

FOR THE BENEFIT OF ALL:

*Ensuring Immigrant
Health and Well-Being*

ISSUE BRIEF NO.24

NOVEMBER 2005

PREPARED FOR A

GRANTMAKERS

IN HEALTH

ISSUE DIALOGUE

CHARLOTTE, NC

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Foreword

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers, policy analysts, and community leaders on June 14, 2005 for a lively and informative discussion about immigrant health, including the opportunities, challenges, and roles for funders in welcoming and working with this growing and diverse population. The Issue Dialogue, *For the Benefit of All: Ensuring Immigrant Health and Well-Being*, explored the unique health, social, and policy issues that affect immigrant populations; attitudes toward immigration and how these influence support for social programs and the provision of public benefits; activities to improve health care access and coverage for immigrants and their families; and implications for health philanthropy, including how grantmakers are working to ensure the health and well-being of immigrants in their communities.

This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants. It complements GIH's ongoing work to support grantmakers in their efforts to eliminate racial and ethnic health disparities and builds upon several previous GIH meeting sessions on immigrant health.

Special thanks are due to those who participated in the Issue Dialogue, especially to presenters and discussants: Susan Downs-Karkos, senior program officer at The Colorado Trust; Kaying Hang,

program officer at the Blue Cross and Blue Shield of Minnesota Foundation; Leighton Ku, senior fellow at the Center on Budget and Policy Priorities; Nolo Martinez, assistant director for research and outreach at the Center for New North Carolinians; Antonia Monk Reaves, vice president and chief program officer at the Moses Cone-Wesley Long Community Health Foundation; Luella Penserga, project director of Community Voices Oakland; and Erin Weltzien, research associate at The Henry J. Kaiser Family Foundation. Alison De Lucca and Daranee Petsod from Grantmakers Concerned with Immigrants and Refugees also provided valuable input during the initial planning stages of the Issue Dialogue.

Rea Pañares, program associate at GIH, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Anne Schwartz, vice president of GIH, provided editorial assistance and Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Larry Stepnick of The Severyn Group, Inc. also contributed to this report.

This program was made possible by grants from The Annie E. Casey Foundation, the Moses Cone-Wesley Long Community Health Foundation, and The Duke Endowment.

About GIH

The mission of Grantmakers In Health (GIH) is to help grantmakers improve the nation's health. GIH seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and an on-line presence; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field.

As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens, sorting out what works for health funders of different missions, sizes, and approaches to grantmaking. We take on the operational issues with which many funders struggle (such as governance, communications, evaluation, and relationships with grantees) in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs funding in health and their grants and initiatives, and synthesizes lessons learned from their work. The

Resource Center's database is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization). The database contains information on thousands of grants and initiatives made by more than 300 foundations and corporate giving programs. It can be searched by organizational characteristics (such as tax-exempt status, geographic focus, or assets); health programming areas (such as access, health promotion, mental health, and quality); targeted populations; and type of funding (such as direct service delivery, research, capacity building, or advocacy).

Advice on Foundation Operations

GIH also focuses on operational issues confronting health grantmakers through the work of its Support Center for Health Foundations. We advise foundations just getting started (including dozens of foundations formed as a result of the conversion of nonprofit hospitals and health systems) as well as more established organizations. The Support Center's activities include:

- The Art & Science of Health Grantmaking, an annual two-day meeting offering introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments;

- sessions focusing on operational issues at the GIH Annual Meeting on Health Philanthropy;
- individualized technical assistance for health funders; and
- a frequently asked questions feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues to one another and with those in other fields whose work has important implications for health. GIH meetings, including the Annual Meeting on Health Philanthropy, the Fall Forum (when we focus on policy issues), and Issue Dialogues (intensive one-day meetings on a single health topic) are designed for health funders to learn more about their colleagues' work; talk openly about shared issues; and tap into the knowledge of experts from research, policy, and practice. Our audioconference series allows smaller groups of grantmakers working on issues of mutual interest, such as access to care, overweight and obesity, racial and ethnic disparities, patient safety, or public policy, to meet with colleagues regularly without having to leave their offices.

Fostering Partnerships

The many determinants of health status and the complexity of communities and health care delivery systems temper health grantmakers' expectations about going it

alone. Collaboration with others is essential to lasting health improvements. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and help connect grantmakers to organizations that can help further their goals.

GIH places a high priority on bridging the worlds of health philanthropy and health policy. Our policy portfolio includes efforts to help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we seek to strengthen collaborative relationships between philanthropy and government. GIH has established cooperative relationships, for example, with a number of federal agencies, including the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention.

Educating and Informing the Field

An aggressive publications effort helps GIH reach many grantmakers and provide resources that are available when funders need them. Our products include both in-depth reports and quick reads. Issue Briefs

delve into a single health topic, providing the most recent data, sketching out opportunities for funders, and offering examples of how grantmakers are putting ideas into action. The *GIH Bulletin*, a newsletter published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's frequently asked questions. Key health issue pages on access, aging, children/youth, disparities, health promotion, mental health, public health, and quality provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

Diversity Statement

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and

strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

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Executive Summary

There are almost 35 million immigrants in the U.S., comprising 12 percent of the total population. Immigrants and their families contribute to both the diversity and the economy of the nation, offering the potential for vibrant, productive, and healthy communities. Yet, immigrants face several barriers to health and well-being. Some are the result of being disproportionately low-income and uninsured; others are unique, such as cultural and linguistic barriers, limited eligibility for public benefits, and bearing the brunt of unwelcoming public views, attitudes, and policies. Addressing these barriers not only benefits immigrant populations, but in turn strengthens entire communities, and the nation as a whole.

A Profile of the Immigrant Population

Seventy-four percent of immigrants in this country are here legally. This includes both naturalized citizens and noncitizens (including legal permanent residents, refugees and asylees, and temporary residents). About one-quarter are estimated to be undocumented immigrants, a number that is often overestimated and can lead to negative attitudes about immigration as a whole.

Six states, historically known as major immigrant gateways, were home to over two-thirds of the nation's total foreign-born population in 2000: California, New York, Texas, Florida, New Jersey, and Illinois. While the share of immigrants in these states remains high in absolute terms, the immigrant population has more than doubled in other parts of the country such as the Southeast, Midwest, and Rocky Mountain regions.

Poverty rates continue to be high for noncitizens in comparison to both native and naturalized citizens. Immigrants comprise a growing share of workers in America, making up half of those entering the workforce in the 1990s. And while this group represents roughly 12 percent of the total U.S. population, immigrants make up 20 percent of the nation's low-wage labor force.

The Evolving View of Immigration in the U.S.

A recent public survey found that many Americans are uneasy about the cultural impact of immigration, contending that immigrants are changing American culture and values when they ought to be adopting them. These findings illustrate a longstanding conflict between America's attitudes about immigration: whether immigrants should assimilate or increase the diversity of American culture. Ironically, the children of immigrants and immigrants who arrive in the U.S. as children hold views that are in many ways similar to those of nonimmigrants, raising questions about whether second-generation immigrants can help bridge the gap between immigrants and nonimmigrants.

Health Status of Immigrants

Paradoxically, recent immigrants are often healthier than their counterparts that have resided in the United States longer. But as newcomers begin to acculturate to the American way of life, their health status begins to converge with that of the general U.S. population. Their health behaviors (such as eating habits and food choices) change, often leading to negative health outcomes. Immigrants and their families also face unique challenges to health and well-being, including the following:

Lack of health care coverage—Concentration in industries that frequently do not provide private health insurance coverage, coupled with eligibility restrictions on public health insurance coverage, contribute to the high rate of uninsurance for immigrants. Over half (52 percent) of recent immigrants were uninsured in 2003, compared to 15 percent of native citizens.

Cultural and linguistic barriers to health care—New immigrants are often accustomed to different health care systems and may have different health beliefs, speak another language, or be limited English proficient. These barriers have been shown to impede access to quality health care at several entry points, from securing health insurance to receiving primary and preventive care to accessing specialty services.

Cultural adjustment and changing family dynamics—

In addition to the typical stressors that relocation involves, immigrants also face a period of cultural adjustment that may upset family dynamics. For example, parents tend to learn English more slowly than children, resulting in a reliance on their children for help with interpretation and with navigating community systems. This change in power dynamics can be detrimental, eroding the respect children are often expected to show for their parents.

Philanthropic Activities to Improve Immigrant Health and Well-Being

Foundations play an important role in ensuring the health and well-being of immigrant populations, and are engaged in activities such as:

*Building capacity in immigrant communities—*Grantmakers recognize that their work and accomplishments are intrinsically tied to a grantee's ability to be effective and adaptive, so funders offer multifaceted support to grantees along the way. Strategies range from providing basic technical assistance and training to large, multiyear initiatives that foster strategic partnerships among community members.

*Promoting immigrant integration—*Immigrant integration is defined as the weaving of newcomers into the social, economic, cultural, and political fabric of the receiving community. Several grantmakers are supporting activities that encourage mainstream organizations (such as schools, hospitals, and local governments) to recognize the important role they play in ensuring immigrant health and well-being.

*Expanding access and coverage for immigrants and their families—*The philanthropic community has examined access from many angles, seeking ways to break down barriers created by costs, culture, miscommunication, system structure, and differing notions about who and what should be covered by both public and private insurance. Efforts have focused on many vulnerable populations, including immigrants and their families, and grantmakers are working to expand coverage for this population, many of whom are not eligible for public insurance.

