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KATHERINE FENNELLY

LISTENING TO THE EXPERTS: PROVIDER RECOMMENDATIONS ON THE HEALTH NEEDS OF IMMIGRANTS AND REFUGEES

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Editor
Maja Povrzanović Frykman
maja.frykman@imer.mah.se

Editor-in-Chief
Björn Fryklund

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LISTENING TO THE EXPERTS: PROVIDER RECOMMENDATIONS ON THE HEALTH NEEDS OF IMMIGRANTS AND REFUGEES

A growing body of literature describes what has come to be know as the 'healthy migrant' phenomenon - the fact that immigrants to the United States and Western Europe countries are often healthier than native-born residents in their new countries of residence. Over time, many immigrants lose this health advantage for reasons that are not fully understood. Data are presented from in-depth interviews with 62 health and social service providers working with immigrants in the state of Minnesota. Although the state is home to many refugees who were victims of torture or severe deprivation in their home countries, the majority of providers defined the principal needs of their clients as affordable housing, jobs and access to health services, rather than needs related to health conditions and services *per se*. The providers' open-ended comments paint a picture of the ways in which post-immigration experiences lead to tangible stresses that compromise immigrants' health and well-being.

Keywords: immigrants, refugees, barriers to access, mental health, poverty

Introduction

A growing body of literature describes what has come to be know as the 'healthy migrant' phenomenon - the fact that immigrants to the United States and Western Europe countries are often healthier than native-born residents in their new countries of residence. This advantage has been demonstrated on some health indicators and mortality comparisons between various immigrant groups and natives in Germany (Razum et al., 2000), Italy (Toma, 2001); England and Wales (Swerdlow, 1991), Sweden (Ura, 1997), Canada (Noh and Kaspar, 2003)

and the United States (Neria, 2000; Singh and Siahpush, 2001; Muennig and Fahs, 2002). While immigrants do have higher rates of some infectious diseases than native born residents, on measures of chronic conditions and mortality they are generally better off. In the United States Singh and Siahpush (2001) used data from the National Longitudinal Mortality Study (1979-1989) and found that immigrant men and women had significantly lower risks of mortality than their US-born counterparts. Muennig and Fahs (2002) compared hospital utilization and mortality rates of foreign-born and U.S.-born residents in New York and concluded that immigrants were healthier and had significantly longer life expectancies than natives. They estimated that the over-all cost of providing hospital-based care to the foreign-born residents in New York would be $611 million dollars *less* than care for an equivalent number of U.S.-born persons in 1996.

Ironically, this health advantage declines with time in the U.S.; there is a marked deterioration in some indicators of the health of immigrants after settlement, and with each successive generation (see, for example Harris, 1999; Hernandez, 1999; CAMS, 1999; Hernandez and Charney, 1998; deBruyn, 2002; LaVeist, 2002; Razum et al., 2000; Singh and Siahpush, 2001). In what Rumbaut (1997) calls the "paradox of assimilation" length of time in the U.S. is positively correlated with increases in low birthweight infants (Peak and Weeks, 2002), adolescent risk behaviors (Harris, 1999), cancer (Institute of Medicine, 2002), anxiety and depression (Finch and Vega, 2003), and general mortality (Singh and Siahpush, 2001; Muennig and Fahs, 2002).

Noh and Kaspar (2003: 25) suggest some of the mechanisms for these elevated risks:

> The more 'they' become like 'us', immigrants and immigrant children fail to maintain their initial health advantages... The process is poorly understood, but may be the result of the adoption of our poor health behaviors and life styles, leaving behind resources (social networks, cultural practices, employment in their field of training, etc.), and ways in which the settlement process wears down hardiness and resilience.

Providers who work directly with immigrants and refugees[1] represent an important group of 'key informants' to help researchers better understand how immigrants' experiences, networks and differential access to services affect their health behaviors and outcomes, yet few studies have documented provider observations. In this paper we report on provider perceptions of the needs of their clients and the social context of health in Minnesota, a state that has experienced dramatic increases in the numbers of foreign-born residents over the past decade. Data come from in-depth face-to-face interviews with a sample of

62 health and social service providers working in clinics, hospitals and mental health facilities in Minnesota. Interview topics cover detailed information on what providers perceive to be the main needs of their clients, reports from their clients of experiences with discrimination or racism, and provider recommendations regarding needed services, and how to prepare culturally competent staff.

