**AN ANALYSIS OF IMMIGRANT HEALTH RESOURCES IN THE UNITED STATES**

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**ABSTRACT**

Throughout the ever-changing history of immigrants in the US, one thing has been common—the lack of health resources and structure to provide access to healthcare for immigrants. Recently, there have been some efforts to provide for immigrants’ needs, such as interpreter services and clinics for immigrant farmers; however, these programs have several shortfalls and do not resolve the issue. The illusion of services and lack of support can end up harming immigrants even further by eroding trust and diverting public attention away from immigrants’ health care needs. Some barriers to health among immigrants include: time and cost, language barrier, discrimination, cultural differences, lack of trust in healthcare providers and local authorities, and location and access. Immigrant health status also varies by age, education, gender, socioeconomic status, acculturation, legal status, and residing community.

**Introduction**

 There are two categories for people who reside but were not born in the United States: refugees and immigrants. Immigrants are those who choose to move to another country, whatever their reason may be, to improve their lives. Refugees are those who are fleeing their countries because of persecution or armed conflicts and are protected under the International Humanitarian Law (UNHCR, 2016). Refugees often times have different legal rights and resources available to them, including a resettlement agency to guide them. Immigrants are not guaranteed this security and right. Immigration standards tend to be stricter for non-refugee immigrants (Nelson, 1997). Immigration restrictions date back to 1875, and despite a few changes throughout history, many of those restrictions still stand today (Cohn, 2015). In the 1970s-1990s, congress passed laws focusing on refugees’ entrance and protection (Cohn, 2015). This made the immigration process easier for refugees than traditional immigrants. For the purpose of this paper, we will focus on the needs and barriers of immigrants—both undocumented and documented.

Most recently, the political climate created a hostile environment towards immigrants. Throughout the ever-changing history of immigrants in the United States, one thing has remained common— the lack of health resources and structure to provide access to healthcare for immigrants. Recently, there have been efforts to provide for immigrants needs, such as interpreter services and clinics for immigrant farmers; however, these programs have several shortfalls and do not resolve the issue. This illusion of services and lack of support can end up harming the immigrants even more by eroding trust and diverting attention away from public needs. This paper will examine the issues around immigrant health and the resources available to immigrants through primary and secondary data sets and literature reviews. It will explain the shortfalls of the current system by identifying the illusion and absence of health resources provided to the immigrant population. This paper will also present recommendations for addressing this public health problem.

**Immigrant Health Status Changes**

 Research supports that immigrants at the first entry are actually healthier than native born U.S. citizens (Taylor & Sarathchadra, 2016). Studies have reported this as an immigrant health advantage or healthy immigrant paradox. This advantage may be due to migrant selectivity and cultural buffering (Taylor & Sarathchadra, 2016). Cultural buffering is a concept that explains the effects of origin country cultural factors on different health behaviors that often times lead to a healthier lifestyle compared to native born (Taylor & Sarathchandra, 2016). Migrant selectivity is explained by how healthy immigrants are selected at the point of entry through required health screenings.

However, studies also support that despite immigrants having healthier status at the point of entry, their health declines over the time of residing within the United States. Epidemiological data provide evidence that the good health status of immigrants declines after arrival due to stress and new lifestyle factors. The stress and change in lifestyle increase risk of cardiovascular disorders, diabetes, and asthmas (Hemminki, 2014). Living in the United States exposes immigrants to high calorie and low nutritional value foods at low prices which can have a nutritional impact on newly arrived immigrants (Venters, 2011). Acculturation is defined as the process of an individual acquiring the behavior, attitude, and value of American society (Viruell-Fuentes, 2012). There is a significant correlation between the length of acculturation and decline in an immigrant's health.

