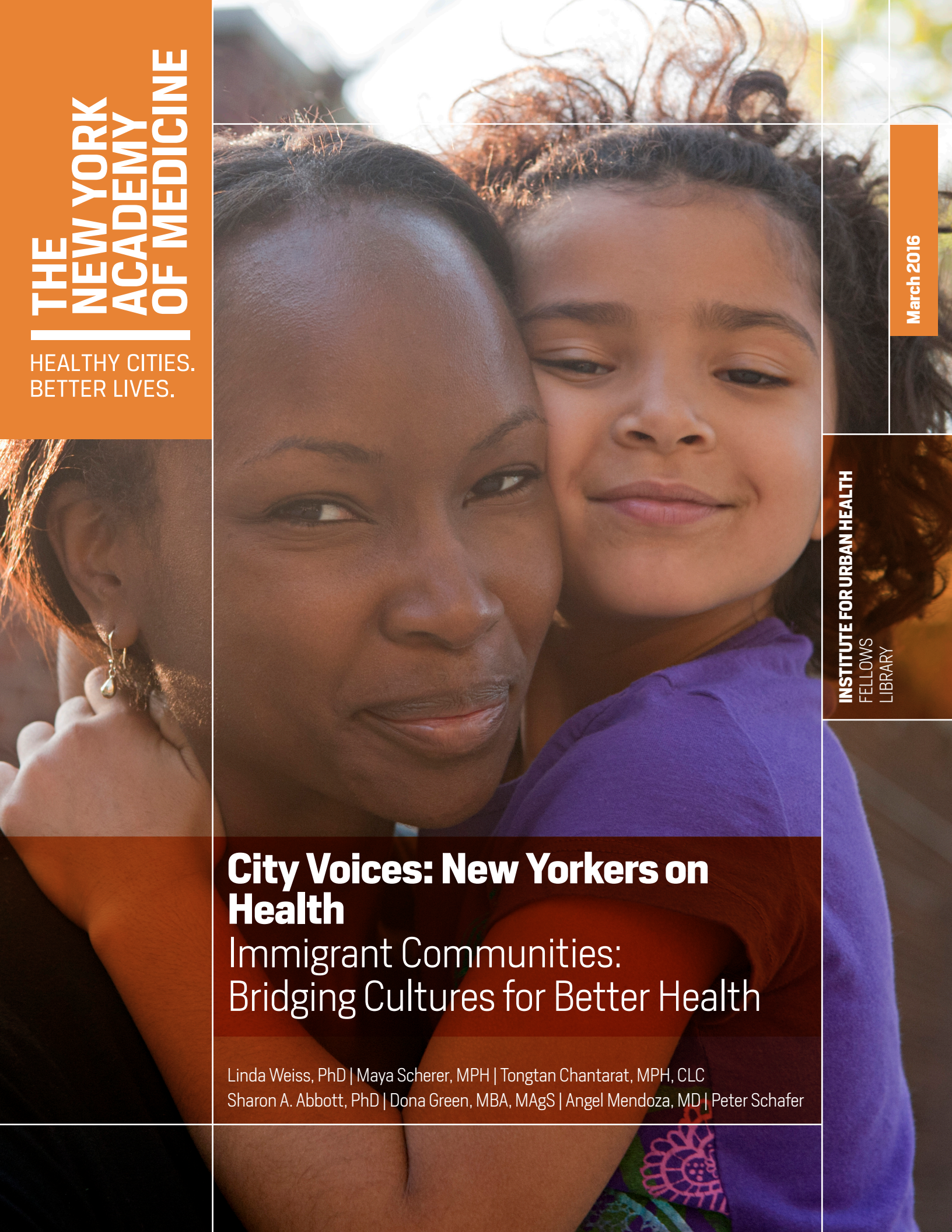

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City Voices: New Yorkers on Health

Immigrant Communities: Bridging Cultures for Better Health

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CITY VOICES

This data brief is part of a series—"City Voices: New Yorkers on Health"—developed to give a voice to the health needs of people in the city who are often unheard. "Immigrant Communities: Bridging Cultures for Better Health" does this by highlighting informative personal experiences of primarily low-income New Yorkers in the Bronx, Brooklyn, Manhattan and Queens.

This collection of voices provides a direct glimpse inside the health issues and needs of New Yorkers to help inform the many decisions that are being made on a daily basis by community service and health care providers as well as policy makers. For more insights and perspectives directly from New Yorkers, visit NYAM.org to download the full "City Voices: New Yorkers on Health" series of reports.