Background and Methods

Immigrants in Minnesota

International migration reached historic levels in the United States in 2002, with 32.5 million foreign-born residents, representing 11.5% of the total population (Martin and Midgley, 2003). Both numbers and percentages of immigrants are much higher in the coastal and border states than in the Midwest. Minnesota had only 5% foreign-born in 2000, but the state has experienced rapid increases over the past decade. Between 1990 and 2000 this population increased by 138 percent, compared to a 57 percent increase nation-wide (Fennelly, 2004). Increases were particularly dramatic in the Twin Cities metropolitan area, which is home to over three quarters of the foreign-born population. By 2000 25% of the students in the Minneapolis School District and 38% of those in St. Paul came from homes in which English was not the primary language (Reinhart and Gillaspy, 2002).

Study Procedures

Data for the study come from face-to-face interviews conducted during 2002-3 with 62 health and social service providers in a variety of clinics, hospitals and neighborhood programs serving immigrants and refugees in Minnesota. Specific questions to be addressed in the analysis include the following:

1. What do providers perceive to be the principal health and social needs of their foreign-born clients, and what examples do they provide as justification?
2. How do provider rankings of needs vary between physicians and non-physicians, between foreign-born and U.S.-born providers, and between providers working with refugees, as opposed to immigrants?
3. What specific policy recommendations do providers make regarding ways to improve services for immigrants and refugees, and to help other providers become more culturally competent?

Interviewers were graduate students in a public policy class on immigrant health issues. Before scheduling interviews the students mailed letters to providers explaining the purpose of the study, and requesting an appointment with a provider who worked directly with immigrants or refugees. In exchange for the interviews respondents were offered an annotated bibliography on a topic of their choice related to immigrant health.

Sample Description

The procedures described above yielded a non-random sample of institutions, but one that included a broad cross-section of providers serving immigrants in Minnesota. Eighty-seven percent of the programs sampled were in the Minneapolis-St. Paul metropolitan area, home to the vast majority of foreign-born residents in the state (see Table I). This is precisely the percentage of Minnesota refugees (87%) who settled in the seven-county metro area between 1990 and 2000 (Minnesota Department of Health, 2000).[2]

Table 1: Characteristics of Programs Represented in the Study: Minnesota Provider Study 2002-03 (n=62)

Characteristics	**%**
Clinic/Hospital Location	
Minneapolis-St Paul Metro Area	87.1
Other Minnesota Cities	12.9
Total	100.0
Main Services Offered	
Medical	80.6
Social Services	12.9
Other*	6.5
Total	100.0

*Includes chiropractic, health education, interpreter services, legal services, and research.

Most of the providers in the study (81%) worked in programs offering health services; 13% worked in non-medical social service agencies, and an additional 7% worked in an assortment of specialized programs providing health education, language interpretation or legal services. Interview questions included characteristics of programs and providers, provider views of the main needs of their clients, and their recommendations regarding needed services, and how to prepare culturally competent staff. Open-ended responses to questions were recorded verbatim by the interviewers and coded for analysis using the NUD*ST qualitative data analysis package. Responses to structured questions were entered into Xcel and analyzed using SPSS.

Characteristics of the providers in the study are shown in Table II. About 46% of the respondents were physicians or nurses. Smaller percentages described their main functions as 'interpreter' or 'outreach worker'; this is an underestimate of the number of providers who perform these functions since, in ma-

ny small programs health and social service providers perform dual roles as patient advocates and interpreters.

Over two thirds of the providers in the study were women, and about a third were born outside of the U.S. - principally in Africa, Southeast Asia or Latin America. Most of these individuals worked in client support roles. Only two of the nurses, and none of the physicians were foreign-born.

Table 2: Characteristics of Providers Interviewed: Minnesota Provider Study 2002-03 (n=62)

Characteristics	**%**
Type of provider	
Physicians[1]	21.3
Nurses	24.6
Interpreters and Patient Advocates	8.2
Social Workers	11.5
Administrators[2]	14.8
Outreach workers	9.8
Other providers	9.8
Total	100.0
Gender	
Male	32.8
Female	67.2
Total	100.0
Provider's Place of Birth	
U.S.	62.9
Africa	19.4
SE Asia	8.1
Latin America[3]	8.1
Europe	1.5
Total	100.0
Years Worked in Program	
<5	52.6
5-9	19.3
10+	28.1
Total	100.0

1 Includes one chiropractor
2 Includes only administrators who have direct client contact
3 Includes one from Puerto Rico

There was wide variability in the number of years that providers had worked in their agencies; the mean was 6.4 years, with a standard deviation of 5.8. Over half had worked for their current institution for less than five years, while 28% had worked there for ten years or more.

Providers were asked a few questions about the characteristics of their clients (see Table III). Most programs serve both male and female clients and both adults and children. The number of programs serving predominantly African clients (37%) and Asians (24%) reflects the large numbers of refugees and their family members from these regions who have settled in Minnesota.