**Mental Health and Physical Problems Faced by Immigrants**

 Stress is one of the major factors that may lead to the declining health of an immigrant. It builds up as the acculturation process matures (Acevedo-Garcia, Sanchez, Vaznaugh, et al., 2012). Over time, stress can lead to several negative physical and mental health conditions.Stress symptoms can include headaches, insomnia, muscle pain, anxiety (Mayo Clinic, 2016). Some mental health problems that African immigrants were facing were found to be directly related to their experience transitioning to the United States, including life-threatening water crossings from Northern Africa to Europe (Venters, 2011). Some other immigrants also experienced depressive symptoms and dissociative symptoms in the result of their journey (Venters, 2011). Some of these stress factors include occupational and economic instability upon arrival, cultural and social marginalization, family estrangement, the pressure to provide economically to family members back in their country of origin, and lack of documentation (Hemminki, 2014). Social position, level of socioeconomic status, and social inequality also accounted for stress factors (John, 2012). Cultural factors can also lead to stress, as it may lead to the immigrant feeling marginalized. For example, African women immigrants who experienced female circumcision reported feeling isolation and shame in the host country (Venters, 2011). These stressors can lead to depression and anxiety with lack of personal empowerment and advocacy (Kacker, Chu, Leung, et al., 2011). In addition, immigration status determines rights, benefits, resources, and even fear and mistrust with authorities (Yang & Hwang, 2016). This could lead to negative mental health outcomes and negative physical health outcomes due to lack of resources when in need.

 In another study, 22% of immigrants aged 30 to 79 were diagnosed with high blood pressure (Ng, 2015). As previous mentioned, immigrants are more at risk of developing mental health disorders, such as depression and anxiety due to the high-stress environment. Part of the physical and mental health concerns are related to social support and access to prevention. Many of the physical health disorders reported by immigrants are diseases that can be managed, especially with preventative care. However, immigrants are less likely to have a regular primary care provider or health care facility (Yang & Hwang, 2016). It is most likely that immigrants will seek care only when their health is urgent rather than investing in preventative care measures. Urgent immediate health care needs typically utilize emergency room care, which is costlier (Brown, Wilson, &Angel, 2015).

 The community in which immigrants reside in and its level of social support also has a direct impact on the immigrant’s health. Living in an area with large number of immigrants from the same origin of country that speak the same language can provide additional resources and information influencing the labor market and healthcare market (Chiswick, Lee, & Miller, 2008). Social support and the resources that it provides from marriage, family, or even the community can act as a buffer for negative effects on mental health (John, 2012). Studies have found that immigrants who are married have higher health statuses than those who are not which indicates social support influence (Chiswick, Lee, & Miller, 2008). In addition, having children may also impact overall health as children could transmit more health problems from the host population while acting as another source of contact to the host community. However, children’s health may also increase the amount of contact that parents have with the host country’s healthcare system, increasing the resources that are available to them (Chiswick, Lee, & Miller, 2008). Immigrants often participate in social activities which encourages collaboration and emotional support to positively impact health against the anti-immigrant sentiments and discrimination that is often faced (Acevedo-Garcia, Sachez- Vaznaugh, et al., 2012). However, this level of support would change depending on how many immigrants reside in a given community. This means that the level of support for an immigrant will differ depending if the immigrant resided in a rural or city community. The social support of immigrants in their country of origin could also play a role in their health status. Immigrants commonly use their connections in their home country to find free or less expensive medical resources resulting in a lower dependence in their host country’s resources (Yang & Hwang, 2016). This particular social connection could serve as another source of health care, but also serves as a barrier to the utilization of the United States health care system and may impact a delay in services that are needed.

**Barriers to Health Among Immigrants**

 In addition to factors that impact immigrants ‘physical and mental health directly, there are barriers to health that can negatively impact health outcomes. In a World Values Survey of 108, 071 individuals from 32 countries, ten of the 32 countries reported as immigrants having poorer self-assessed health indicating that immigrants are seen to have poorer health (Novemer & Lee, 2013). Perceived susceptibility to disease, perceived severity of illness, perceived benefits of taking action and perceived barriers to taking action all influence factors on preventative healthcare (Yang & Hwang, 2016). This means that having poorer perceived health influences the access immigrants have to preventative care. Self-rated health are strong predictors of whether or not the immigrant would seek care and use medication or other health resources and services (Yang & Hwang, 2016). In addition, other literatures state limited healthcare resources specific for immigrants, lack of insurance, poor interpretation services, non-citizenship status, discrimination, cultural differences in healthcare settings, and access are some other commonly reported barriers to health services among immigrants (Sangaramoorthy, 2017).