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– ARAB COMMUNITY HEALTH ADVOCATE

ABSTRACT

This data brief is part of a series—"City Voices: New Yorkers on Health"—developed to give a voice to the health needs of people in the city who are often unheard. "Immigrant Communities: Bridging Cultures for Better Health" does this by highlighting informative personal experiences of primarily low-income New Yorkers in the Bronx, Brooklyn, Manhattan and Queens.

More than one quarter of New York City's residents are foreign born and as such face a unique set of barriers to accessing and utilizing health care, including language issues, more limited access to health insurance, and a lack of familiarity with the United States (US) health care system. In 2014, a mixed-method community needs assessment (CNA) was conducted including 2,875 surveys with primarily low-income New Yorkers in four boroughs, 81 focus groups, and 41 key informant interviews. Multiple immigrant groups participated in the CNA as focus groups participants and key informants, including Latino, Chinese, Korean, Haitian, Middle Eastern, West African, West Indian, South Asian and Southeast Asian populations. Qualitative findings illuminated the challenges low-income immigrant New Yorkers face when accessing and utilizing health care. The realities of immigrant life and work, such as long hours at low-paying jobs, and the importance of prioritizing children and economic advancement over individual health, act as significant barriers to care. In addition, structural barriers, which limit immigrant access to health insurance as well as culturally and linguistically appropriate services, further affect immigrants' ability to utilize health care services. According to these findings, more differentiated approaches tailored to the realities of specific immigrant groups could increase access to adequate health care services for immigrant New Yorkers.

OVERVIEW

More than 3 million people—roughly 30 percent of New York City's (NYC) population—are foreign born.[1] Immigrant New Yorkers speak more than 200 languages.[2] Although research shows that immigrants tend to be healthier than their United States (US) born counterparts, there are differences in health status according to immigrant group[3] and, in general, this health advantage dissipates the longer they live in the United States.[4]

Immigrants face specific barriers to health care that may limit utilization of available services, including language issues, limited access to insurance, a general lack of familiarity with the US health care system, fear of debt and, for undocumented immigrants, fear of deportation.[5] These barriers represent challenges to health care systems and providers, who struggle to develop trust and to provide culturally and linguistically competent services. In addition, despite significant variability, many immigrants have low incomes and unstable working conditions, which affect health care access and utilization.[6]

This report is part of the "City Voices: New Yorkers on Health" series and based on findings from a comprehensive community needs assessment (CNA) conducted in four NYC boroughs. The CNA describes health, health care access and utilization, as well as factors contributing to suboptimal health, among low-income, foreign-born New Yorkers, including the broader determinants of their health. The goal is to inform policies, practices, and programs—across sectors—that may contribute to improving the health of this diverse and underserved population.

FINDINGS

Consistent with our sampling strategy, there was a diverse representation of low-income immigrants participating in the CNA according to ethnicity and country of origin. While varied in background, language and culture, many had the common experience of immigrating to New York City with few resources and little income. As a result, several consistent themes emerged and are described in more detail below. Themes included:

- Difficulties meeting basic needs, leading to extended work hours and emotional stresses;
- Prioritization of work, children and education over health;
- Significance of language access barriers across the spectrum of services;
- Cultural issues, including greater stigmatization of particular health conditions;
- Lack of sufficient information on health and health services;
- Minimal knowledge, interest, and engagement in prevention services;
- Relatively high rates of non-insurance; and
- Fear of medical bills, medical debt, and deportation.

Immigrant Lives

The low-income immigrant populations included in the CNA faced conditions similar to other low-income populations in NYC, including insufficient resources for appropriate housing, healthy food and other basic necessities. Key informants and focus group participants also noted the strengths of immigrant communities, which often include close family ties, a strong work ethic, and (in some groups) relatively healthy eating habits. Multiple immigrant groups also described very long work hours, which negatively affected their health and access to health care services—reports of 16-hour days, six or seven days a week, were not uncommon. Small business owners felt the need to keep shops open for extended hours, taxi drivers reported 12-hour shifts without a break, and manual laborers (e.g., construction, nail salons, restaurant staff) worked multiple jobs because pay is low and positions are unstable.

Family responsibilities often motivated long work hours: key informants and focus group participants reported that some workers supported large families in the US. Others have familial responsibilities in NYC and in their country of origin.