Table 3: Characteristics of Clients Served: Minnesota ProviderStudy 2002-03 (n=62)

Characteristics	**%**
Region of Origin[1]	
Africa	37.1
Asia	24.2
E. Europe/former Soviet	4.8
Latin America	24.2
U.S.	9.7
Total	100.0
Age Groups	
Children only	11.7
Adults only	28.3
Children and adults	60.0
Total	100.0
Gender of Clients	
Female only	76.7
Male and female	93.3
Total	100.0

1 Coded as first group mentioned in response to the question: "Where do the majority of your clients come from?"

Findings

After ascertaining the nature of the services provided by a respondent and the characteristics of the population served, interviewers asked the following question:

> We are interested in learning about health, educational, employment, housing and other needs which new immigrants may have. Thinking about these categories, what would you describe as the main needs of the clients you serve?

Responses were summarized in two ways in Table IV. We report the 'first need' mentioned in response to the question, and also record whether certain modal categories of needs were 'ever mentioned'. Equal numbers of providers mentioned housing (31%) and healthcare (31%) as the first needs of their clients. However, when we tallied categories of needs that were ever mentioned, over two thirds (69%) mentioned housing, and slightly fewer mentioned health needs or job-related needs (63% respectively).

Table 4: Categories of First Need Mentioned and Needs Ever Mentioned: Minnesota Provider Study, 2002-2003

Variables	**No.**	**%**
First Need		
Housing	19	30.6
Health care	19	30.6
Jobs/Poverty	10	16.1
Language	4	6.5
Education	3	4.8
Other	2	3.2
Transportation	1	1.6
N.R	4	6.5
Total	100.0	100.0
Ever-Mentioned[1]		
Housing	43	69.4
Jobs/Poverty	39	62.9
Healthcare	39	62.9
Education	34	54.8
Language	30	48.4
Transportation	9	14.5

1 Note that ever-mentioned responses are not additive because providers could mention more than one category.

In Table V we compare categories of needs ever mentioned by various groups of providers. The first comparison was by the provider's own place of birth. A lower percentage of foreign-born than U.S.-born providers mentioned health care needs, and a higher percentage mentioned housing needs, but none of these

Table 5: Percent of Providers Who Ever-Mentioned These Needs[1]

Characteristics of Providers	n	Housing	Health	Jobs/Poverty	Language	Education	Transp.
U.S. born	39	66	76	66	50	58	8
Foreign born	22	82	46	64	50	55	27
x^2 significance	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	
Providers Job							
MD	13	69	92	77	69	69	15
Nurse	15	67	80	47	33	47	13
Other	32	75	47	69	50	56	16
x^2 significance	n.s.	p<.01	n.s.	n.s.	n.s.	n.s.	
Majority of Clients Are[2]							
Refugees as clients	39	69	80	67	67	47	20
Latinos as clients	15	93	67	83	50	100	17
x^2 significance	p<.05	n.s.	n.s.	n.s.	n.s.	n.s.	

2 Excludes 6 providers who serve immigrants in programs with a majority of U.S.-born clients.

differences was statistically significant at $p<.05$. The second comparison on Table V is among various types of providers. The only statistically significant difference is that physicians and nurses are much more likely than non-medical providers to mention health-related needs. The last comparisons on Table V are categories of needs ever mentioned by providers serving predominantly refugee groups versus Latino immigrant clients[1]. The latter were significantly more likely to ever mention housing needs. We discuss each of these categories of needs in detail in the following sections.

Housing Needs

Myers et al. (1996) reported that over half of severely crowded households in the U.S. were inhabited by immigrants. Although inadequate housing can contribute to poor health for all low income residents, immigrants are especially vulnerable because of barriers of language, large family size and their concentration in ethnic enclaves. They are also particularly vulnerable to housing discrimination, either because they are unaware of their rights, or because they fear reprisals for reporting substandard housing conditions or exploitation.

The depth of the housing crisis in Minnesota is demonstrated by the number of providers who listed it as a primary need of their clients, and by the open-ended comments justifying their choices. A public health nurse doing public health screening for primarily African and Southeast Asian patients put it clearly:

> The main needs of immigrant clients are housing, housing, and housing. There is a lack of affordable housing in the Minneapolis area. Many of the clients live with different family members or friends for varying lengths of time. This makes tracking and treating TB especially challenging.

A social worker in an urban clinic with many Somali clients echoed these comments when asked about needs:

> Housing!!!!! It is a tragedy unfolding. There's a shortage of housing, especially in the Minneapolis area... Landlords are vultures, predators... They prey on the ill-educated and minorities. People are squeezed into apartments with bad housing conditions - substandard. Most places are uninhabitable.

A Somali social worker commented on the problems that immigrants have establishing credit histories:

> Many landlords require previous references from other landlords, which new refugees cannot provide. Many Somalis end up living in shelters for a long time.