*Supporting education and outreach about eligibility and health care rights—*In response to several policy changes that have reduced immigrants' access to health coverage, several funders have supported efforts to inform immigrants of their rights and encourage enrollment in public programs.

*Increasing public awareness and understanding of recent immigrants—*Because misperceptions about recent immigrants often fuel negative attitudes, foundations are working to enhance the public's awareness and understanding of recent immigrants, in part by creating opportunities for increased interaction between immigrants and nonimmigrants.

*Addressing cultural and linguistic barriers to health care—*Health grantmakers are supporting several activities to reduce cultural and linguistic barriers in health care delivery settings, including improving the linguistic and cultural skills of providers and staff, expanding access to third-party interpretation, translating written materials into various languages, advancing research on innovative delivery models, and promoting advocacy and policy change.

As immigrants and their families continue to become a part of communities across the United States, foundations play an important role in recognizing newcomers' unique contributions, while also addressing their myriad health and social needs.

Introduction

There are almost 35 million immigrants in the U.S., comprising 12 percent of the total population. Immigrants and their families contribute to both the diversity and the economy of the nation, offering the potential for vibrant, productive, and healthy communities. Yet immigrants face several barriers to health and well-being. Some are the result of being disproportionately low-income and uninsured; others are unique, such as cultural and linguistic barriers, limited eligibility for public benefits, and bearing the brunt of unwelcoming public views, attitudes, and policies. Addressing these barriers not only benefits immigrant populations, but in turn strengthens entire communities, and the nation as a whole.

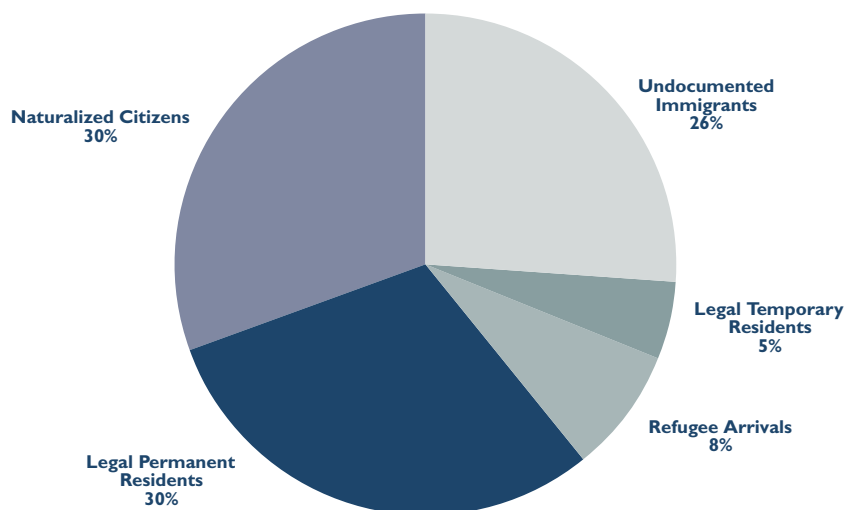
Defining the Population

Immigrants can be divided into those who have become naturalized U.S. citizens and those who remain noncitizens. For the purposes of this Issue Brief, noncitizens generally fall into one of the following four major legal status categories (Figure 1):

- **Legal (or lawful) permanent residents (LPRs):** These are foreign-born individuals who are legally admitted to live permanently in the United States by qualifying for immigrant visas abroad or through adjustment to permanent resident status in the United States. LPRs are issued documentation commonly

referred to as green cards. Almost all LPRs are brought to the United States, or sponsored, by close family members or employers and are eligible to naturalize three or five years after receiving a green card. This is the largest group of noncitizen immigrants.

- **Refugees and asylees:** These are foreign-born individuals granted legal status due to a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States, and may be granted to a group of persons, although each individual must also qualify for the status. Asylees must meet the same criteria regarding fear of persecution. Unlike refugees, asylees usually arrive in the country without authorization (or overstay a valid visa), later claim asylum, and are granted their legal status while in the United States. After one year, refugees and asylees are generally eligible for permanent residency. Almost all adjust their status and become LPRs, although they retain certain rights (for instance, eligibility for major federal benefit programs) by virtue of their designation as refugees or asylees.
- **Temporary residents:** Diverse sets of foreign-born U.S. residents have been admitted to the United States for a temporary or indefinite period, but have not attained permanent residency. Most are people who have entered for a temporary period, for work or school or because of political disruption or natural disasters in their home countries. Some seek to stay for a permanent or indefinite period and have a pending status that allows them to remain in the

Figure 1. *Legal Status of the Immigrant Population, 2002*

Source: Fremstad and Cox 2004.

country and often to work, but does not carry the same rights as legal permanent residency.

- Undocumented/ illegal immigrants:**
 These are foreign-born individuals who do not possess a valid visa or other immigration document because they entered the United States clandestinely, stayed longer than their temporary visas permitted, or otherwise violated the terms under which they were admitted. Some eventually adjust their status and attain legal residency after a sponsorship petition has been filed by a relative, spouse, or employer (Capps et al. 2003a).

Seventy-four percent of immigrants in this country are here legally. This includes naturalized citizens, legal permanent residents, refugees and asylees, and temporary residents. About one-quarter are estimated to be undocumented immigrants. More than half of all legal

immigrants eventually become naturalized citizens (Capps et al. 2003a).

A number of factors influence an immigrant's ability to thrive, succeed, and be healthy in the United States. Educational level and job skills determine economic opportunity and earning potential. Familiarity with American culture and language influences the level of assimilation and integration into U.S. communities. Legal status and citizenship status also remain important determinants of health and well-being, particularly for populations that rely on access to public benefits. Eligibility for certain benefits, such as Medicaid and the State Children's Health Insurance Program (SCHIP), is tied to immigration status. For instance, refugees have access to some social benefit programs that are unavailable to other legal immigrants, including legal permanent residents and temporary residents (Capps et al. 2003a).

TYPES OF U.S. CITIZENS

Naturalized citizens: LPRs may become U.S. citizens through the naturalization process. Typically, they must be in the United States for five or more years to qualify for naturalization, although immigrants who marry citizens can qualify in three years, and some small categories qualify even sooner. LPRs must take a citizenship test in English and pass background checks before qualifying to naturalize. Many LPRs take English language and civics instruction to help them qualify for citizenship.

Native-born citizens: All people born in the United States are granted birthright citizenship, regardless of their parents' birthplace or legal status. Native-born citizens also include people born in Puerto Rico, U.S. Virgin Islands, other U.S. territories and possessions, and those born in foreign countries to a U.S. citizen parent.

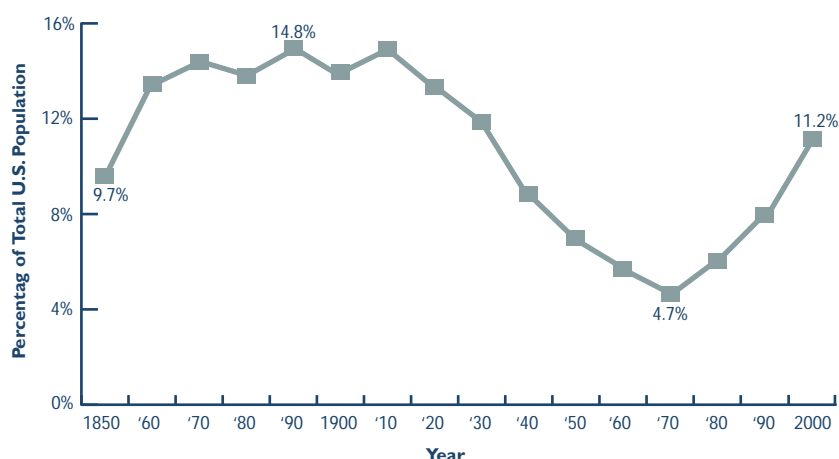
Source: Capps et al. 2003b.

Citizenship, in particular, has been shown to be an important factor in the health, social, and economic well-being of immigrants and their families. Naturalized citizens are more similar to native-born citizens than to noncitizens in the areas of education, income, and health insurance status. For example, among noncitizen immigrants, only 34 percent have more than 12 years of education, compared to 51 percent of naturalized citizens (the same rate as native-born citizens). Naturalized citizens are more likely to have higher rates of employment and earn higher salaries than noncitizens (Burkholder 2002). Noncitizens are also disproportionately low-income and more likely to be employed in industries that lack employer-sponsored health insurance as compared to citizens, both naturalized and native-born.

A Profile of Today's Immigrant Population

Roughly one in every eight individuals living in the U.S. today is an immigrant. The Census Bureau projects that immigrants' share of the total U.S. population will continue to rise in the coming decade and that by the middle of the century, this group will make up more than 13 percent of the total population (Fremstad and Cox 2004). A common misperception is that immigration rates today are the highest they have ever been. This is not true. Immigration, in fact, was highest at the turn of the 20th century, both in terms of absolute numbers and as a percentage of the total U.S. population (Figure 2) (KFF 2000). Still, the share of the population that is foreign born is more than double the level in the 1960's.

Figure 2. *Immigrants' Share of Total U.S. Population, 1850 to 2000 (percentage)*



Source: Kaiser Family Foundation 2000.

