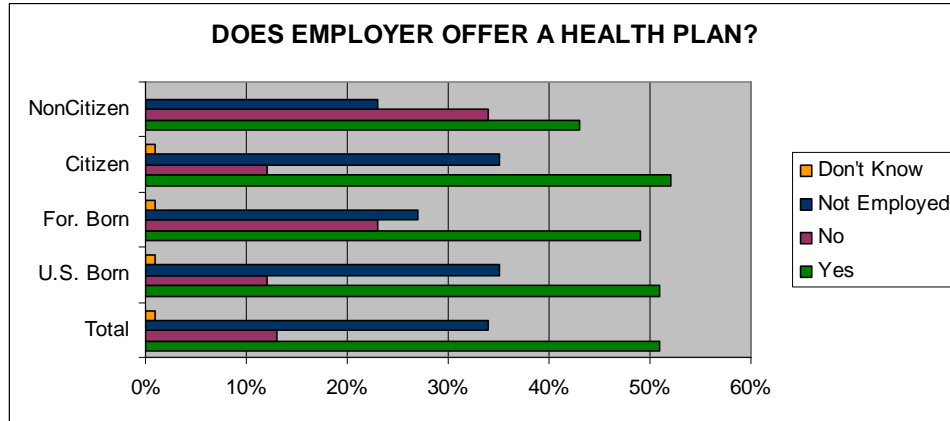
A lower percentage of uninsured immigrants than uninsured native-born Americans cited cost as the main reason for lack of insurance, although cost still received the greatest percentage of responses. While 49% of U.S. citizens said that cost was the main reason they did not have insurance, 20% of non-citizens said that cost was the main reason, a significant difference. 14% of non-citizens reported that they did not have insurance due to their legal status, the second most common answer for this subpopulation.



Employer-Sponsored Health Care Coverage

When all respondents were asked whether their employer offers a health insurance plan, 51% responded yes, 13% responded no and 34% responded that they are not currently employed (including the retired).

Not surprisingly, citizenship status and nativity were significant factors with regard to employer-offered insurance. For example, 52% of U.S. citizen respondents had an employer who offers a health care plan compared to 43% of non-citizen respondents.



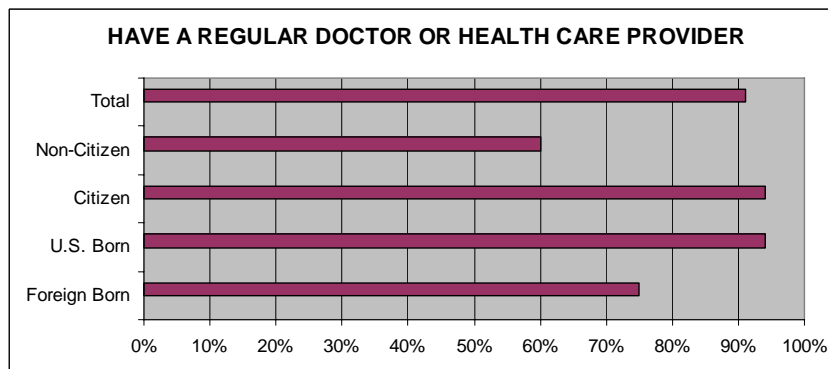
Access to Health Care

Barriers to health care exist both outside the health care system and within it, resulting in different health outcomes and quality of care. National surveys indicate that disparities between immigrants and U.S. born adults exist in such areas as regular health care visits, use of regular providers or a usual source of care, disease prevention, such as screenings and vaccinations, health procedures, recommendations, and postoperative care.⁹

Regular Provider and Usual Source of Care

The LIHCS asked all respondents whether they had a regular doctor or health care provider.