Immigrants tend to have larger families than native-born residents because they are younger, have more children, and because they may choose to live with extended family members for economic or social reasons. This makes it particularly difficult to find affordable housing, as articulated by a Hmong translator:

> Many have large families so sometimes it can make it tough for them to get housing... all we have here are like 2 bedroom for a large family. (In the) Hmong community a whole family of like 6 or 7 (has to stay) in a two-bedroom apartment, and I can't imagine whole family living like that.

Unstable housing is linked to poor health in a variety of ways. A nurse working with African torture survivors described the link between housing problems and diet:

> Housing is most of the clients' greatest need. Many are sleeping on couches in acquaintances' living rooms. The schedule of our clients may not match the schedule of the people they are living with-particularly if there are young children in the house; meal times are also an issue. Some clients can only eat when the people they live with eat, so that could mean maybe only breakfast and supper.

A nurse practitioner working with acutely ill children from Mexico and Somalia described a relationship between over-crowded housing and infectious disease:

> Extended families are living in crowded homes. This causes more infectious diseases, and adds to the chaos of their lives. It is hard to find affordable housing. A large percentage of their income goes to housing. A lot of illness that we see is a result of this.

The lack of stable housing can produce profound anxiety that affects all aspects of life. Evans and Wells (2003) have reviewed the literature and described the links between housing and mental health. Magaña and Hovey (2003) asked Midwestern farmworkers about stresses they faced and found that 'rigid work demands and poor housing conditions' were associated with high levels of anxiety. In the present study a coordinator of a Latino clinic described this association.

> I think that housing is clearly tied to all the above needs in terms of both health and stability. Individuals with a steady place to reside have a greater sense of safety in their community compared to those who are moving from place to place or on the street. Moreover, it is easier for someone to get stable employment and tend to their health better if they have a home and are not worrying about a primary need such as a place to stay each night.

Refugees receive some governmental housing assistance when they settle in the U.S., but this is not generally true for legal immigrants. For undocumented workers the lack of legal status often makes it particularly difficult to establish credit or to rent or purchase a home, as described by this coordinator of a clinic serving Mexicans and Ecuadorians:

> I have a number of clients who have gone to shelters because they can't get housing they can afford, or they don't have a credit history, so no one will rent to them. There are a lot of undocumented people in shelters - mostly men, but some women with children too. I refer people to shelters pretty regularly, like maybe two or three times a month.

A public health nurse describes the ways in which lack of stable housing can limit access to education and health or social services:

> If children do not reside in one long-term location, going to school becomes an issue. Moving from place to place makes it more difficult to access services that may be available, such as ESL classes. Having a command of the English language is key in being able to access opportunities which may lead to a more stable life. If you don't have access to affordable housing, everything else becomes more difficult.

The shortage of affordable housing is not limited to the metropolitan area. A refugee coordinator in a rural town echoed the descriptions of the housing crisis made by providers in the Twin Cities:

> Housing is a huge need because in subsidized apartments in our community you can only get up to three bedrooms. Somali families can be very large. One family had 12 or 14 members, so they lived in two apartments... All the buildings are expensive.

Jobs and Poverty

The ability to secure and retain stable housing is, of course, directly related to poverty and employment. Poverty among immigrants is a serious problem across the United States. Sixteen percent of the foreign-born and 11% of U.S.-born residents in the United States were living below the poverty line in 2002 (Martin and Midgley, 2003). The percentage of immigrants in poverty varies greatly by national origin group and educational levels, but regardless of national origin, non-citizens are much more likely than citizens to be poor even though they are equally likely to participate in the labor force (Kaiser Commission on Medicaid and the Uninsured, 2001).

In the present study 63% of the providers in our study described immigrant needs that fell into the 'poverty and jobs' category.

> A lot of the immigrants have trouble making ends meet. That comes up in the application, because they have to list their income, and it's obvious that people with no income can't get no food. So lots of times I send them to Catholic Charities, or the food shelf. (Community health worker)

Like access to housing, poverty levels differ for immigrants of different legal statuses.

Although Minnesota has the highest Hispanic labor force participation rate in the country, many Latinos are relegated to low paying jobs that offer few or no benefits. As described by a community health worker:

> People have to work off the books because they have no papers. They get paid half the price for the same work; like this guy I know who is a roofer. No company wants him, but he's a professional.

In contrast with Latinos, most Southeast Asian, African, Russian and Eastern European individuals first came to Minnesota as refugees, or as immigrants sponsored by family members who were refugees or asylees. For these individuals government bureaucratic delays may exacerbate or even cause poverty.