***Time and Cost***

Many immigrants, especially those who are undocumented are required to work 40+ hours a week, which limits their time for other activities. Undocumented immigrants typically work two or more jobs at minimum or less than minimum wage (Edberg, Clearly, et al., 2015). This means that immigrants, especially those who are undocumented, must work more hours to achieve the same financial gains as those who are native born. Income among immigrants are more likely to fluctuate in the first years of arrival (Acevedo-Garcia, Sanchez-Vaznaugh, et al., 2012). The economic status of immigrants often times fluctuate and change during the first few years of arrival. Therefore, even if they arrive at a high socio-economic status, there is a high probability that their status may change once they arrive in the United States. Generally new immigrants tend to find employment in low-paying blue-collar jobs that require little skill. (Yang & Hwang, 2016). African immigrants avoided medical care in fear of acquiring debt which may threaten future immigration proceedings (Venters, 2011). Most undocumented immigrants expressed that the high costs of healthcare were more of a barrier in accessing care than the fear of authorities (Sangaramoorthy, 2017).

***Language Barrier***

 In addition to financial barriers, language is another common barrier to healthcare for immigrants. Grossman Health Production Model explains that language skills play a two-fold role in affecting health acquisition as well as access to factors that affect health, such as employment and social integration (Clarke, 2016). Being able to speak English means an immigrant would have greater ability to interact with the healthcare system, communicate with providers, and access public information needed to maintain a healthy status (Clarke, 2016). Language is seen to have a similar impact on health status as health education (Clarke, 2016). This shows the impact English proficiency has on immigrants to their health outcomes. English proficiency, however, does not guarantee the same level of access to healthcare services. An immigrant may have the basic English-speaking capabilities to live in the United States, however, they may not have the language capability to fully understand and communicate health needs within the U.S. healthcare system, especially given its complexity. Not only does language affect ability to communicate with healthcare providers, it affects accessing health services and obtaining insurance (John, 2012). Speaking fair or poor English was strongly associated with self-reported depression, lack of social support, discrimination, and stress (John, 2012). Language and communication barriers also contribute to improper use of healthcare among immigrant populations, which affects the effectiveness of care provided (Tsai and lee, 2015). Language affects facilitation in understanding instructions for home care such as medications for effective health treatment (Chiswick, Lee, & Miller, 2008).

***Discrimination***

 Discrimination in and out of the healthcare setting is another barrier to health services faced by immigrants in the United States. Discrimination can affect health directly and indirectly. Structural barriers and racism may block socioeconomic mobility and integration of immigrants (John, 2012). Specific immigrant groups (e.g.,Asians) are seen as model minority with assumed high socioeconomic status. Yet, they still experience racial income inequity and occupational discrimination, also known as the glass ceiling that blocks upward mobility (John, 2012). These discriminations as well as barriers in development may potentially limit access to life opportunities and negatively impact health outcomes due to added stress (Viruell-Fuentes, 2012). Immigrants-- especially those who work in predominantly white settings—may experience isolation and marginalization with lack of workplace support which hinders integration into the United States and often times lead to psychosocial stress (John, 2012). Research suggests that the label “immigrant” triggers national anxiety due to recent politic climate which has created a hostile environment for immigrants (Park, 2011). The anti-immigrant policies and sentiments in the last two decades may be at fault in this national anxiety and increase in discrimination (Viruell-Fuentes, 2012). Once again, the perceived discrimination is associated with lower physical and mental health, along with poor access to quality health services (Viruell-Fuentes, 2012). The association between discrimination and decline in health actually increases as the length of time that an immigrant is in the United States increases. Therefore, the effects of discrimination on health is stronger for immigrants who have resided in the United States longer than the recent immigrant population (Viruell-Fuentes, 2012). Historically, immigrants have gone through a “racial formation project” to identify as a White individual to gain citizenship status and assimilate with the majority population. The Arab descents actively engaged in the “racial formation project” to become White and gain citizenship status (Viruell-Fuentes, 2012). Discrimination also results in attempts to cope and mitigate the tensions. It creates additional stress and affects physical and mental health as well as influences access to health services (Viruell-Fuentes, 2012). Discrimination can be experienced in work settings, residential communities, and even healthcare settings.