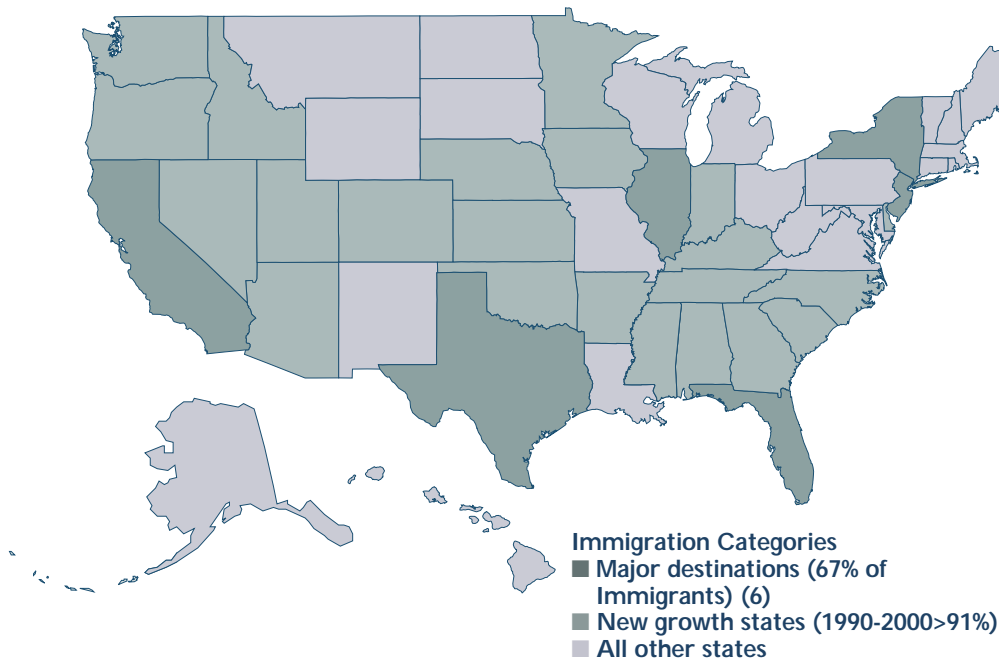
This section provides a snapshot of today's immigrant population with information on the dispersal of immigrants in the past decade, reasons for migration, and the changing composition of this nation's newcomer populations.

Settlement Patterns

Six states, historically known as major immigrant gateways, were home to over two-thirds of the nation's total foreign-born population in 2000: California (28 percent), New York (12 percent), Texas (9 percent), Florida (9 percent), New Jersey (5 percent), and Illinois (5 percent). But the dispersal of immigrants to these states has declined recently, from 75 percent in 1990 to 68 percent in 2000. In the same time period, the foreign-born population more than doubled across a wide band of states in the Southeast, Midwest, and Rocky Mountain region (Urban Institute 2002).

Although the share of immigrants in the six major receiving states remains high in absolute terms, there has been a rapid increase in the number of new immigrants to other states—many of which have not received significant numbers of new immigrants for over a century. For example, the foreign-born population grew by 145 percent between 1990 and 2000 in the new growth states (Figure 3), while nationwide it grew by 57 percent (Urban Institute 2002). The 22 states that absorbed these largely labor-driven flows form a broad band across the middle of the country, with the highest growth levels occurring in North Carolina, Georgia, Nevada, and Arkansas (Figure 4). In fact, during the 1990s, the immigrant population more than doubled in 19 of these states (Urban Institute 2002).

Figure 3. *Distribution of Immigrants in the U.S., 2000*

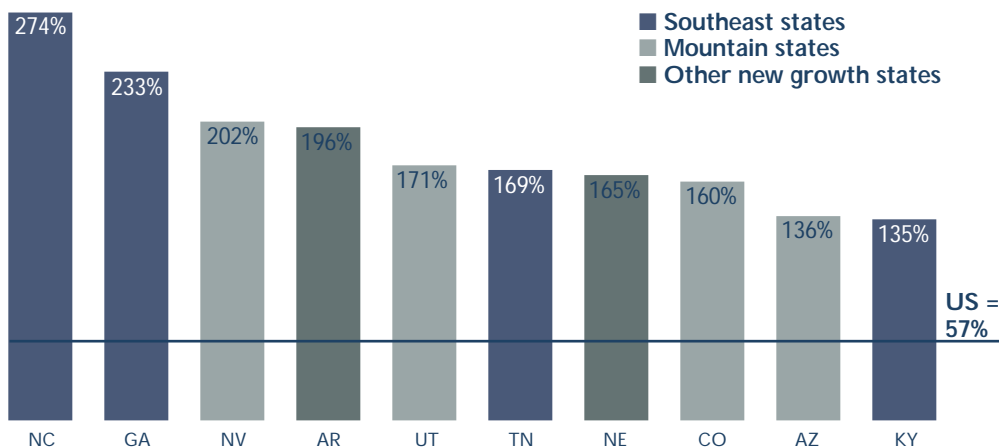


Source: Urban Institute 2002.

Another common misperception is that immigrants migrate to states with the most generous public benefits. In fact, the search for jobs appears to have driven the majority of these migration choices. Evidence from California suggests that immigration

rates slowed with the downturn in the economy in the 1990s (Urban Institute 2002). For example, according to a report by the North Carolina Institute of Medicine, Latinos move to North Carolina for employment, and are more likely to be

Figure 4. *States with the Fastest Growing Immigrant Population, 1990-2000*
(percentage growth in foreign-born population)



Source: Urban Institute 2002.

employed and in the workforce than any other population in the state. Latinos are often employed in North Carolina's most hazardous industries (agriculture and construction) or in low-paying jobs that are less attractive to other North Carolinians. Because of their willingness to work in these industries, some North Carolina businesses actively recruit Latinos from Mexico and other Central American countries (NC IOM 2003).

Economic Characteristics

Immigrants comprise a growing share of workers in America; in fact, half of all workers entering the workforce in the 1990s were foreign-born. But immigrants are substantially overrepresented among both low-wage and less educated U.S. workers. For instance, while immigrants represent roughly 12 percent of the total U.S. population, they make up 20 percent of the nation's low-wage labor force. Nearly half (48 percent) of all immigrant workers earn less than twice the minimum wage, compared with 32 percent of native workers (Capps et al. 2003b).

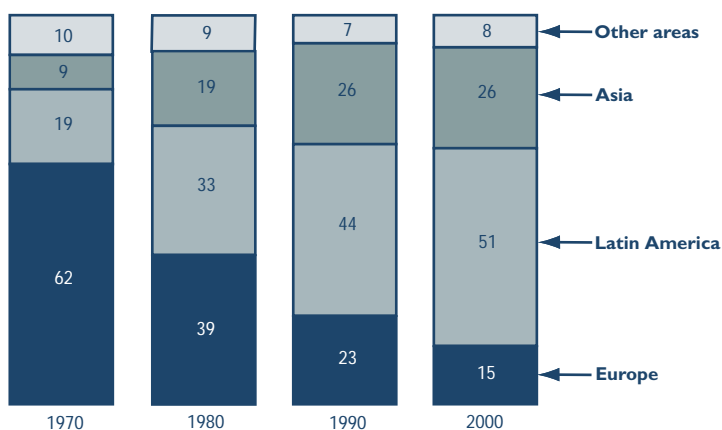
While some immigrants enter the United States with strong academic credentials and skills, many do not. Nearly two-thirds of low-wage immigrants do not speak English well and most have had little formal education (Capps et al. 2003b). For this reason, foreign-born workers were more likely than native workers to be in service occupations (23.3 percent and 14.9 percent, respectively), whereas native workers are more likely than foreign-born workers to be in management or professional specialty occupations (36.2 percent and 26.9 percent, respectively) (U.S. Census Bureau 2004).

Poverty rates continue to be high for noncitizens in comparison to both native and naturalized citizens. In 2002, 16.6 percent of immigrants were living below the poverty level, compared with 11.5 percent of native-born citizens. Foreign-born noncitizens were twice as likely to be poor as foreign-born naturalized citizens (20.7 percent and 10.0 percent, respectively), whose poverty rate was closer to that of the native population (11.5 percent). Among the foreign-born, those from Latin America had the highest estimated poverty rate (21.6 percent) and those from Europe had the lowest (8.7 percent) (U.S. Census 2004).

Region of Birth

Immigrants today are emigrating from regions of the world different from those immigrants who arrived at the turn of the century. Since 1970, the number of immigrants from Europe has steadily declined, whereas populations from Latin America and Asia have both increased (Figure 5) (U.S. Census Bureau 2002). Latin American countries accounted for over half of the foreign-born population, with countries such as Mexico, Cuba, El Salvador, and the Dominican Republic leading the way. In fact, Mexico alone accounted for over half of the foreign-born population from this region and more than one-quarter of the total immigrant population (U.S. Census Bureau 2002). Immigration from Asian nations comprised 26 percent of the foreign-born population and was distributed relatively evenly among the five largest contributors: China, the Philippines, India, Vietnam, and Korea (U.S. Census Bureau 2002).

Figure 5. *Foreign-Born Population by Region of Birth: 1970 to 2000 (percentage)*



Source: U.S. Census Bureau, 2002.

The Evolving View of Immigration in the U.S.

A recent public survey conducted by The Henry J. Kaiser Family Foundation, National Public Radio, and Harvard's Kennedy School of Government found that many nonimmigrants believe immigrants may be changing the nature of the country in a way in which they disapprove. Nonimmigrant Americans express ambivalence, if not outright unease, about the cultural impact of immigration, contending that immigrants are changing American culture and values when they ought to be adopting them.