> When seeking asylum one has to wait 150 days after all paper work has been processed, which in itself can take months, before they are able to look for employment. (Director of volunteer training in a metropolitan area clinic)

> When people come here, they first need help to find housing and employment. They need money so we help them to apply for general assistance. Once they are settled in they need help to get access to health care insurance until their place of employment offers them insurance coverage. This can take months and his or her family may need urgent health care. (Health educator, Vietnamese social service agency)

Unfamiliarity with a complex system can be daunting for immigrants. A Somali interpreter commented that

> Immigrants need to be trained in the process of how to get a job. Many have no idea or leads on how to go about this (...). Some immigrants don't understand their rights or responsibilities in their jobs (...). Some don't understand too that just filling out paperwork does not guarantee them a job. (...) Some immigrant employees don't know that they're qualified for things like health insurance.

Cuts in government benefits to immigrants as part of Welfare Reform in Minnesota has deepened the economic crisis for many, and a number of providers commented on this problem. A physician working with Hmong clients said:

> Most of my Hmong patients receive government financial assistance. Most are not working. Most have medical assistance or prepaid medical assistance. Financial needs are huge. Now the government is cutting back. No work, no job skills, no language skills, many mental health issues such as depression and PTSD (post traumatic stress disorder).

Physical Health Needs

Almost a third of the providers we interviewed mentioned health-related needs of their clients. Since the sample was made up of health and social service providers, they might have been expected them to list specific medical needs as high priorities, but only 4 (7%) mentioned physical health conditions or treatment as their clients' first needs, and 20% ever mentioned physical health needs. One example comes from a family physician:

> There are a number of acute and chronic conditions that need to be addressed and this is our first responsibility as a medical clinic. People may have old injuries, undiagnosed hypertension, diabetes etc.

Some of the few providers who mentioned physical health needs described conditions that first emerged in the United States or were aggravated by residence here. These include adolescent risk behaviors, or mental health problems that are exacerbated by stresses associated with poverty. Acculturation to an unhealthy American diet is also implicated in increased incidences of some health conditions such as obesity, diabetes and cancer (Li and Pawlish, 1998). Fismah et al. (1999) found that Latino migrant children were less likely to eat junk food or to skip meals than their non-migrant peers, but that over time these differences disappeared. A health educator underscored some of these problems:

> Junk food consumption is a big problem, too. Many Hmong parents believe American food is healthy food; one dad even fed his toddler a bag of Oreos each day. (Somali physician working as health educator)

This same provider commented on an increase in risk behaviors among Somali youth:

> We have many youth here who need to find the right direction. In Somalia we do not have drugs and alcohol problems. Of course we have smoking, but we do not have these other problems. Here they are faced with new problems and we need to

> find a way to help youth to succeed so they can have good lives here.

Stress and Mental Health Needs

More typical of the general sample of providers was an emphasis on stress related to emigration and integration into a new country as noted in the following responses by a Vietnamese social worker and an American physician:

> Health care is important but is lower priority when the families have more urgent matters to be concerned about. (Social worker)

> I find Somalis to be physically healthy people. Instead, a great deal of the emotional stresses expressed by patients are concerning finances, safety, and navigating the systems here in Minnesota. (Physician)

This importance of mental health needs was underscored by providers working with immigrants from all regions, but especially by providers serving refugees. Refugees' exposure to deprivation and violence from forced migration can lead to both physical and mental health problems (Palinkas et al., 2003). In spite of this, many refugee health programs do not do routine screening. Vergara et al. (2003) surveyed nine large metropolitan refugee health programs across the U.S. and found that only a third performed mental status examinations, although over two thirds offered some mental health services. A mental health provider in the present study noted the importance of screening:

> Looking through the lens of mental health, for all the refugees the primary problem is post-traumatic stress disorder. Depression is very common.

For immigrants and refugees alike, mental health problems are aggravated by the stresses of poverty and adaptation to an unfamiliar society.

> Depression is becoming a problem in the Vietnamese communities. For men, they are depressed because of job loss and language barrier. Women are depressed because of family problems, children becoming too Americanized, and not having enough time with the family because they have to work long hours. (Vietnamese social worker)

The stigma of acknowledging mental health problems can pose a significant barrier to help-seeking.