***Cultural Differences***

 Along with discrimination, cultural differences can also act as a barrier to healthcare. Different cultures can have different understandings and practices of medicine and health services. The most commonly observed cultural difference in healthcare settings is the practice of western vs. eastern medicine, where western medicine relies more on biomedical studies, while eastern medicine relies more on herbal medicine. Eastern medicine also known as Traditional Chinese Medicine includes herbs, acupuncture, massage, balance of ying and yang, therapeutic exercise, diet, and healing within regular routines (Yang &Hwang, 2016). Discrediting these practices could actually increase a barrier in providing health services needed to these immigrant populations who have practiced and believe in these medicinal practices. Often times, the healthcare workforce in the United States lacks representation of the ethnic minority (Ziotnick, 2017). This means the number of providers who can understand the cultural needs of immigrants, as well as the willingness to seek services on behalf of immigrants decreases. A focus group comprised of immigrants found that many perceived the community members as not being reliable in terms of seeking out for help including healthcare providers due to cultural differences (Edberg, Clearly, et al., 2015). Another study found that culturally matched materials were used as the most effective strategy in engaging community members in research and interventions (Esperanza, Ortiz-Barreda, et al, 2017).

***Lack of Trust***

Differences in cultural understandings also lead to a lack of trust which is important in seeking out care. In addition to mistrusting healthcare providers, immigrants also reported feeling uneasy requesting help from local authorities = (Edberg, Clearly, et al., 2015). In addition to cultural differences, immigrants’ lack of trust with local authorities often stems from their fear of deportation or the belief that local authorities collaborate with Immigration and Customs Enforcement (Kacker, Chu, Leung, et al., 2011). This view and mistrust limits the ability and resources available to reach out for healthcare services and aid.

***Location and Access***

Lastly, location and access to healthcare facilities is another barrier observed among immigrant populations. Often times immigrants have to leave residential communities to access clinics, childcare, social services, and places of employment that are accessible to their needs (Edberg, Clearly, et al., 2015). Some existing community centers provide activities, but are fee-based which are not as accessible to some immigrant communities. In addition, many of these programs are geared more towards the elderly and children which may be less appealing to non-white or working-class attendees (Edberg, Clearly, et al., 2015). Several immigrant participants also viewed FQHCs as the only source of care for those who lack income and/or insurance or those who are uninsured (Sangaramoorthy, 2017). These participants felt that they were treated well, yet also felt that in other states may not have received the same type of care (Sangaramoorthy, 2017). They also referred to emergency rooms for medical care and expected several hours for wait times with chances of being ignored due to the quantity of people who come to FQHCs (Sangaramoorthy, 2017). Immigrant participants felt that timely access to quality healthcare and continuity of care was limited, especially with the number of uninsured patients (Sangaramoorthy, 2017). This summarizes the lack of services available for immigrants. Limited language and economic affordability may further limit healthcare services that are otherwise accessible to a given area.

**Comparison between Immigrant and Native-born** **Health**

 There are considerable differences between immigrants and native born that influence health needs. Often times, the media portrays immigrants as unhealthy as or less healthy than native-born individuals (Noymer & Lee, 2013). This perspective could influence the treatment and services that immigrants receive. In general, immigrants are less likely to smoke or consume alcohol, fat, and sugar-sweetened beverages upon arrival to the United States. The probability of immigrants to smoke or consume unhealthy foods tends to increase with the acculturation to the United States (Acevedo-Garcia, Sanchez-Vaznaugh, et al., 2012). Morbidity and mortality from coronary heart disease is higher among immigrants than the native born (Hemminki, 2014). In addition, compared to U.S. born individuals, immigrants have worse socioeconomic conditions with higher reporting for poor mental health (John, 2012). Immigrants also have higher rates of stomach and liver cancer mortality than U.S. born individuals, especially for groups that have higher incidence of hepatitis B virus and Helibacter-pylori infection (Singh, Rodriguez-Lainz, & Kogan, 2013). Despite the lower risky behaviors and higher need for health services, immigrants interact with the health system less frequently than that of U.S. born individuals. This lack of interaction can be due to aspects of settlement, lack of knowledge, or lack of resources to access (Read & Reynolds, 2012). In addition, 8.5% of all U.S. deaths and 0.23% of all U.S. births in 2010 were immigrants (Singh, Rodrigues-Lainz, & Kogan, 2013). The data highlighted the need for health services among immigrants, despite the lack of use. Immigrants also have higher risk of certain diseases, while having lower risky behaviors, which also emphasizes the need for a different approach when intervening with the health needs of immigrants.