While nonimmigrants and immigrants agree about what kind of country the U.S. is, they disagree about what kind of country the U.S. should be. For example, only a third of both nonimmigrants and immigrants believe the U.S. is a country with a basic American culture and values

that immigrants take on when they arrive, while nearly two-thirds believe it is a country made up of many cultures and values that change as new people come here. When asked, however, about what kind of country the U.S. should be, the numbers essentially reverse for nonimmigrants. The majority (62 percent) now say that the U.S. should be a country with a basic American culture and values, while 57 percent of immigrants still believe that the U.S. should be a country made up of many cultures and values (Figure 6) (KFF 2004b).

These findings illustrate a longstanding conflict between America's attitudes about immigration: whether immigrants should assimilate or increase the diversity of American culture. Some see multiculturalism as a potential problem and argue that a nation needs a core culture to remain strong and that a core culture creates a unified national identity, a unified national spirit, and a common purpose. Some take this notion even further. According to Samuel Huntington, a professor of inter-

.....

"Most of us in this country have ancestors who at one time were part of an immigrant group that experienced itself as an unaccepted minority. What have we learned from the experiences of those groups that we can now apply to the new immigrants? Or are we simply talking about the same issues without the benefit of learning from what other groups have experienced?"

KATHRYN CSANK,
SISTERS OF CHARITY
FOUNDATION OF
CLEVELAND

.....

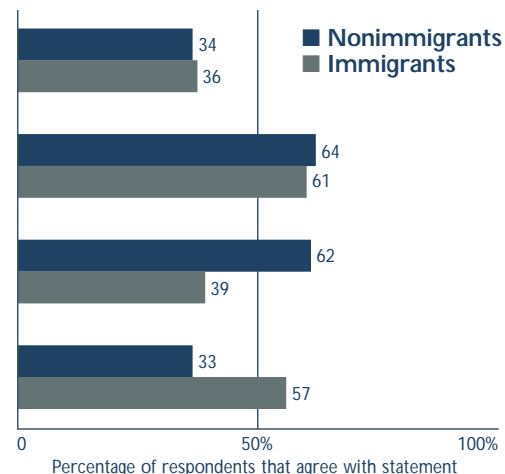
Figure 6. Agreement with Statements Regarding U.S. Culture and Values (percentage of respondents)

The U.S. is a country with a basic American culture and values that immigrants take on when they come here.

The U.S. is a country made up of many cultures and values that change as new people come here.

The U.S. should be a country with a basic American culture and values that immigrants take on when they come here.

The U.S. should be a country made up of many cultures and values that change as new people come here.



Source: Weltzien 2005.

national and area studies at Harvard University, "this core culture is under threat from a wave of immigration unlike any other in America's history. Never before have so many immigrants come from one country: Mexico. It's adjacent to the U.S., so immigrants can return there easily, and they speak the same language. As a result, there is a danger of a separate culture establishing itself in the United States" (NPR 2004).

On the other hand, others believe that immigrants add to the diversity of American culture and that this nation's history shows immigration to be an ongoing process that revitalizes and reinvigorates a community. As new residents blend with the old, the mixing of culture, language, and beliefs can form the basis of a new and improved community (The Minneapolis Foundation 2005). Some scholars also argue that multiculturalism can coexist

with a core American spirit and purpose, and that the U.S. has long been a nation of subcultures. According to Alan Wolfe, a professor of political science at Boston College, "what makes Americans American is their creed, not their culture." The term creed describes the set of beliefs embodied in the nation's founding documents, including human dignity, equality, and the right to freedom, justice, and opportunity. According to this perspective, immigrants can add to the cultural diversity of this nation, and still uphold the fundamental American beliefs of life, liberty, and the pursuit of happiness (NPR 2004).

GENERATION MATTERS

Interestingly, the children of immigrants and those immigrants who arrive in the U.S. as children hold views that are in many ways similar to those of nonimmigrants. On virtually all questions in the public survey, children of immigrants look like other native-born Americans. For example, roughly similar proportions of children of immigrants and nonimmigrants:

- are very or somewhat concerned about illegal immigration,
- believe that immigrants today are a burden on the country,
- believe that recent immigrants take jobs away from Americans, and
- believe that recent immigration has been bad for the country.

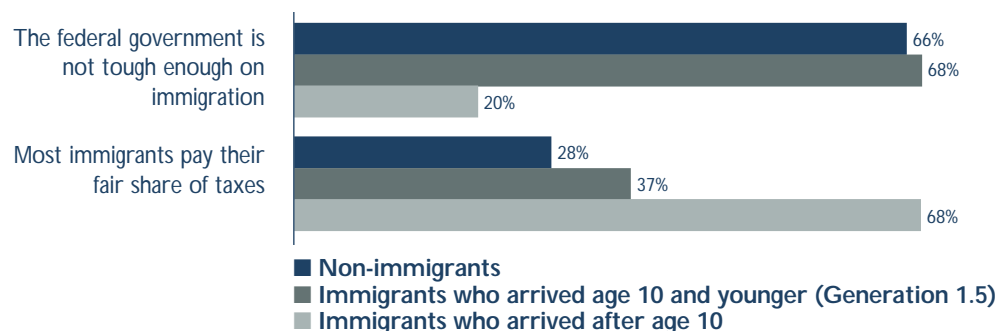
There are some differences, however, in the views of the children of immigrants and nonimmigrants. Children of immigrants are significantly more likely to believe that recent immigrants are harder working than other Americans, that recent migration (both legal and illegal) has been good for their communities, and that the federal government is too tough on immigration.

Immigrants who arrive in the U.S. when they are age 10 or younger, a group referred to as Generation 1.5, also appear to hold views that are more in line with nonimmigrants than with fellow immigrants who arrive after age 10. Roughly similar proportions of nonimmigrants and Generation 1.5 respondents believe that the federal government is not tough enough on immigration. In addition, the views of Generation 1.5 respondents on whether immigrants pay their fair share of taxes also appear to be closer to the views of nonimmigrants than to those of other immigrants (Figure 7).

These findings raise questions about the role that Generation 1.5 and the children of immigrants can play in helping to bridge the gap and foster understanding between immigrant and nonimmigrant populations. Some focus groups suggest that over time immigrants identify less and less with immigrant groups that arrive after them. Part of this may be a tendency to want to identify with individuals higher up on the social hierarchy, rather than those new to a community (Downs-Karkos 2005).

Figure 7. Agreement with Statements Regarding Immigrants (percentage of respondents)

Percentage who agree...



Source: Weltzien 2005.

Health and Social Issues of Immigrants and Their Families

Several findings suggest that recent immigrants may be healthier than those that have been in the United States longer. For example, in a study of Arizona birth certificates between 1990 and 1996, foreign-born Hispanic women experienced the lowest rate of low- and very low-birth-weight babies, even though they had the highest rate of inadequate prenatal care among all ethnic and immigrant groups. This paradoxical effect appeared to last for about five years. As these women became more acculturated to American life, their birth outcomes worsened (Burkholder 2002). Findings were similar in a North Carolina study, where recent Latino immigrants had lower age-adjusted death rates than whites or African Americans (NC IOM 2003).

The reasons for this phenomenon are complex, but may be explained, in part, by adoption of the American way of life and a change in healthy behaviors. Several

studies have shown changes often associated with acculturation (such as worsening dietary intake, increased smoking, illicit drug use, alcohol use, loss of family support, increased stress during pregnancy, and an increase in out-of-wedlock births) may have an impact on low birthweight (Burkholder 2002). Additionally, reduced access to traditional diets that emphasize vegetables and grains, and easier access to high-fat foods, may explain why recent immigrants are relatively healthy when they first arrive, but then adopt unhealthy behaviors with more time spent in the U.S. (NC IOM 2003).

Further evidence suggests that as immigrants are exposed to and adopt traditional American health behaviors over time, their health status begins to converge with that of the general U.S. population. For example, increased time in the U.S. has been associated with increased rates of usage of both alcohol and illicit drugs among foreign-born populations. While recent immigrants have significantly lower rates of substance abuse, immigrants residing in the United States for more than 15 years use illicit drugs at rates similar to the native-born population. A similar

phenomenon exists for obesity rates. Adolescent obesity increases significantly with each generation after immigration. Asian American and Hispanic adolescents born in the United States are more than twice as likely to be obese than first-generation (foreign-born) adolescents. One study analyzed the diets of Mexican Americans in various stages of transition from traditional Mexican diets to more mainstream American diets. The authors report that with increased acculturation and time in the United States, immigrants consume fewer complex carbohydrates and more highly processed convenience foods that are high in sugar and fats (Kandula et. al 2004).

These findings suggest that incorporating some of the cultural traditions of newcomers into the mainstream could benefit those in receiving communities. Over time, Americans have come to embrace options for healthy living from other cultures, such as diets that emphasize freshness and low-calorie ingredients and forms of exercise that emphasize relaxation, flexibility, and balance. Promoting a culture of integration, versus assimilation, may help to further acceptance of immigrants' healthy behaviors, and improve the health of the broader community.