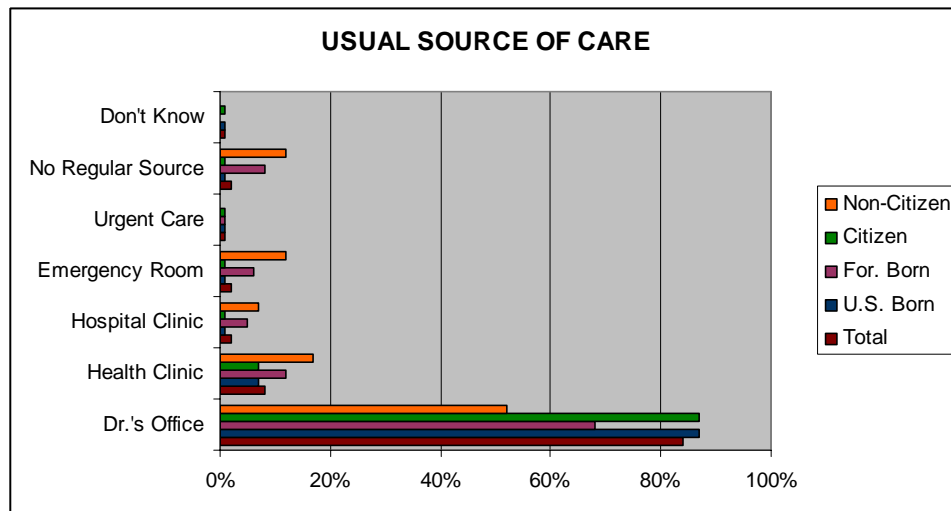
Differences by nativity and citizenship status were significant. 94% of U.S. born respondents had a regular provider compared to 75% of foreign-born respondents. Moreover, 94% of citizens compared to 60% of non-citizens had a regular health care provider.



Usual Source of Care

All respondents were asked their usual source of care when sick or in need of medical attention, regardless of whether or not they have a regular health care provider. For the total sample, 84% reported that they usually use a doctor's office, 2% reported that they usually use a hospital clinic, 2% reported that they usually use an emergency room and 8% reported that they usually use a health clinic. 2% reported no regular place of care.

Findings by nativity and country of origin differed from the results for the total and U.S. born samples. For example, only 68% of foreign-born respondents and 52% of non-citizen respondents said that they usually use a doctor's office for medical visits. Foreign-born adults were significantly more likely to report the emergency room as a usual source of care than U.S. born adults. Non-citizens were also significantly more likely to use the emergency room than U.S. citizens. 12% of non-citizen respondents and 8% of foreign-born respondents reported no usual source of care. These findings differed significantly from findings for citizens and U.S. born adults. 24% of Hispanics interviewed in Spanish reported no usual source of care. However, the finding was not significant. Zero percent of the Hispanics interviewed in English reported no usual source of care.



Quality of Care

The patient-provider relationship is a critical dynamic affecting quality of care. “Patient-centeredness” incorporates patient viewpoints in health care decision-making and stresses provider empathy, responsiveness and sensitivity to patient needs.¹⁰ Cross-culture practice or “cultural competency” emphasizes cultural awareness on the part of the provider and the health system overall.¹¹ Both patient-centeredness and cultural competency can increase trust and communication between patients and providers and improve health outcomes through better diagnosis, adherence to treatment plans, continuity of care and the prevention of new health problems.¹²

Discrimination

In order to evaluate cross-cultural sensitivity, the LIHCS asked respondents who had visited a health care provider in the past year whether they felt that the doctor or medical staff discriminated against them based on ability to pay, English proficiency, race/ethnicity, age, disability, sex, religion, and sexual orientation.

Eight percent of all respondents who had visited a health provider in the past year stated that they had experienced discrimination based on at least one of the above factors.

There were no significant findings by nativity or citizenships status with regard to discrimination based on ability to pay, sex, age, religion, disability or sexual orientation.