**Comparisons between Covariates**

Immigrants in the United States do not have the same characteristic or come from the same background. As a result, this may influence the impact on their health outcomes. Such differences include: age, educational attainment, socioeconomic status, gender, length of acculturation, legal documentation, and communal support (Table 1).

Age is a common covariate used in various studies. Likewise, age also affects the health status of immigrants. Immigrants arriving after a certain age threshold, also known as the critical period, have to invest more effort in adapting and learning the culture and language (Clarke, 2016). With the additional effort comes additional barriers, challenges, and stress. Younger age is associated with higher reporting of health status (Chiswick, Lee, & Miller, 2008). Arriving in the United States at a young age also affects immigrants’ health. Immigrants suffer from health disadvantages when they arrive in the United States at a later age (Clarke, 2016). Age affects overall health outcomes of immigrants, but also the age of arrival affects health outcomes.

Another common covariate is educational level. Higher education level is associated with greater knowledge, better decision-making skills, and greater wealth, which results in greater access to health services and higher health status (Chiswick, Lee, & Miller, 2008). Many studies also suggest that those who are more educated usually have higher opportunity cost for time and invest more in health so that they avoid becoming ill (Chiswick, Lee, & Miller, 2008). Another reason why higher education is associated with better health is the ability to speak English. Research conducted among Korean immigrants found that 57.1% of highly educated Korean immigrants spoke English very well compared to just 23% of those who were less educated (Chaelin, Cho, & Hummer, 2013). Immigrants who come to the United States for professional jobs with their high level of education have different environments than immigrants with little education that migrate to the US for manual labor jobs, which also affects health outcomes (Chaelin, Cho, & Hummer, 2013). However, unlike native-born individuals, even immigrants who have attained high levels of education face difficulty in employment in the United States due to language difficulties which result in poorer health status when compared to that of native born individuals with the same level of education (John, 2012). A higher level of education provides a positive impact on health even for immigrants, but it does not have as much of an effect as those who are native born.

Gender differences among immigrants affect health in varying ranges depending on the culture and gender roles of the country of origin. Gender roles can influence health risks, as well as available health resources. Women are found to have higher risk in psychosocial health (Hemminki, 2014). Women’s education and employment rate tend to be lower in countries in Middle East and Mexico, which can explain the higher health risk (Read and Reynolds, 2012). Immigrant women tend to have more interactions with the U.S. healthcare system because of their cultural gender role as a caregiver, especially with children. Women’s motivation for migration tends to be family related, while men tend to migrate for employment (Read and Reynold, 2012). This means that work-related stress and socioeconomic factors influence males more than females. Research supports that immigrant males tend to be reluctant to seek healthcare due to masculinity ideals (Read &Reynolds, 2012). Immigrant men are more likely than females to have gone more than five years without seeing a health professional (Read & Reynolds, 2012). The immigration process disrupts the traditional and cultural gender role, but it still has an impact on access as well as factors that directly influence health.

As mentioned previously, socioeconomic status affects health outcomes even in immigrant health. Lower socioeconomic but status is associated with lower health status than those that are higher socioeconomic status, low socioeconomic status is also associated with having lower risky health behaviors. Socio-economic status (SES) affects the health of immigrants upon arrival (Acevedo-Garcia, Sanchez-Vaznaugh, et al., 2012). Socio-economic status during childhood has lasting life course affects in an immigrant’s health (Acevedo-Garcia, Sanchez-Vaznaugh, et al., 2012). SES status means the availability to access more health resources and information. In 2001, the average earning of white-collar workers exceeded 45% of the hourly earnings of blue-collar workers, displaying the income disparity among each group (John, 2012). Immigrant workers particularly tend to have low-wage and low-skilled jobs in the United States. Low-skilled jobs are associated with a lack of insurance, access to services, and paid leave, along with dangerous working conditions, insecurity of employment, long working hours, and increased stress (John, 2012). Immigrants in lower socioeconomic status are also less able to afford unhealthy products, such as cigarettes and alcohol, while engaging in more physical activity through manual labor (Acevedo-Garcia, Sanchez-Vaznaugh, et al., 2012). Socioeconomic status and its impact on lower health status are related to lack of access to health rather than unhealthy behaviors.