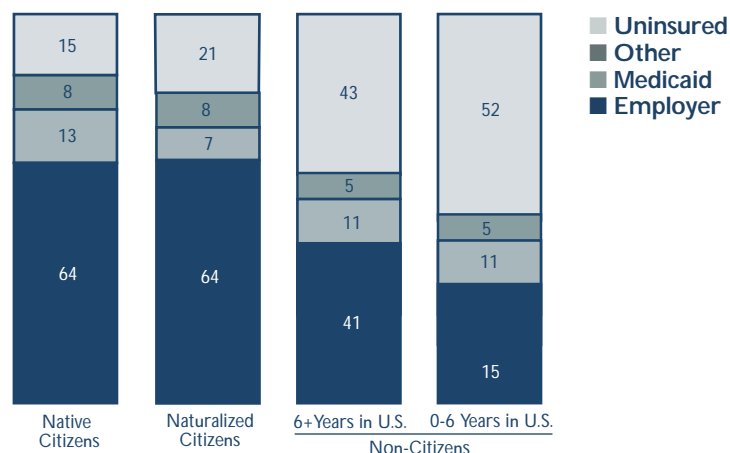
In addition to the health risks inherent in acculturation, immigrants and their families face myriad challenges to health and well-being. The following sections describe some of these health concerns, including lack of health care coverage and access, cultural and linguistic barriers, and cultural adjustment and changing family dynamics.

Health Care Coverage and Access

Low-income immigrant families faces many of the same challenges to health and well-being that all low-income American families face: lack of health care coverage and access to preventive care, no usual source of care, and increased risk for hospitalization for avoidable health problems and diagnosis at the late-stages of disease. But immigrants and their families also face unique challenges. Concentration in industries that frequently do not provide health insurance coverage, coupled with eligibility restrictions on public health insurance coverage, contribute to the high rate of uninsurance for immigrants. Immigrants are also more likely to reside in low-income neighborhoods with reduced access to hospitals, clinics, physicians and pharmacies. Moreover, the challenges of adapting to a new health care system, often with a different language and cultural beliefs, create significant access barriers for immigrants and their families.

Evidence suggests that citizenship status may play a larger role in coverage than race and ethnicity. Over half (52 percent) of recent immigrants were uninsured in 2003, compared to 15 percent of native citizens and 21 percent of naturalized citizens (Figure 8) (KFF 2004a).

In one study, after controlling for health status, income, employment, race and ethnicity, and other factors that affect insurance coverage status and utilization, noncitizens were more likely to be uninsured, and citizen Latinos had levels of insurance comparable to those of white citizens (Ku and Waidmann 2003).

Figure 8. *Health Insurance Status by Citizenship Status, 2003 (percent distribution)*

Note: Based on nonelderly population. Other includes private nongroup, Medicare, and CHAMPUS.
Source: KFF 2004a.

Private Coverage

Recent and low-income immigrants are less likely to have access to private health insurance coverage through their employers. While a majority of immigrants (81 percent) have a full-time worker in the family and low-income immigrants are more likely to include a full-time worker than low-income native families, many of these jobs do not offer health coverage.

Immigrants are more likely to work in low-wage jobs or be self-employed, and work in the agricultural, labor, or repair industries. Thus, while nearly two-thirds of citizens had employer-sponsored health coverage in 2003, only one-third of noncitizens had such coverage (KFF 2004a). Some experts point to discrimination in the workplace and labor exploitation as additional explanations for this situation (Ku 2005).

A common theory for explaining low rates of private insurance among immigrants is that immigrants are less likely to recognize the need for health insurance, instead

choosing to spend limited resources on more pressing needs such as food, housing, and clothing. But to the contrary, evidence suggests that immigrant populations value health insurance coverage as much as any other group. For example, while Latino noncitizen workers are less likely to be offered employer-sponsored health insurance (50 percent) compared to both whites (87 percent) and Latino native citizens (80 percent), they are nearly as likely to accept coverage when offered (81 percent, compared to 87 percent for both whites and Latino native citizens) (Ku 2005).

Public Coverage

Medicaid and SCHIP, the nation's major health coverage programs for low-income populations, play an important role in filling the gap in employer-sponsored coverage. But policy changes in the past decade have dramatically limited immigrants' access to these programs and created a climate of confusion in which immigrants who are eligible for Medicaid and SCHIP remained uninsured for fear of

jeopardizing their citizenship status. For example, the 1996 federal welfare reform law (Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) restricted Medicaid eligibility of immigrants, so that those admitted to the United States after August 1996 are ineligible for coverage, except for emergencies, in their first five years in the country. Prior to this, legally admitted immigrants were eligible for Medicaid and other benefits on the same terms as citizens (Ku and Matani 2001). Additionally, the enactment of “sponsor deeming” rules, which attribute the income of an immigrant’s sponsor to the immigrant, render many immigrant families ineligible for public coverage, even after the five-year ban expires (Alker and Urritia 2004).

Publicity about the Immigration and Naturalization Service’s (INS) efforts to apply public charge enforcement to Medicaid caused many immigrants to shy away from enrolling in Medicaid even if they were uninsured and eligible (Ku and Matani 2001). Public charge is a term used by the INS to describe persons who cannot support themselves and who depend on public benefits for their support. A public charge determination may result in denial of permission to adjust to legal permanent resident status; denial of a visa to enter the United States; denial of readmission to the United States after a trip abroad lasting more than six months; or, in very rare circumstances, deportation (Fremstad 2000). Prior to 1999, lack of a clear government standard that explained how the law was applied, as well as anecdotal accounts of immigrants being deemed a public charge for receipt

of Medicaid and the resulting repercussions, were major barriers to immigrant families’ participation in health and social programs. In May 1999, however, the Clinton Administration issued a guidance that clarified the law and declared that the use of Medicaid, SCHIP, or other health services by immigrants or their families would not affect their immigration status (National Immigration Law Center 1999).

Collectively, these activities have caused fear and confusion among immigrant communities about eligibility for and participation in public programs and have led to a decline in the number of legal immigrants receiving Medicaid and SCHIP coverage. As a result, the gap in overall health insurance coverage between low-income citizens and noncitizens has widened. For example, between 1995 and 2001:

- The proportion of low-income noncitizen children who were enrolled in Medicaid or SCHIP fell by 12 percent, while enrollment increased for citizen children by 2 percent. Moreover, the uninsured rate rose by 8 percent for noncitizen children, while it fell for citizen children.
- The proportion of low-income noncitizen parents who were enrolled in Medicaid fell by 10 percent, while enrollment for citizen parents fell by 6 percent. Similarly, the uninsured rate rose by 8 percent for noncitizen parents, compared to a 3 percent increase for citizen parents (Fremstad and Cox 2004).

.....
“When it is offered to them, immigrants place the same priority on having health insurance as everyone else does. The difference is they have less access to it.”

.....
 LEIGHTON KU,
 CENTER ON BUDGET
 AND POLICY PRIORITIES

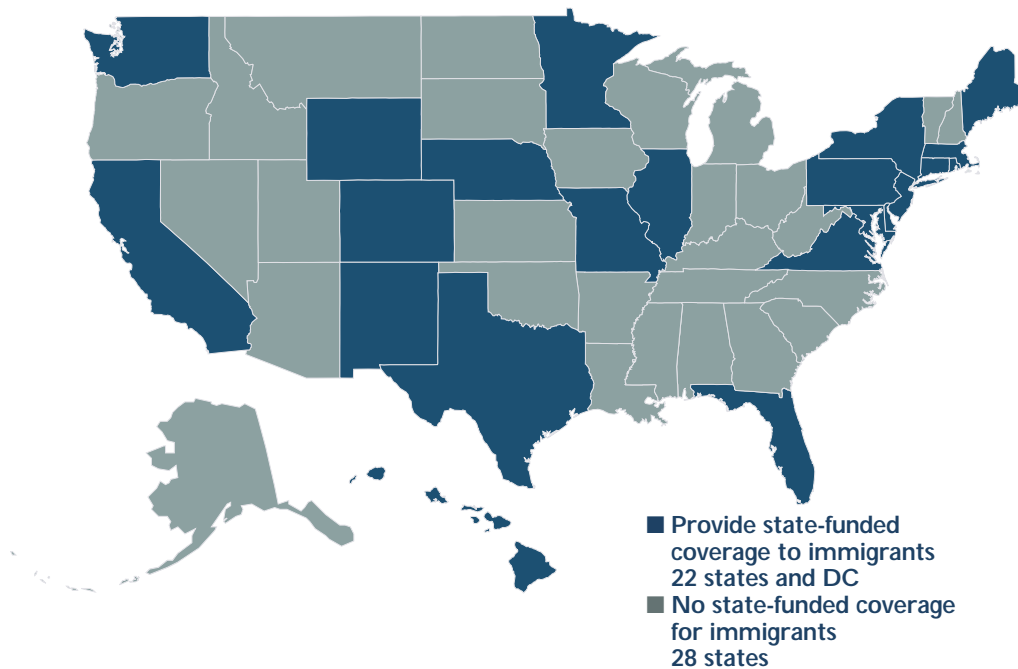
THE COSTS OF RISING EMERGENCY CARE

While there is debate about immigrants' use, or overuse, of emergency departments, insurance status may better explain these rising costs than legal status. Evidence suggests that noncitizen immigrants are less likely to use emergency rooms than native-born citizens (Ku 2005 and Mohanty et al 2005). But because immigrants are disproportionately uninsured, and lack of health coverage leads to higher risks for hospitalizations, emergency room costs are often higher for immigrants. For example, while immigrant children made fewer trips to the emergency room, their emergency room costs were nearly triple those for nonimmigrant children (Mohanty et al. 2005). These findings highlight the important roles that health insurance coverage and preventive care play in reducing unnecessary health care expenditures.