> ***You're selling stuff on the street from 7:00 AM to 7:00 at night. You can't take a two-hour break because you're gonna lose a client. Right? So then all that time you don't seem to eat anything, because you don't want to miss a dollar. You've got a bill to pay. You have to work six days in a week to get maybe less than $300. If you don't come to work, you don't get paid that day.... (Focus group participant, West African community)***

> *We see people [in the Latino community] who have very low-paying jobs. But as long as they're able to have their children in school, as long as they're able to maybe send them to a community college—really the vision and the longer term goal is about their children, and their children having better futures... I don't like to frame it as it's their concern and that it's their fault, but they're so concerned about jobs that other things kind of fall to the wayside.* (Latino community health advocate)

Language and Culture

Language access issues were a common concern across immigrant groups. Although it was clear that there is significant language capacity among NYC providers, gaps in services remain, particularly for less common languages, for groups living outside an ethnic enclave, and for specific services, including mental health care and specialist care. There were also concerns regarding inadequate training, skill, and credentials, particularly for dual role interpreters (i.e., bilingual staff who are asked to interpret on an *ad hoc* basis).

The main issue [in the Nepali community] is language. … Our family member shouldn't have to explain medical conditions to us unless they are also medical practitioners, because even an educated and good English speaker may not understand medical terms, and so they aren't able to interpret what is going on. (Focus group participant, Nepali community)

When you look at specialty care, say around mental health, for example, if an individual wants to go to someone who's culturally competent, we don't have a lot of Asian–Americans who are going into fields like mental health or behavioral health issues. (Asian community health advocate)

So we have heard of [Asian] folks that are living up in the Bronx, perhaps because that's where they got placed in NYCHA housing, but all of their services are in Brooklyn… Their doctors are there. So that's a tremendous amount of time to be able to travel to get culturally competent, language–accessible programs and services. (Asian community health advocate)

In addition to language issues, key informants and focus group participants described cultural, attitudinal and knowledge–based barriers to care among the foreign born, including greater stigmatization of poor health and of particular health conditions, such as substance abuse and mental illness (as described in a later section), as well as cancer:

[Arab] women if they have breast cancer, they try to hide it as much as they can, because they don't want the community to know that their girls might get it. They might inherit it from the mother. Nobody will marry their daughters, so all these problems, they feel like they don't let anyone in the community [know]—even though confidentiality is a very big issue for us and very important for us, but they feel very protective of themselves. They don't want anybody to know about health issues and health problems. (Arab community health advocate)

Many foreign-born New Yorkers also report that accessing health care is a low priority, due to factors that may include cultural norms that discourage disclosure of weakness or poor health, as well as competing concerns (e.g., work). In addition, immigrants may be new to the concept of preventive health care, if they come from a country lacking such services.

> ***It's a cultural issue. Where we come from greatly impacts our behaviors, and it's clear, in Africa, health is not a priority. It's a fact. The fact that health isn't a priority, and the financial difficulties, they go together. This combination is devastating for us. I have a certain level of education, but I swear, as long as I'm not caput, I won't go to the hospital. (Focus group participant, West African community)***

> *Some people, they have colon cancer for a long time. They discover it too late. Breast cancer. Sometimes it's too late. You can't survive because it's already spread. Why? Because they didn't get their mammograms. So our community back home, they never had these screenings, so when they come here, they never ask for it. Sometimes it takes two or three years to have their annual checkup.* (Arab community health advocate)

Mental Health

Although mental health issues were evident across CNA populations, immigrant participants described somewhat unique stressors. Being a newcomer presented multiple challenges. For example, in many instances, education and professional experience attained outside the US were not sufficiently valued by potential NYC employers, forcing many immigrants to take on poorly paid positions. The imbalance between qualifications and expectations on the one hand, and limited opportunity on the other, was described as a source of significant anxiety. Discrimination, social isolation due to long work hours and/or limited English language skills, disruption of social ties, and exhaustion were other commonly mentioned stressors. In addition, immigrants may have experienced war, violence and other traumas in their country of origin, with persistent impacts on mental health.