One unique comparison for immigrant health is how long they have resided in the United States. Acculturation is the process of an immigrant adapting to the United States culture and lifestyle over the length of stay. Acculturation models suggest that immigrant over time adopt health-deteriorating behaviors as the time of residing in the United States increases (Chaelin, Cho, & Hummer, 2013). For example, the odds of current smoking for those with 61-99% of life spent in the United States are three times as high for those with 1-20% of life spent in the U.S. (Chaelin, Cho, & Hummer, 2013). In addition, Asian immigrants who migrated at a younger age and lived longer in the United States had greater prevalence of mood dysfunction than those who migrated recently (John, 2012). Life stressors, discrimination, and adoption of diet and mainstream behavior were found to decrease both physical and mental health of immigrants with longer residency (John, 2012). Acculturation is also found to be inversely related to original culture meaning as the immigrant adopts the U.S. culture and lifestyle, they tend to lose their original culture which also impacts their health (John, 2012). Overall, it seems that the longer the immigrant resided in the U.S. their health outcomes are negatively impacted due to added stressors, adopted negative health behaviors, and loss of original cultural practices.

Legal status is another unique characteristic that impacts an immigrant’s health. Legal status influences access and resources available along with stressors. The Affordable Care Act increased health access for the uninsured; however, undocumented immigrants still do not have access to primary or preventative care and are ineligible for Medicare, Medicaid, and the Children’s Health Insurance Program (Yang & Hwang, 2016). In addition, recent immigrants who have been in the United States for less than 5 years also do not have access to these federal and state programs. For many immigrants, the emergency room and federally qualified health centers (FQHC) are their main form of provider. In the last few fiscal years from 2005 to 2016, funding for FQHCs increased 200% up to $5.1 billion (Heisler, 2017). This funding was extended to 2017, providing $7.2 billion, through the Medicare Access and CHIP Reauthorization Act of 2015 (Heisler, 2017). The increased in funding allowed more resources for FQHCs to provide for the community, including immigrants. However, this funding is reduced to $5.1 billion for the 2018 fiscal year, along with an overall reduction in the Health and Human Services funding (Department of Health & Human Services, 2017).

Despite legal status, the undocumented and documented face fear of deportation, fear of law enforcement, stressors related to documentation, and are wary of providing personal information to acquire health insurance (Kacker, Chu, Leung, et al., 2011). Immigrants have also reported hostile environments and hate crimes against certain ethnic groups despite legal status due to the stereotype of thinking certain immigrant groups are undocumented (Viruell-Fuentes, 2012). Undocumented immigrants specifically have greater risk in marginalization and exploitation that can also increase their risk to negative health outcomes (John, 2012). Immigrants who have health conditions may even be at more of a disadvantage because employers may be reluctant to sponsor those who are ill (Chiswick, Lee, & Miller, 2008). Thus, those immigrants who most need health services may experience more difficulty in gaining access to those services. Legal status not only impacts access and resources, but the environment and risk that affects their health.

 Lastly, the community in which the immigrant settles also impacts health outcomes. Immigrants who reside in highly immigrant populated communities versus communities with low to no immigrant population will have different health outcomes as the support system and source of information differs. New Immigrant Survey, a nationally representative data set on immigrants, examined 42245 immigrants who were recently grated legal permanent residency in 2016. The survey found that assimilation and health is affected the neighborhood in which an immigrant resides. Immigrants who resided in disadvantaged neighborhoods had poorer health outcomes than those in advantaged neighborhoods (Akresh, 2016). Recently, more immigrants are settling down in rural regions and smaller towns where there are lower concentrations of immigrant communities for economic opportunities (Sangaramoorthy, 2017). These neighborhoods have little to no history of immigration meaning they lack health infrastructures needed to serve immigrants including language needs, cultural understandings, and support (Viruell-Fuentes, 2012). This also means that there are fewer resources for immigrants to gain health information and support. Discrimination and isolation experienced by immigrants also increase in these destinations compared to those who have settle down in traditionally immigrant destinations (Viruell-Fuentes, 2012). Neighborhoods where immigrants settle down affect access to health and overall health outcomes.