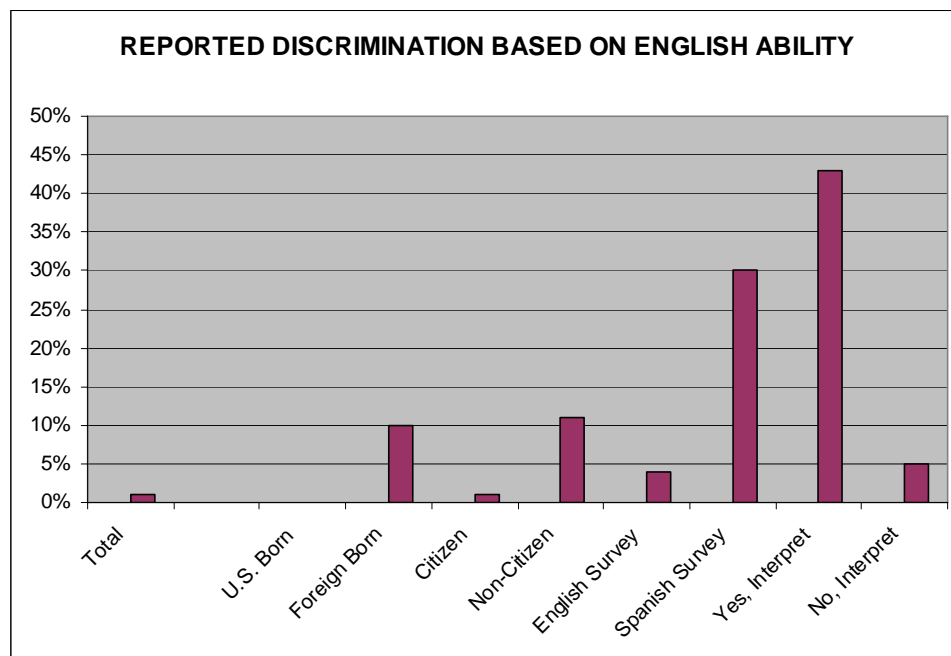
Race/Ethnic Discrimination

Foreign-born respondents were significantly more likely to report discrimination based on race/ethnicity than U.S. born respondents. 10% of foreign-born respondents reported discrimination compared to only 1% of U.S. born respondents.

English Speaking Ability

Just one percent of all those who visited a health care provider in the past year indicated that they had been discriminated against based on their English proficiency. However, 10% of foreign-born respondents reported that they had been discriminated against based on language ability compared to none of the U.S. born respondents. 11% of non-citizens reported English language ability discrimination.

Hispanics interviewed in Spanish reported significantly higher rates of discrimination than those interviewed in English (30% and 4%, respectively). In addition, 43% of individuals who used an interpreter reported language-based discrimination compared to 5% of those who did not use an interpreter.¹³

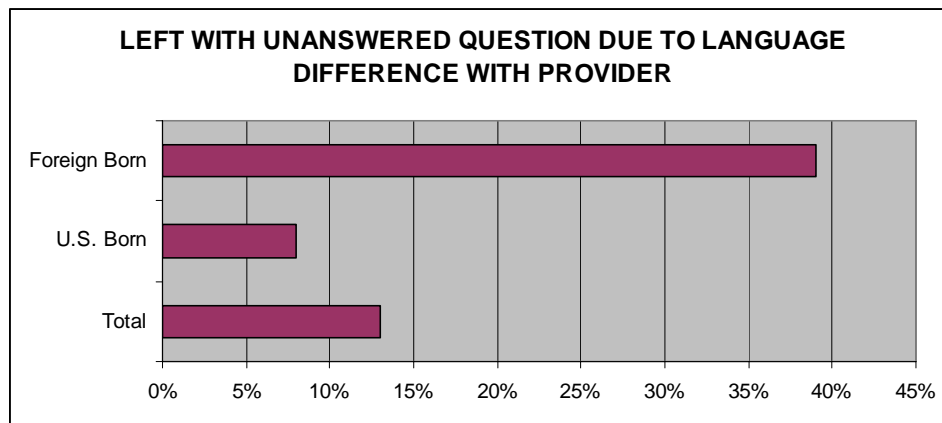


Communication and Unanswered Questions

In order to explore patient-provider communication from the perspective of patient-centeredness, the LIHCS asked respondents who had visited a provider in the past year whether they had ever left a session with their health care provider without getting questions answered. 9% said they had.

While the most common reason for unanswered questions was “insufficient time with the provider,” 13% of respondents who left with unanswered questions said that language differences were the reason.

While not statistically significant, foreign-born respondents were almost five times as likely as U.S. born respondents to cite language discordance as the reason for unanswered questions (39% and 8%, respectively).