> Psychosomatic complaints are a huge issue in working with Russians, as mental health problems are not accepted well. (Somali nurse)

> With Somalis there is a large stigma against mental health. There is also no word in the language that can accurately describe the disease. Most Somali's will attribute many of their problems solely to physical things rather than mental or emotional issues. (Somali bilingual aide)

> Many of the patients I see have a hard time with depression. They do not understand what depression is; they think that they are just not eating or not sleeping. (Laotian interpreter)

Barriers to Access

Most of the 63% of providers who ever mentioned what we categorized as 'health-related needs' described *barriers* to access caused or exacerbated by welfare reform restrictions on eligibility and lack of health insurance. In a review of barriers to immigrant access to health care Riedel (1998) notes that this is a problem facing all vulnerable populations in the United States, and one which health policy makers, administrators and consumers have decried for over thirty years. However, the problems are particularly acute for the foreign-born. Kaiser Commission on Medicaid and the Uninsured, 2001 (2001) reports that in 1999 "of the 9.8 million low-income non-citizens, almost 59% had no health insurance in 1999 and only 15 percent received Medicaid" (compared with 30 percent uninsured low-income citizens and 28% with Medicaid.

Low levels of insurance coverage for immigrants are the result of two factors. First, although foreign-born residents have high rates of labor force participation, they are over-represented in jobs that do not provide health insurance. Minnesota can boast of the highest Latino labor force participation rate in the nation (McMurray, 2002), yet a many of these workers are in low-wage jobs that do not offer benefits. Both in Minnesota and nationally the Hispanic uninsured rate is the highest of any racial or ethnic group (Minnesota Department of Health, 2003; Institute of Medicine, 2002).

Secondly, federal and state legislative changes tied to Welfare Reform have resulted in severe restrictions on immigrant eligibility for Medicaid and other benefits Restrictions are most severe for undocumented immigrants - largely Latinos (Fix and Passell, 2002). In our study a clinic manager and a public health nurse working with Latinos describe this problem:

> The Spanish population we work with is an excellent example of the need for health insurance. They work, but have no health benefits with the job... Some Hispanic roofers might have very risky, accident-prone jobs, but lack health insurance. (Clinic manager)

> There are also special needs for undocumented immigrants. These individuals may

> be more reluctant to access health care, especially when they really need it, for fear of being deported. (Public health nurse)

Other Needs

Forty-eight percent of providers mentioned language-related needs, and over half (55%) mentioned needs that were classified as 'education'. A lack of formal education and difficulty speaking English both contribute to isolation and pose barriers to receipt of health and social services. Limited English proficiency is a problem for both immigrants and refugees:

> We see a lot of adults who are isolated and don't speak English. This is a huge social barrier because the family is gone during the day (kids at school, some people working) and they are alone at home. Having an opportunity to learn English would help them navigate their way around (at least take a bus to a community center or store) and give them opportunities for work or socialization outside of the house. (Family physician and clinic administrator)

Educational needs vary greatly across immigrant groups. Some Latinos and many Hmong have low levels of completed schooling, while for many Somalis and some Asian and Eastern European immigrants more common 'educational needs' are related to training and opportunities to utilize high levels of education and training obtained before emigration. A community health worker in a Latino clinic describes the former situation:

> In a lot of cases... people didn't finish school in their native country, so they can't even read Spanish. They don't have a signature. They print their name in these big blocky letters. So it's hard for them to cope with all these confusing forms and rude people to get what they need. (Community health worker)

Provider Recommendations

Given the panoply of needs described by providers, what policy recommendations would they make? We asked *"If you were making recommendations to the Governor or the legislature about better serving immigrants and the communities in which they live, what would you suggest?* Several respondents mentioned the need for broad changes in attitudes toward immigrants, such as one provider who suggested that the Governor and legislature "recognize that immigrants can contribute to the wealth of this nation and do not have to burden society". Most other provider recommendations fell into four broad categories: policy changes to increase eligibility and access; help negotiating the healthcare system; recommendations for educating immigrants; and recommendations for educating providers. Although affordable housing was the most frequently

mentioned need in the interviews, few providers made specific recommendations related to housing. This may be because the problem seemed too intractable, or because it lay outside their areas of expertise. Other recommendations are summarized below.

1. Policy changes to increase eligibility and access

A number of providers recommended changes in federal immigration policy and removal of the limits on benefits to all categories of immigrants. Typical was the comment by a physician in an urban community clinic:

> I think we should provide a basic health care safety net for all immigrants. We need to do this for a number of reasons. There are public health concerns, especially around infectious diseases. Many immigrants are coming here with active TB. We should improve health screening in refugee health clinics, which is, from my experience, quite poor in some cases. (MD community clinic)

Other providers recommended improving coordination of health care and sharing of information. Some of these comments had to do with better communication of federal information about refugee resettlement to allow communities to prepare for new arrivals. Others had to do with sharing of information benefits across state borders, such as the recommendation below regarding Medicaid portability for migrant farmworkers:

> Medicaid portability—this means that, once a migrant farmworker has applied and been approved for Medicaid, this coverage can be carried with the worker into another state. The problem right now is that state-run Medicaid programs only cover people within that state. Since migrant farmworkers often move from state to state during the agricultural season, they may be covered by one state but have to repeat the application process for another state. This, along with the 40-day minimum wait period, causes a problem in their access for care. (Outreach coordinator, Migrant clinic)

In the most recent wave of interviews several providers mentioned the hardship caused to their patients by recent required co-payments for services. Minnesota statute requires co-payments for many medical services under Medical Assistance, the jointly-funded state and federal program that provides medical care for low-income persons (Minnesota Department of Health, 2003).