**What is Being Done**

Currently the needs of immigrant health can be found in programming, health systems, communities, and government policies. In 1996, US Federal Welfare Reform limited documented immigrants from being eligible for federal benefit programs which worsened conditions of immigrant’s health in terms of access (Acevedo-Garcia, Sanchez-Vaznaugh, et al., 2012). To overcome this negative effect, the Affordable Care Act expanded to provide coverage for the uninsured. However, 11.2 million undocumented immigrants are still uncovered (Brown, Wilson, & Angel, 2015). Recent immigrants are also not covered under the ACA. However, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 allows legal non-citizen immigrants to buy insurance through negotiations created under the ACA and quality to receive tax credits based on income to FPL (Brown, Wilson, & Angel, 2015). Immigrants can also obtain insurance through employers, only if their employer has more than 50 workers and the immigrant is registered as a full-time worker.

 Several refugee organizations and refugee resettlement agencies were created to provide for some immigrants that qualify as a refugee. Refugees are immigrants who flee their country due to political or religious endangerment. Under these agencies, these specific immigrant groups have access to support systems that help with the transition along with resources to help them meet physical and mental needs.

 Chinatown and Koreatown are common examples of immigrant communal efforts to create a support system for each other. These are neighborhoods and communities created in history where immigrants gather and act as a support system for each other in the United States. These communities have providers that speak their native language and understand the culture and other members that help connect immigrants to resources in the United States. These communities also provide a safe space against discrimination and a place to settle despite lack of English proficiency.

 Other communities have created Multicultural Affairs Commissions including immigrant members to create an open dialogue with community members and city leaders to discuss needs of immigrant members such as access to health care services (Kacker, Chu, Leung, et al., 2011). Some community organizations also provide direct health services for immigrants including those who are undocumented. State-funded programs provide payments for Health Safety Net Programs like Federally Qualified Health Centers (Kacker, Chu, Leung, et al., 2011). Other community organizations and nonprofits provide resources and educational programs. Some of these organizations act as community centers where people can engage in physical activity or seek social services (Edberg, Clearly, et al., 2015). In addition, interpreters can now be accessed in most federally funded healthcare facilities.

 In terms of research, studies on immigrant health have increased significantly in the last two decades as an influx of immigrants came to the United States (Pandey and Lloyd, 2014). These studies focus on health care access of immigrant populations. In the last 20 years, 50 out of 67 immigrant health research focused on access to care (Pandey and Lloyd, 2014). Research regarding immigrant health has allowed providers and other health related fields to understand the needs an unmet population.

**Shortfalls of Current System**

 Despite efforts to mend the needs of the growing immigrant populations, there are several shortfalls. Some of the current resources available to immigrants are not effective in addressing the problem. The resources presented as solutions are often times unstable, insufficient, and fragile. This illusion of resources can harm immigrants because it fails to deliver what is needed. Rather it could be doing more damage by depleting funds and resources without much impact. It could also lose trust among the immigrant populations, which is important in providing an intervention to this group.

 In 1994, California drafted a state proposition 187 which prevented undocumented immigrants from accessing publicly funded healthcare. As a result, immigrants delayed or discontinued care out of fear (Kacker, Chu, Leung, et al., 2011). Throughout the United States, the federal government increasingly re-delegated roles of providing public safety net services for immigrants’ families and underserved populations to other organizations (Park, 2011). This outsourcing not only made immigrants vulnerable, but it also limits the availability of resources and access to care. As for state specific programs, they are also limited to immigrants in certain states. In addition, these services are subject to change annually depending on state budgets of that year.

 As mentioned previously in this paper, more immigrants are moving to rural communities. These communities face a challenge in providing for immigrant health needs with limited public resources and lack of racial diversity (Sangaramoorthy, 2017). For other health safety net programs, immigrants face a challenge in signing up for these programs due to fear in disclosing their legal status to law enforcement (Kacker, Chu, Leung, et al, 2011). By comparison, immigrants use about 55% fewer health resources than U.S. born individuals (Pandey and Lloyd, 2014). Despite the existence of some programs, without the protection of immigrants and trust, immigrants will stray away from taking advantage of these programs.

As for community centers and organizations, several of these programs are off putting for immigrant populations. Most of the activities are also located in communities that are in higher economic status communities (Edberg, Clearly, et al., 2015). In these cases, financial barrier along with location could be a challenge in accessing the resources that are provided through these organizations.