Paying for Medical and Prescription Drug Costs

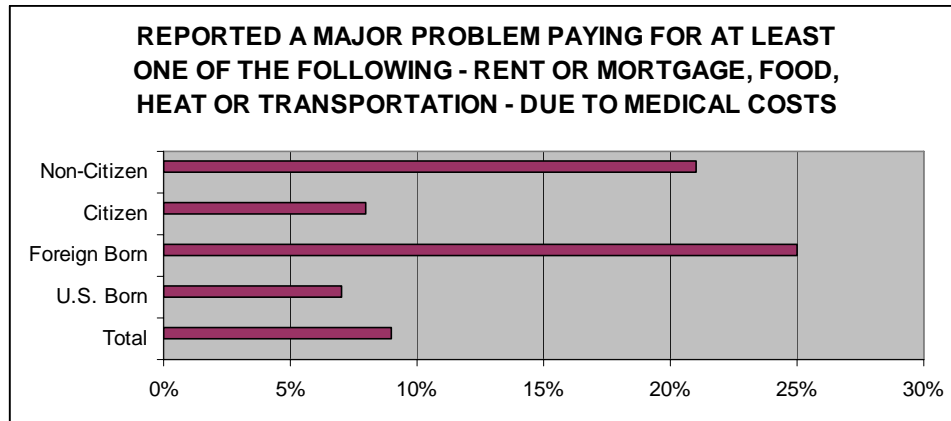
High out-of-pocket health care expenses are a significant barrier to health care. For example, research shows that housing and food insecurity are associated with poorer access to ambulatory care and higher rates of acute care. Yet, even when individuals are able to access care, medical costs may reduce the resources available to pay for other household needs. For example, studies show that the uninsured are three times more likely than the insured to have difficulty paying for basic expenses such as food, rent, heat and electricity.¹⁴

Immigrants tend to have lower household incomes than native-born Americans as well as lower rates of insurance coverage. They therefore may experience greater difficulties paying for health care out-of-pocket expenses, including prescription drugs.

With these issues in mind, the LIHCS asked all respondents who had received medical care in the past year whether paying for each of the following basic necessities – housing costs, food, heat or transportation - had been a major problem, a minor problem or not a problem at all due to medical costs and bills.

Overall, 9% said that at least one of the above had been a major problem in the past 12 months. 5% said at least one had been a minor problem.

These percentages were significantly higher for foreign-born respondents, with 25% of foreign-born respondents reporting having a major problem paying for at least one of the above household expenses compared to 7% of those born in the United States.



Difficulty Paying for Rent and Mortgage

Foreign-born respondents were significantly more likely to report that paying for their rent or mortgage had been a major problem than U.S. born respondents (15% compared to 4%, respectively). Non-citizens were also significantly more likely to have a major problem paying for their rent or mortgage than citizens.

Difficulty Paying for Food

Foreign-born respondents were significantly more likely to report that paying for their food had been a major problem than U.S. born respondents (15% compared to 6%, respectively). Non-citizens were also more likely to have a major problem paying for their rent or mortgage than citizens.

Difficulty Paying for Heat

17% of foreign-born respondents reported that paying for heat had been a major problem compared to 4% of U.S. born respondents, a significant difference. 9% of non-citizens reported that paying for heat had been a major problem.

Difficulty Paying for Transportation

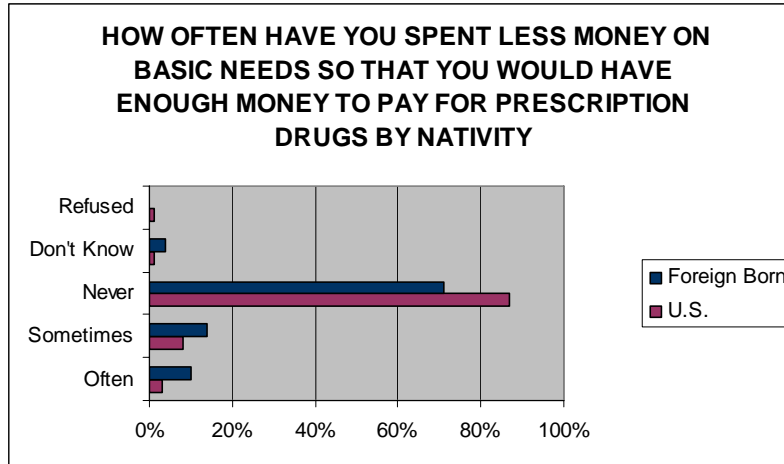
Foreign-born respondents were significantly more likely to report that paying for gas or other transportation was a major problem because of medical costs compared to U.S. born respondents (13% and 4%, respectively).