Immigration is a big headache. You have to deal with immigration issues, your life is full of stress, and this leads to depression. When will the papers come? When am I going to go to India? When will I have kids? If you have kids there is no one else to take care of them. Your elderly parents don't want to come here. If there is no one home, you cannot go to work. You pay for babysitter ten dollars. When you got to work, you get ten dollars. (Focus group participant, South Asian community)

The amount of economic pressure, when you lose your job then there goes the resources and increased pressure. It breaks you down. If you are a husband, there goes your manhood. Maybe there is no strong family foundation to talk to about it, no one close to tell them they are going through this, so they have to carry that. If there is no spiritual life, it eats them up inside; they become mentally ill, short-tempered. (Focus group participant, Caribbean community)

When you're working so much, you don't really have as much time to seek out other things that are not hard work. So we've seen that as like kind of crisis moments where people come in and they're like "I can't take this anymore." (Latino community health advocate)

[The Arab] population, because of the political problems in the Middle East, they feel unsafe, unprotected. They are scared all the time. They are afraid to go anywhere or speak out. All these issues, it doesn't help them financially, psychologically, and other problems like mental health issues are on the rise in our community, because they can't provide food for their children. (Arab community health advocate)

Mental and behavioral health conditions* were stigmatized in multiple immigrant communities. In response, families attempted to keep problems hidden and were hesitant to seek services. Additional barriers to seeking care were also described, including a lack of access to health insurance to cover mental health services, and an absence of language concordant mental health care professionals available to serve immigrant communities.

> *I think there is a lot of stigma across the board about getting services. Something that we hear—even the parents who understand that there are young people that could really benefit from getting treatment and services. It is like, "Let's just keep it in the family. We will go ahead and find a place and just don't let anyone else know"... I definitely see [stigmatization] more among immigrants—even immigrants who have been here for 30, 40 years, are still like, "Just keep it within the family."* (Asian community health advocate)

> ***People going through really crappy situations on a day-to-day basis that wears them down over time. And then, people come to us and they're just like, "Where can I go? Who can I see?" And really what they need is not to be admitted to a long-term thing. They need to have someone to be able to talk to. And, you know, the folks that don't have insurance—there's just nothing for them, right? I guess one thing is the language issue. There aren't a ton of good psychologists or psychiatrists or social workers—maybe some more social workers—but psychologists or psychiatrists that speak Spanish and can do talk therapy in Spanish. And then the cost thing, you know. Most good providers do not take insurance at all, let alone Medicaid, so that's been huge. It's been a big challenge for us to figure out, as an organization. (Latino community health advocate)***

* Alcoholism and smoking were described as particularly problematic is certain immigrant populations.

Insurance and Medical Bills

Key informants and focus group participants described higher rates of being uninsured among immigrants, due to restrictions on eligibility for public health insurance programs, and more limited access to employer–sponsored care, resulting from the relatively poor job options. Fear of medical bills for those lacking insurance, or with adequate insurance, resulted in neglected care for many participants.

> *Oftentimes they would forego getting any care, getting screenings, or even if they were deathly ill, they will totally wait until the end. And even with people who had insurance, because they were afraid of the cost of care.* (Asian community health advocate)

Those are some of the most prevalent cases we get. Where people say, "I have this bill. I don't know how I could ever pay this bill." Often, even though in many cases we will help resolve the bill through the financial assistance policy, the person never wants to go back to the hospital again because that happened… Any hospital…. Often they'll have gone for like one appointment, and they get like a $7,000 bill. It just doesn't make sense to them. So it's just scary, right? So it does feel like hospitals don't really get the impact that a scary bill can have to their patient's desire to ever come back to the hospital. (Latino community health advocate)

The access issues of immigrants, in general, are exacerbated among the undocumented, as they are least likely to have insurance. Providers report that people who are undocumented want to avoid providing information about themselves and avoid "the system" to the greatest extent possible, for fear of deportation.

The ones that come illegally, they are afraid sometimes ... they'd rather go to the drugstore, to a pharmacy and buy some honey and this and that, and make—like what we call a bomb—and they do medicine at home, and take it instead of going to a doctor, because of a fear of being deported. (Focus group participant, South Bronx)

Developing immigrant appropriate services

Focus group participants and key informants noted discrepancies between the specific health care needs of immigrant communities and the services available to them. They pointed out that in addition to language issues, basic cultural competency is essential to providing good quality care to immigrants. This means taking specific steps such as hiring staff who reflect the immigrant communities they serve, or training staff to assuage the fears of undocumented immigrants so they are less hesitant to seek care. Participants from different immigrant groups identified a number of distinctive needs, which points to the necessity of adapting services to fit the specific immigrant group served.