Interpretation systems offered in health systems also have shortfalls. Very few official interpreters are available and cannot meet the demand of the non-English speaking population (Sangaramoorthy, 2017). Some providers offer certain languages but that does not mean that they have an interpreter available for all immigrant groups. In addition, some of these interpreter services are only provided via skype or phone calls creating another challenge in building trust between immigrants and providers. One study even found problems of translation. A bilingual health provider was shocked at how much of the information was lost in translation during an interaction with an interpreter and an LEP patient (Sangaramoorthy, 2017). Interpreter systems may be a start in meeting the barriers of language in accessing health but there are several areas in which it needs to improve such as access of various language, increasing availability of in-person interpreters, and providing professional health language training to these interpreters.

Lastly, although research in immigrant health has increased in the last two decades, more research must be done. A wider range of research needs to be conducted to understand the needs of immigrant health, not just access. Currently there is a large portion of the research that focuses on Latino populations. (Sangaramoorthy, 2017). Different groups of immigrants have different needs for certain health problems depending on their country of origin due to difference in disease prevalence (Yang & Hwang, 2016). For example, Asian immigrants are more susceptible to disease such as hepatitis, parasites, liver and lung cancer, and tuberculosis (Yang & Hwang, 2016). Hence, more research needs to be done on this prevalence to help prevent and provide for different health needs of different immigrant groups. Immigrant health should not be approached with a “one size fits all” perspective.

**Conclusion**

 In conclusion, immigrant health is a complicated issue that needs to be addressed. Despite layers that seem to provide for immigrant communities, there is a gap. Immigrants face multiple barriers in seeking health care including language differences, understanding the complicated health care system, financial burdens, time constraints, lack of insurance coverage, legal documentations, fear of law enforcement, location, discrimination, and cultural differences. Immigrants generally come to the United States healthier than native-born citizens but their health quickly declines the longer they reside in the United States due to adaptation of unhealthy behaviors and stressors. This makes immigrants a vulnerable population with high risks. The immigrant community is so diverse. This makes the problem a more complicated issue to address; however, with a multi-level and multi-sectoral approach, immigrant health barriers can be reduced.

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**LIST OF TABLES**

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| **TABLE 1.*****Comparison Between Covariates*** |
| **Individual Covariates** | **Comparisons** |
|  |  |
| AGE | Younger AgeHigher reporting of health statusPost-Critical PeriodNeed to invest more effort in adapting and learning culture and languageAdditional barriers, challenges, and stressorsLater AgeSuffer from health disadvantages |
| EDUCATION | Higher EducationDifficulty in employmentGreater access to health services and higher health statusMore informationHigher opportunity cost for time, so invest more in health to avoid illnessLower EducationHigher language barrierHave greater difficulty in employment |
| GENDER | FemaleLower education and employment rate (Middle East and Mexico) with higher health riskMore interaction with US Healthcare system due to role as care giverReason for migration= family relatedMaleReluctant to seek healthcare due to masculinity idealsHigher work-related stress and socioeconomic influence  |
| SOCIOECONOMIC STATUS | LowLower health statusLower risky behavior- less able to afford cigarettes/alcoholMore physical activity through manual laborLasting life course affects for childrenLack of insurance and access to servicesLack of paid leaves, dangerous work conditions, insecurity of employment, long work hoursHighMore health resources and information available Higher quality in healthcare services |
| ACCULTURATION | Longer Adopt deteriorating behaviorsGreater mood dysfunctionDecrease in physical and mental healthGreater life stressorsLoss of origin culture |
| LEGAL STATUS | Undocumented Lack of insurance optionsIneligible for Medicare/Medicaid/CHIPGreater risk for marginalization and exploitationAt risk for hostile environment and hate crimesRecent ImmigrantsIneligible for Medicare/Medicaid/CHIPNo access to federal and state programsAt risk for hostile environment and hate crimesDocumentedAt risk for hostile environment and hate crimes |
| RESIDING COMMUNITY | Lower Immigrant Population CommunityHigher discrimination and isolationDisadvantage NeighborhoodsPoorer health outcomesRural CommunityLack of infrastructures to serve immigrant needsFewer resources for information and support |