When asked for recommendations one patient advocate said:

> Look at the issues of co-pays. The actions that have been taken may have adverse outcomes (for example heart attacks because of failure to be able to afford preventative meds). Co-pays add up quickly...and they will keep people away.

2. Help negotiating the healthcare system

Many providers spoke of the need to help foreign-born clients understand and negotiate an unfamiliar system. A Somali health advocate put it succinctly:

> It is a different system in Somalia. Health and Education is free there. Well, it used to be - now it is anarchy since the civil war. But before that, everyone had access. When you feel sick you go to the doctor and take a number and you sit and wait and then you see the doctor and you go home. There were no appointments. They also have difficulty understanding the concept of insurance. They don't understand why, if you have insurance, you can't go to any doctor... Here it takes awhile to get an appointment and they forget. So the clinic here started a walk-in clinic so these people can walk-in when they need to, just like at home, but this is only for emergencies.

A number of providers acknowledged the central role of interpreters in helping clients understand and utilize health and social service systems. Although the U.S. Department of Health and Human Services requires agencies receiving federal funds to provide assistance to clients with limited English proficiency, these policies are unevenly implemented (Kaiser Commission on Medicaid and the Uninsured, 2001, 2001). Minnesota provider recommendations varied from suggestions that medical facilities hire their own interpreters to calls for improved training and standards for interpreters.

3. Educating immigrants

Some providers focused less upon alterations in existing systems and more on the need to help immigrants learn and adapt. Several mentioned problems related to client unfamiliarity with insurance and with scheduling and appointment systems. A Somali nurse serving refugees from many countries mentioned differences in expectations regarding patient-provider relations:

> Our new Russian immigrant clients need education on how the US health care system operates. They are used to a very paternalistic system where decisions are made by the physicians. Here we expect them to be active consumers and this is a new role.

Many other providers mentioned the need for formal education and English language training for immigrants.

3.1 Educating providers

Like their clients, providers need training and advice on a number of issues if they are to work effectively in cross-cultural settings. Changes in state and federal laws regarding immigrant eligibility for services are complex and sometimes

poorly understood by providers. In addition, providers working with immigrants need education regarding client backgrounds, needs and expectations. In many settings foreign-born co-workers can serve as effective tutors, as noted by this Somali patient advocate:

> Sometimes doctors need advice on how to treat their Somali patients. They want to know more about our culture so I teach them.

Some respondents emphasized the need for more bi-lingual, bi-cultural providers; others emphasized specific training needed to improve cultural competence. A physician in a non-profit community clinic said:

> I think providers need to know more about the traditions of the clients they are serving, as well as how those clients are used to interacting with medical providers...They need to learn about the culture and the role of physicians in their clients' traditions.

A physical therapist added:

> They need education on cultural values, especially perceptions of the body and illness. Respect for different body language and modesty from different cultures should also be learned. They should also practice working through interpreters and (receive) education on how to be respectful around people who don't speak your language.

Table 6: Skills Needed by Providers to Work Effectively with Immigrants

Skills	No.	%
Cultural Competence	38	67.8
Flexibility and patience	5	8.9
Language skills	7	12.5
Motivation and good attitude	3	5.4
Other	3	5.4
Total	56	100.0

We asked providers '*What skills or knowledge do service providers and educators need to work effectively with immigrants?*' Interestingly, many providers emphasized *attitudes* over cognitive abilities when responding to the question. Typical responses mentioned the need for flexibility, good communication skills and a desire to work with immigrants.

> Number 1: listening, number 2: listening, and number 3: listening. Learning their stories, knowing what makes them function, what touches their hearts and soul is important in order to help them...Caring is also a big skill. People sense caring and it is therapeutic in itself. If your heart as a provider is not in it, people will pick up on it. (MD in a clinic serving African refugees)

A patient advocate gave a response that incorporated many of the views of other providers:

> You should be trustworthy, you need to have a solid understanding of the conditions asylees and refugees come from and what they deal with here, you need to be able to keep your word, confidentiality is also important, you should never assume anything, you need to meet the people where they are at and move from there, you have to be prepared to hear anything, you have to be creative and flexible, you have to know how to empower people – you have to teach people how to take control again, you also have to have a good knowledge of community resources so you know where you can refer your clients.