Prescription Medication

Prescription Medication and Basic Needs

In order to explore the impact of prescription drug costs, the LIHCS asked respondents a series of questions about prescription drug use and the ability to pay for basic needs due to the cost of prescription medication. Respondents who currently take prescription medication were asked how often in the past year they had spent less money on food, heat or other basic needs so that they had enough to pay for prescription medicines. Four percent reported that they had often spent less on basic needs, while 9% reported that they sometimes had, and 85% reported that they had never done so.

U.S. born respondents were significantly less likely to say that they had often or sometimes spent less money on basic needs in order to buy prescription medicines than foreign-born respondents (12% compared to 25%, respectively).



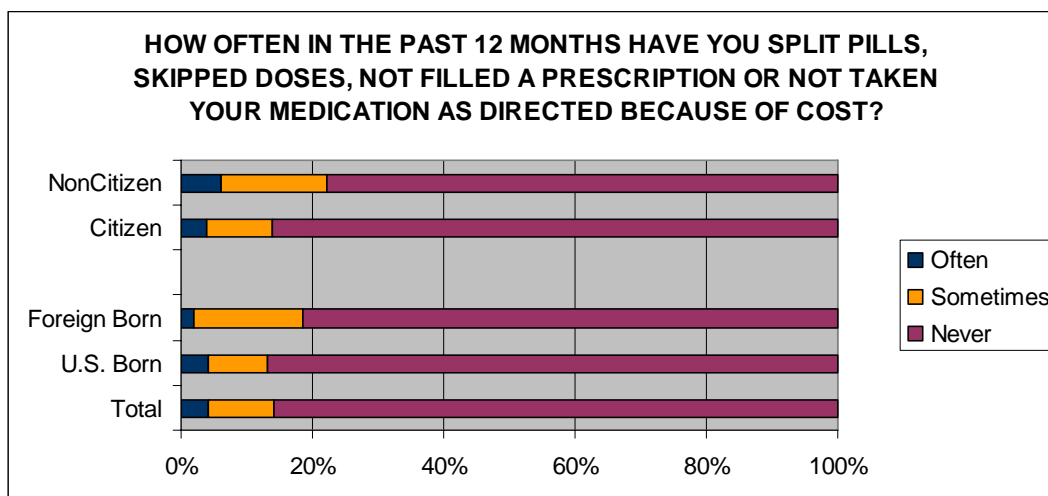
Prescription Medication and Rationing Strategies

In order to evaluate the impact of prescription drug costs further, the LIHCS asked respondents who currently take prescription medication how often they had split pills in half, skipped doses, not filled a prescription or not taken medicine as directed by a doctor due to cost during the past 12 months.

Four percent responded that they had often rationed their medication in this way. Ten percent said that they had done it sometimes, and 85% said that they had never done it.

Thirteen percent of U.S. born respondents said that they had often or sometimes rationed their medication compared to 17% of foreign-born respondents. This difference, however, was not statistically significant.

Fourteen percent of citizens reported that they had often or sometimes rationed their medication compared to 22% of non-citizens. Again, the difference was not statically significant.



CONCLUSION

For the most part, immigrants on Long Island fare only slightly better than their peers across the United States. However, on a range of health care access measures, including health insurance coverage, use of a regular provider, and patient-provider communication, foreign-born Long Islanders face greater barriers to services than U.S. born Long Islanders.

As the region’s immigrant population continues to grow, these health care issues will perhaps become even more pressing. At multiple levels and in multiple domains, enhanced strategic and policy efforts are required to meet the needs of underserved populations, specifically foreign-born and non-citizen residents. Addressing these challenges in the short term will reduce future costs and will help ensure a more equitable and successful future for all Long Islanders.

END NOTES

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