One policy alternative is to reimburse hospitals directly for the costs of emergency care for all uninsured patients, including immigrants. Under a program announced by the Centers for Medicare and Medicaid Services in July 2004, the federal government will offer U.S. hospitals \$1 billion over four years to cover emergency room costs for uninsured patients, regardless of their immigration status. The largest allocations are going to the states with the biggest immigrant populations, with California receiving the lion's share of the funding. Hospital groups maintain that the program likely will help the finances of hospitals with large immigrant populations. And while immigrant advocacy groups agree that increasing funding for immigrant health care is noteworthy, they argue that this program does not address lack of insurance or access barriers, which cause many immigrant families to forgo care until conditions worsen and require expensive treatment.

Moreover, immigrant rights groups argue that provisions of the program could lead to greater fear and confusion among immigrant communities, ultimately deterring them from seeking care. While hospital personnel cannot ask patients directly whether they are undocumented immigrants, staffs are required to ask patients whether they are foreign-born, whether they have a border-crossing card, and whether they are eligible for Medicaid. If patients voluntarily admit that they are undocumented immigrants, hospital personnel do not have to ask the questions. Advocates suggest using statistical formulas to determine the allocation of funds under the program, rather than requiring hospital staff to ask questions related to the immigration status of patients (Pear 2005).

Figure 9. State-Funded Coverage for Immigrants Who are Ineligible for Medicaid or SCHIP, May 2004



NOTE: In some cases coverage is only available to limited categories of immigrants, is substantially more limited than Medicaid or SCHIP coverage, or has other rules that can limit participation, such as premiums, cost sharing, more burdensome enrollment procedures, and enrollment caps. Arkansas, Illinois, Massachusetts, Michigan, Minnesota, Nebraska, and Rhode Island use federal SCHIP funds to provide prenatal care coverage regardless of immigration status.

Source: Fremstad and Cox 2004.

State Efforts to Increase Coverage for Immigrants

As of 2004, 25 states had undertaken efforts to help address the coverage limitations imposed on immigrants by the 1996 welfare law. Twenty-two states and the District of Columbia are using state funds to provide coverage to legal immigrants who are ineligible for Medicaid or SCHIP because of the 1996 restrictions; some are also using a recently available option to use federal SCHIP funds to provide prenatal care regardless of the immigration status of the mother, including two that do not provide state-funded coverage for immigrants (Figure 9). Some states have also used these programs to extend coverage to undocumented immigrants

(particularly children and pregnant women) who were ineligible for Medicaid prior to 1996 (Fremstad and Cox 2004). It is important to note that of the new growth states referenced in Figure 4, only 2 out of 10 are using state funds to cover immigrants ineligible for Medicaid and SCHIP, and 1 additional state provides prenatal care coverage regardless of immigration status.

In addition to providing coverage to immigrants who are ineligible for Medicaid or SCHIP, some states have increased efforts to reduce enrollment barriers for those who are eligible. Activities include addressing immigrant confusion surrounding eligibility, reducing language barriers, and alleviating

immigrant concerns about the impact of enrolling in coverage on immigration status. Early analysis indicates that state-funded coverage programs for immigrants and other state efforts have been effective in reducing uninsured rates among immigrants. Noncitizen children living in states with state-funded programs have lower uninsured rates than similar children living in states without these programs (Fremstad and Cox 2004).

Access to Care

While coverage is an important first step in improving immigrant health and well-being, access barriers challenge insured immigrants as well. In one study, for example, after statistically controlling for insurance status, income, and education, citizen Latinos and their children were less likely to have visited a doctor in the preceding year than whites with similar socioeconomic and health characteristics (Ku and Waidmann 2003). This suggests the need for multipronged solutions for improving immigrant health that consider a person's insurance status, geographic location, familiarity with the U.S. health care systems, and cultural beliefs.

Another study found that immigrants use fewer health care services and have much lower health care expenditures than native-born citizens, challenging claims that immigrants are draining the U.S. health care system. Regardless of age, insurance status, or country of origin, health care expenditures for immigrants were about 55 percent less than those of

U.S. native-born residents. On average, immigrants received about \$1,139 in health care in 1998, compared with \$2,546 for native-born residents. Moreover, immigrant health care expenditures totaled \$39.5 billion in 1998, with about \$25 billion reimbursed by private health insurers, \$11.7 billion reimbursed by government programs, and \$2.8 billion paid out of pocket. And while immigrants accounted for 10 percent of the U.S. population in 1998, they accounted for only 8 percent of U.S. health care costs. Disparities were similar for children and persisted among various racial and ethnic groups (Figure 10).¹

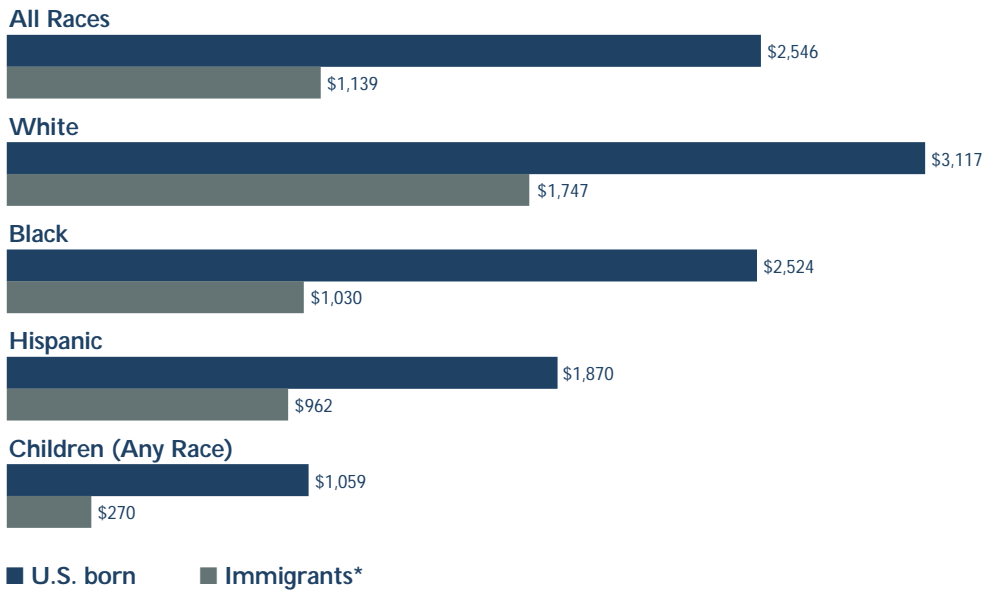
Cultural and Linguistic Barriers to Health Care

The growth in immigrant populations and the corresponding rise in linguistic and cultural diversity in the United States have raised concerns about the ability of the nation's health care system to care for all patients appropriately. Immigrants coming to this country are often accustomed to different health care systems and may have different health beliefs. They may speak another language or be limited English proficient (LEP).² The rapid growth of immigrant populations in new growth states has overwhelmed many public agencies, and the underlying issues of lack of insurance coverage, language barriers, different cultural and health beliefs, and general unfamiliarity with the U.S. health care system have not been adequately addressed. Recent immigrants are likely to have fewer marketable skills, lower

¹ The study included the following racial and ethnic groups, comparing foreign-born individuals to their native counterparts: white, blacks, and Hispanics.

² Limited English proficient, as defined in the context of the health care setting, is "a person who is unable to speak, read, write, or understand the English language at a level that permits him/her to interact effectively with health and social service agencies and providers" (Office of Civil Rights 2002).

Figure 10. Annual Per Capita Health Care Spending for Native and Foreign-Born U.S. Patients by Ethnicity and Age, 1998



* Includes legal and illegal immigrants
Source: Mohanty et al. 2005.

incomes, and a weaker command of English than those who have lived here longer and may be more likely to need benefits and services such as health insurance, interpretation, and English language courses. In many new growth states, demand for these types of services is rising even though these states have less infrastructure (for example, experienced bilingual teachers and immigrant organizations) to meet demands (Urban Institute 2002).

Cultural and language barriers in the health care setting can present enormous obstacles to good medical care and have an impact on the health and well-being of many immigrants and their families. For example, Western medicine may not sup-

port, and can sometimes misinterpret, cultural and religious beliefs of newcomers. In many cultures, speaking to deceased loved ones is a natural means for coping with death, but these individuals may be diagnosed by Western physicians as needing mental health care services. Similarly, language barriers have been shown to impede access at several entry points, from having health insurance to receiving basic and preventive care to accessing specialty services. This can create barriers to the effective use of the U.S. health care system and providers must be aware of these different cultural beliefs in order to effectively treat growing immigrant populations.³

³ For an in-depth discussion of the roles of language and culture in providing health care, including a detailed analysis of the effect of language barriers on health outcomes and health care processes, a summary of the laws and policies regarding the provision of language services to patients, strategies for improving language access, and philanthropic activities in this area, please see the GIH Issue Brief, *In the Right Words: Addressing Language and Culture in Providing Health Care*, available at www.gih.org.

Cultural Adjustment and Changing Family Dynamics

Relocation involves a set of challenging, and sometimes stressful, activities for most individuals: securing a job, finding a place to live, enrolling children in school, and obtaining basic needs, such as transportation, health care, and utilities. Immigrants resettling in a new country face these same stressors, as well as a host of others, including a period of cultural adjustment that influences, and often changes, family dynamics.