Conclusion

Immigrants in Minnesota and the providers who serve them have some unique characteristics. Because the state has a large proportion of immigrants who are refugees, practitioners are more likely than their counterparts in many other parts of the U.S. to have clients from Africa, Southeast Asia, Eastern Europe and the former Soviet states. One might speculate therefore that Minnesota providers who serve refugees and their families would be particularly likely to identify a need for physical and mental health services because they are working with individuals who have suffered severe deprivation and forced migration. However, in the present study providers cited *barriers to access,* poverty and the

Table 7: Recommendations to the Governor

First Recommendation	No.	%
Affordable housing	7	13.0
Funding for social programs and jobs	8	14.8
Improve access to health care	12	22.2
Immigration reform	6	11.1
Education for providers	4	7.4
Community education and outreach	9	16.7
Translation and interpretation services	4	7.4
Other	4	7.4
Total	54	100.0

lack of affordable housing much more frequently than health conditions *per se*.[3] Even providers treating individuals with such severe conditions as tuberculosis, acute childhood illnesses and the sequellae of torture ranked 'housing', poverty and barriers to access above the physical health needs of their clients. Their comments demonstrate the extent to which post-migration conditions affect the well-being of immigrants. Many of the conditions they describe are affected by government policies and programs related to welfare, health insurance, language training and investments in affordable housing.

The notion that poverty impedes access to care and affects health status is not new. There is a substantial and growing literature demonstrating the extent to which poor Americans have reduced access to care and poor health outcomes. However, for immigrants the effects of poverty are compounded by discriminatory legislation mandating reductions and denial of access even for many legal immigrants. Across the United States there have been major reductions in legal immigrants' use of social and health benefit programs since the enactment of the PRWORA welfare reform legislation in 1996 (Fix and Passel, 2002). These declines coincide with increases in poverty among the children of immigrants, many of whom were born in the United States (Van Hook, 2003). Minnesota has historically had more generous welfare benefits than many other states, but this has changed in recent years. On an 8-point scale developed by the Urban Institute scale to rate the generosity of state Medicaid eligibility rules, the Minnesota rating was 4 (Tumlin et al., 1999). At the national level poor *citizens* in the U.S. are twice as likely as poor *non-citizens* to have health insurance (Capps, Ku and Fix, 2002). Recognizing this, a large number of providers in our study called for changes in federal and state policies regarding welfare and health benefits for immigrants.

Some anti-immigrant organizations try to depict immigrants as individuals who over-utilize health services and subject native-born residents to the risks of disease. Yet, on many measures contemporary immigrants enter the US in better health than US-born residents. Ironically, as described by the providers in the present study *post-immigration* experiences lead to tangible stresses that compromise their health and well-being. The policy implications of this are that, rather than reducing health and social benefits for immigrants, state and federal legislators would be wise to improve access to services in order to maintain immigrants' health advantages. To do otherwise will prove far more costly in the long run.

NOTES

1 To avoid convoluted language in this paper we use the term 'immigrant' as a generic term that includes foreign-born residents regardless of visa status. The exceptions are sections where we are making a purposeful distinction between the needs of refugees and immigrants. The latter is complicated by the fact that groups who first entered as refugees (e.g. Russians or Hmong) also include large numbers of family members who entered the US with immigrant visas, as well as U.S.-born children.

2 Spanish speakers, who are largely immigrants, are more dispersed across Minnesota, with only 60% residing in the metro area.

3 In a comparison among providers within the study providers who saw a majority of immigrants were more likely than providers with a majority of refugee clients to mention health-related needs than housing, but even among the former group health needs were frequently *access* needs, and 69% described housing needs.

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ABOUT THE AUTHOR

Katherine Fennelly is Professor of Public Affairs at Hubert H. Humphrey Institute of Public Affairs, University of Minnesota. She is a demographer and public health researcher with an interest in immigration. Her research and outreach interests include leadership in the public sector, the human rights of immigrants and refugees in the United States, and the preparedness of communities and public institutions to adapt to demographic changes. Recent projects and publications focus on the integration of immigrants in rural, Midwestern communities in the United States.

Examples include: ”Policy Recommendations for Communities with New Immigrants” (2000), in *Just in Time Research*, University of Minnesota; ”How the Food Processing Industry is Diversifying Rural Minnesota” (with H. Leitner, 2002), *JSRI Working Paper #59*; ”English Language Proficiency of Immigrants and Refugees in the Twin Cities Metropolitan Area (with N. Palasz, *2003*), *International Migration* 41(*5*); ”New Immigrant Communities in Minnesota” (2004), in *New Immigrant Communities: Addressing Integration Challenges After September 11*, Lexington Books.

Katherine Fennelly was Guest Professor in memory of Willy Brandt at IMER in Autumn term 2003.

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