People want to speak with someone they can identify with. We now have the biggest African community ... hospitals also need to change their methods, their hiring practices. If you want there to be Africans in the hospital, they need to begin by hiring Africans. (Focus group participant, West African community)

Let's look at East Flatbush, it was once Italian and Jewish. It's no longer Italian and Jewish it's 90 percent Caribbean; however, there hasn't been a change within the facilities within that community. So it's the same doctors they've had for the last 20 years ... I go back to saying that cultural competency piece that they, hospitals aren't addressing that becomes very important in outcomes. (Caribbean community health advocate)

Several participants described how issues of access and immigrant-centered care could be addressed by Community Health Workers (CHWs). In particular, they described the importance of, and need for, CHWs, who themselves are community members and can play multiple roles in promoting health and increasing access and utilization of existing health care services. From the perspective of CNA participants, training and employment of CHWs—whether they be health educators, navigators, or advocates—helped to ameliorate the pervasive language and cultural barriers and not only benefited patients and clients, but also provided important training and employment opportunities for community members.

The way that the message is given can be more important than the message. If you and I go into an African community, who do you think people will listen to more? Me, right? So Africans need to be included in the outreach programs. (Focus group participant, West African community)

They [community health workers] are people that come from the community, that speak the language, and that are trained up on how to navigate this hospital, or how to navigate the health insurance system, etc. And so, when you plug in that person as part of the team of people that takes care of someone, and then it just makes a world of difference. So the [patient] isn't confused as to where in the hospital he's supposed to go. They ask their navigator how the primary care department is relating to the specialized care department, and there's communication happening. You know, there's advocacy being done on language resources, on financial aspects... So I don't think it's the magical solution, but having someone that can help guide you through that and make it less of a scary process is huge. (Latino community health advocate)

CONCLUSION

Findings indicate that low–income immigrant New Yorkers face a number of challenges to accessing and utilizing health care. The realities of immigrant life and work, such as long hours at low–paying jobs, and the importance of prioritizing family and economic advancement over individual health, act as significant barriers to care. In addition, structural barriers, which limit immigrant access to health insurance as well as culturally and linguistically appropriate services, further impact on immigrants' ability to utilize health care services.

According to these findings, expanded approaches to increasing access and providing adequate health care services to immigrant New Yorkers are needed. Several new initiatives in NYC are under way that aim to address this gap. For example, the Mayor's Office recently announced the development of the Direct Access Program for immigrants, which acknowledges the gaps in access to care in the Affordable Care Act and aims to provide immigrants, including those who are undocumented, with coordinated access to affordable health care. The program will focus specifically on expanding public education regarding affordable health care options, providing support to health care providers serving immigrant populations, and improving the quality and accessibility of medical interpretation services.[7] New York City is also seeking to expand access to mental health services for immigrants as part of ThriveNYC, which will place additional mental health services in underserved immigrant communities.[8]

Additionally, state and local health system reform efforts are underway in order to, among other things, better integrate Culturally and Linguistically Appropriate Services (CLAS) into the primary care model. Widescale integration of CLAS standards into care has the potential to reduce the gaps in service identified by participants in the CNA. Finally, participants identified the Community Health Worker model as an important tool for improving the access and utilization of services in NYC's immigrant communities. As a resource rooted in the community, CHWs have the potential to bridge the cultural and linguistic gap between providers and patients, as well as help to guide immigrants to care. A number of CBOs in

NYC employ CHWs. However, both certification and reimbursement for CHW services remains problematic and should be more systematically addressed.

This collection of voices provides a direct glimpse into the health issues and needs of New Yorkers to help inform the many decisions that are being made on a daily basis by community service providers, health care providers and policy makers. For more insights and perspectives directly from New Yorkers, visit nyam.org to download the full "City Voices: New Yorkers on Health" series of reports.

METHODOLOGY

As described in greater detail elsewhere,[9] The New York Academy of Medicine, in collaboration with NYC Health and Hospitals Corporation, led a four-borough community needs assessment (CNA) during the summer and autumn of 2014. The CNA included 2,875 surveys (translated into 10 languages) with primarily low-income residents, 41 key informant interviews and 81 focus groups. Community members and key informants were from Latino, Chinese, Korean, Haitian, Middle Eastern, West African, West Indian, South Asian, and Southeast Asian immigrant communities. Participants were recruited using a purposeful sampling strategy, in collaboration with community-based organizations. There was intentional overrepresentation from those engaged with social services programs or with identified needs. The goal of the CNA was to better understand New Yorkers' health issues, access to resources to promote health, use of medical and behavioral services, and their recommendations for improved service delivery.

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