Every member of an immigrant or mixed-status family faces unique challenges as a result of living in a new country and adjusting to accompanying cultural norms and expectations.⁴ Children (both immigrant children and native-born children of immigrants) often feel as though they are caught between two worlds and must deal with conflicting demands; they feel parental pressure to stay true to their native culture, while peer pressure encourages them to act more American and fit in with popular culture. For parents, community expectations regarding parental involvement in schools and securing preventive health care services (such as immunizations) may be different than those in their home country. Parents also tend to learn English more slowly than children, resulting in a reliance on their children for help with interpretation and with navigating community systems. This change in power dynamics can be detrimental, eroding the respect children typically have for their parents (Downs-Karkos 2004).

Of all family members, grandparents are at the most risk for social isolation. Their adult children often work full-time, and the rapid Americanization of their grandchildren may cause them to feel uncomfortable around them. Additionally, older adults are less likely to feel comfortable speaking English, and therefore, may not readily venture outside their homes. Lastly, immigrant seniors often feel that respect for one's elders is not as valued in American culture as it is in their own. Because of these many stressors and challenges, family dysfunctions may result, leading to such problems as depression, substance abuse, family violence, or children dropping out of school (Downs-Karkos 2004).

Philanthropic Activities to Improve Immigrant Health and Well-Being

Immigrants and their families will play an increasingly important role in communities across the United States in the years ahead. Recognizing their contributions while addressing their myriad health and social needs will be critical for keeping communities strong and vibrant. Foundations play an important role in ensuring the health and well-being of immigrant populations, and are engaged in activities that build capacity in immigrant

⁴ A mixed-status family includes both citizen and at least one noncitizen member. In most mixed-status families, the children are the U.S. citizens, but the parents are not (Capps et al. 2003a).

communities, promote immigrant integration, expand health care coverage, educate immigrants on their rights and eligibility for health care services, increase public awareness and understanding of immigration, and address the cultural and linguistic needs of these populations.

Capacity Building in Immigrant Communities

Most health funders are helping to build the capacity of the nonprofit organizations they fund. Grantmakers recognize that their work and accomplishments are intrinsically tied to a grantee's ability to be effective and adaptive, so they offer multifaceted support to grantees along the way. Many health funders now have programs that include capacity building or organizational effectiveness, with strategies that range from providing basic technical assistance and training to large, multiyear initiatives to create strategic partnerships in particular service communities.

The Alliance Healthcare Foundation in San Diego, California funded the *African Collaborative Health Initiative (ACHI)* to support five African, community-based organizations (CBOs) that came together to educate African immigrants and selected health care providers about the legal, medical, and cultural issues surrounding female circumcision. The target African community included immigrants and refugees from seven countries. The goals of the *ACHI* were to improve access to appropriate health care services for circumcised women, prevent additional circumcisions, and to build the capacity of its members to address the broader health care issues within these communities.

Through this initiative, and a subsequent one focusing on prenatal care, well-baby and child care, and breast cancer, the foundation learned about both the challenges and rewards of supporting capacity building in small, immigrant communities. Internal challenges included the patriarchal bent of the East African cultural groups, extreme distrust and dissension within and among the CBOs, and the absence of financial management. As such CBO training, capacity building, and restructuring were critical components of the project. External challenges included the widespread fear of prejudgment of cultural practices and possible prosecution, and the lack of cultural competency in San Diego's health care system. While challenging, the initiative produced some noteworthy results. Of the five African, community-based organizations funded through the *ACHI*, only one was an established social service agency with stable funding; the other four were small, grassroots entities surviving on donations from the community. At the end of the initiative, two of the four small groups were recognized as stable, credible social service providers that now play an important role in delivering a variety of services to African immigrants.

The foundation also learned once more the importance of long-term commitment. To build true capacity in a community, one has to remain committed for several years and stick with it, despite challenges that may arise. During the *ACHI*, power struggles among the different organizations within each African ethnic group made the foundation's commitment even harder, particularly when other organizations needed funding. But the foundation stayed the course; and their commitment to

funding these agencies through the rough times over this five-year period made a difference. Through this experience, the foundation learned that to be serious about working with newly arrived immigrant groups (many of whom are refugees from war-torn areas with long-standing tribal conflicts and a justified fear of authority), the foundation needed to go through this challenging process in order to support the community's ability to develop its own capacity to serve its members (Lloyd 2005).

The Washington Area Partnership for Immigrants was established in 1998 by The Community Foundation for the National Capital Region through support from the Emma Lazarus Fund of the Open Society Institute. Initially established to support the ability of immigrants to obtain U.S. citizenship, the partnership has developed into a strong regional leadership group assuming an important role in the development of emerging immigrant leadership and in the protection of legal rights. It is guided by a coalition of local foundations, corporations, and government representatives from local jurisdictions within the region, and supported by both local and national philanthropic foundations.

The partnership has granted over \$1.2 million to support immigrant-serving organizations in the Washington, DC metropolitan region. The goals of the partnership are to:

- Raise awareness about the changing demographics in the region and the implications that these changes have for funding decisions, the development

of public policy, and the provision of human services. For example, The Brookings Institution was commissioned to create a demographic profile of immigrant communities living in the Washington, DC metropolitan area based on the results of the 2000 Census. The profile will be used to increase awareness of the demographics of the immigrant community and to support the work of program planners and community advocates.

- Build the capacity of community organizations and immigrant networks in order to support their ability to serve immigrant communities. Funding will be targeted to programs that support the organizational development of emerging, as well as established community-based organizations serving immigrant communities; and the establishment of a regional leadership development model supporting the civic engagement of adult immigrants and immigrant youth.
- Strengthen the ability of community organizations and immigrant networks to work collaboratively and to advocate on behalf of their constituents across the metropolitan region. For example, funding has enabled local leaders to advocate around key issues, such as access to quality education for limited English speakers and immigrant youth within public school systems, protection of the rights of low-wage workers and day laborers, and access to English as a Second Language programs for adults.

Promoting Immigrant Integration

Immigrant integration is defined as the weaving of newcomers into the social, economic, cultural, and political fabric of the receiving community. It is a two-way process that places mutual responsibilities on both the immigrant community and the receiving community, ideally transforming both. Receiving communities are expected to value the diversity that immigrants bring to communities, as well as play an active role in meeting their needs. Immigrants themselves bear responsibility for integration by doing their part to become contributing members of society; among other things, this includes learning English, getting involved in their children's education, and participating in this nation's democracy (Petsod 2004).

Immigrant integration holds considerable promise as a framework to guide the development of program, policy, and funding priorities that benefit both the newcomers and their receiving communities. When applying the immigrant integration framework to health, however, it is important to be cautious about placing the burden of integration on immigrant communities. Although the principle of immigrant integration asserts mutual responsibilities, Grantmakers Concerned with Immigrants and Refugees points out that “for most new immigrants and refugees, the initial focus upon arrival will be on day-to-day survival, and it may take years for them to move from immediate survival to establish roots and become active in community life (Petsod 2004).” This is especially significant to the health arena for the several reasons. First, immediate health needs make it impossible to wait for linguistic

competence and cultural assimilation. Secondly, if individuals wait until language acquisition to access the health care system, they may miss opportunities for important preventive services, which may lead to complicated and costly health concerns. Finally, acquiring English skills may not be sufficient preparation for navigating the health care system. Even native speakers have problems accessing the health care system, understanding medical terminology, and following a provider's instructions.

Several grantmakers are supporting activities that promote immigrant integration in their own communities, both by increasing the capacity of immigrant-based organizations to serve these populations, as well as ensuring that stakeholders in the receiving community recognize the important role they also play in ensuring immigrant health and well-being. For example, in 2004, the John S. and James L. Knight Foundation launched the *Immigrant Integration Initiative*, investing \$13.5 million over the next five years to help integrate immigrants into American communities. Working with nationally respected nonprofit organizations (such as National Council of La Raza and National Immigration Forum), as well as local organizations in the 26 communities where the foundation has an established presence, the foundation will support approaches that increase rates of naturalization, improve English-language education, and strengthen the local and national network of immigrant-serving organizations across the country. As part of this initiative, the foundation has established the American Dream Fund (\$6 million over four years), which will support local organizations that serve and

advocate for immigrants. The new fund will help link local immigrant groups to national and state organizations working on public policy change. The overall goal of the initiative is to ensure that immigrant families achieve economic self-sufficiency and individual liberty, and have access to basic human rights.

Minnesota's immigrant population grew 130 percent between 1990 and 2000, making the state the 12th fastest in terms of immigrant population growth in the country (ahead of traditional gateways such as California, Texas, and Florida). Minnesota is home to 260,000 immigrants, including the largest Somali population outside of Somalia, a large Hmong population, and a fast-growing Liberian population. In 2005, the Blue Cross and Blue Shield of Minnesota Foundation announced a new grantmaking focus on the factors that determine health beyond genes, lifestyle, and access to health care. The foundation's first grantmaking initiative under this new focus, *Healthy Together: Creating Community with New Americans*, seeks to improve the health of recent immigrants by supporting healthy social adjustment and, in the long-term, strengthen communities and reduce health disparities. In its first year, the program will make up to \$1 million in grants for projects that explore, implement, and evaluate strategies at the intersection of health, social connectedness, and immigrant integration. Specific objectives include addressing the mental health and social adjustment of new Americans; strengthening the capacity of immigrant-led organizations to address health issues; and promoting exchanges

among newcomers and between newcomers and the resident community, with the intent of increasing social connectedness. The Healthy Together initiative received 70 letters of intent from potential grantees; 20 of these were passed on to the next stage of review. As a part of this initiative, the foundation is working with the Hubert H. Humphrey School of Public Policy at the University of Minnesota to develop and implement a replicable model for effective exchange between newcomers and long-term residents.

Finally, the *Immigrants and Refugees Program* of the Zellerbach Family Foundation, in the San Francisco Bay Area, is designed to take a comprehensive approach to supporting projects that help smooth the way for successful integration of newcomers into communities and promote their full participation in civic life. Funds are directed to community organizations that engage in direct services, leadership development, civic participation, and policy analysis and development. Grants are also aimed at strengthening the capacity of immigrant-serving organizations, and at promoting creative solutions to the challenges local communities face in accommodating diverse populations. Collectively, the grants in this program support projects that build the skills and knowledge of community members, advance equitable public policies, and promote greater communication and coordination among organizations so the needs of community members can be met more effectively.

FROM CAPACITY BUILDING TO IMMIGRANT INTEGRATION: THE EVOLUTION OF AN INITIATIVE

Colorado's immigrant population has increased 160 percent over the last decade and now makes up 8.6 percent of the state's total population. But even before the official Census reports came out in 2000, The Colorado Trust began looking for ways to respond to these changing demographics. Foundation staff started with surveying service providers throughout the state, holding key informant interviews, and conducting focus groups with immigrant and refugee families. From these activities, the foundation decided to create the *Supporting Immigrant and Refugee Families Initiative* in 2000, designed to strengthen the capacity of immigrant and refugee serving organizations across the state. A total of 23 immigrant-serving organizations were funded to provide mental health or cultural adjustment services to immigrants and refugees over a three-year period. Each group had access to technical assistance and a third-party project consultant who tailored services to meet each organization's needs.

After focusing on these capacity-building projects for four years, the foundation thought strategically about its next approach. While having a strong cohort of immigrant-serving organizations was critical, this approach only addressed part of the problem. To be fully responsive to immigrant and refugee needs, significant work was also needed at the broader community level, particularly with large, mainstream institutions such as schools, hospitals, and local governments. A comprehensive approach involving mainstream institutions, immigrant-serving organizations, and even individual community members was the clear next step in more fully addressing immigrant needs in Colorado.

In 2004, the foundation embarked on the current phase of the initiative, a \$6.4 million effort that focuses on immigrant integration. Forty-three communities applied to receive funding and ten were selected to participate; the communities are developing and will put in place comprehensive plans to help immigrants and refugees adjust to and become an integral part of their communities. The grantee communities have each formed broad coalitions, including representatives from health care, education, business, law enforcement, libraries, local government, faith-based organizations, immigrant-serving organizations, and immigrants themselves. Following an initial four- to six-month planning process, the 10 communities will submit proposals to the foundation for grants of up to \$75,000 per year per community for four years to implement portions of their plans. Throughout the grant period, grantees receive significant meeting facilitation and technical assistance. The Colorado Trust's process and outcome evaluations of the immigrant integration efforts will be designed to examine if, and to what degree, community members are able to rally around the concept of immigrant integration, and to what extent newcomers and long-term residents perceive changes in immigrant integration in their communities (The Colorado Trust 2004).

Expanding Access and Coverage for Immigrants and Their Families

Access to care is a dominant theme in the work of many health grantmakers. The philanthropic community has examined access from many angles, seeking ways to break down barriers created by costs, culture, miscommunication, system structure, and differing notions about who and what should be covered by both public and private insurance. Efforts have focused on many vulnerable populations, including immigrants and their families, and grantmakers are working to expand coverage for this population, many of whom are not eligible for public insurance.

The Moses Cone-Wesley Long Community Health Foundation is supporting the *Adopt-a-Mom* program in Guilford, NC, an area which traditionally has had high infant mortality rates. Under this program, the foundation pays \$400 to cover the costs of all prenatal care for low-income pregnant women, with the women paying \$100 toward the costs. Those who are found to be at high risk are sent to Duke University to receive additional needed care. Several hundred Hispanic immigrants have been helped through this program and the foundation is now working with the local health system to develop a program that will allow high-risk women to receive the additional care they need within the community.

The Oakland, California site of the W.K. Kellogg Foundation's multisite *Community Voices* project is focused on increasing coverage and access to care for the county's large immigrant population. Partnering with two local community health centers,

Asian Health Services and La Clinica, the *Community Voices for Immigrant Health Project* worked with the Alameda Alliance for Health, the local nonprofit managed care plan, to develop *Family Care*, a comprehensive, subsidized health insurance product designed for low-income families (defined as those below 300 percent of the federal poverty level) who do not qualify for government health assistance programs. Other activities of this project include:

- focus groups with small business employers and the working poor in the Latino and Asian and Pacific Islander communities to develop or improve affordable insurance products that fully address the needs of these populations;
- community forums to seek input from immigrant communities about the impact of policies and health access barriers;
- job training to help residents enter the health care field provided by La Clinica, a large employer in the community; and
- a survey of the uninsured in Alameda County.

Grantmakers are also looking for opportunities to learn from their grantmaking and identify policy reforms that focus on improving existing systems of care for all underserved populations. In California, efforts are underway to find the most effective strategies for improving access and expanding coverage in the short term and, ultimately, determining how these actions can serve as the blueprint for future policy solutions. Funding from The California

Endowment and other foundations has helped to expand health coverage to all children in the state, regardless of immigration status. Through focus groups and conversations with service providers and advocacy groups, the foundation learned that different enrollment processes and eligibility criteria created barriers to covering all kids. Particularly, for mixed-status families, when one child is eligible for public insurance and another is not, parents often refrain from enrolling even the eligible child. Broad-based coalitions in counties across the state are exploring, developing, and implementing children's health insurance programs that are comprehensive and inclusive for all children, including low-income immigrant children who do not qualify for existing programs. These efforts have led to the development of policy goals that focus on changing the current system of how children obtain coverage and care, such as simple enrollment entities, use of technology to improve efficiency and to help outreach workers be effective, built-in safety net supports, coverage that is portable across providers, and standardized benefits for undocumented children. Subsequent efforts have focused on ensuring consistency in the development and implementation of local models and on engaging state administrators on needed policy changes.

Supporting Education and Outreach About Eligibility and Health Care Rights

Several funders have supported efforts to reverse the effect of welfare reform and improve policy initiatives targeting immigrant health needs. For example, The Boston Foundation funded immigrant-led organizations to train peer educators to

inform their communities about the effect of welfare reform on coverage and address eligibility concerns. Additionally, funding for the Newcomers Campaign provided training to outreach workers, already working within their communities, on information about existing health programs and access to enrollment. The outreach workers also discussed and explored the systemic obstacles immigrant communities faced when trying to obtain medical service.

Health grantmakers in California have funded organizations to inform immigrants of their eligibility for Medi-Cal, the state's Medicaid program. For example, the California HealthCare Foundation funded the Asian Pacific American Legal Center of Southern California to conduct an outreach and education campaign targeting low-income Asian and Pacific Islander communities in counties across the state to help educate them on the benefits of enrolling their children in the Medi-Cal programs and to clarify issues of public charge. Similarly, The California Wellness Foundation supported *Improving Access for Underserved Ethnic Communities*, a \$200,000 project of the California Pan-Ethnic Health Network (CPEHN). As a statewide network of organizations, CPEHN represents more than 50 health-focused organizations serving communities of color and advocates to key government and private sector decisionmakers. CPEHN works with a number of organizations to make sure Medi-Cal and Healthy Families provide culturally and linguistically competent care to their enrollees and to ensure that commercial health plans pay for and provide appropriate care to their members. CPEHN

estimates that 10 to 30 percent of commercial health plan members are of limited English proficiency.

The California Endowment embarked on a public engagement campaign in partnership with California's ethnic media targeting the state's immigrant and LEP populations. The project supported the development, placement, and tracking of an integrated advertising and editorial campaign targeting LEP groups to educate them on their health care rights. Specific campaign activities include: informing consumers about the issue of language access through 200 print, radio, television, and on-line ethnic media outlets that target 12 linguistic groups; administering pre and post surveys monitoring the level of awareness of these issues among the top 12 linguistic groups; and forming linkages to ongoing advocacy and systems change efforts.

Increasing Public Awareness and Understanding of Recent Immigrants

The public survey conducted by The Henry J. Kaiser Family Foundation, National Public Radio, and Harvard's Kennedy School of Government, referenced previously, found that misperceptions about the proportion of illegal to legal immigrants fuel negative attitudes toward immigration as a whole. The majority of respondents (54 percent) believe that most recent immigrants are in the country illegally. These individuals, in comparison with those who think most immigrants are here legally, are more likely to think that the federal government is not tough enough on immigration, that

immigrants do not pay their fair share of taxes and burden the country, and that recent immigration has been bad for the country.

On an encouraging note, native-born Americans who have more contact with immigrants express more positive views toward them than those who have less contact. For instance, nonimmigrants with high contact with immigrants and living in states with high immigrant populations are:

- more likely to say that immigration in recent years has been a good thing for the country,
- more likely to say that immigrants today strengthen the country and less likely to say that they are a burden on the country,
- more likely to say that recent immigrants are unfairly discriminated against,
- less likely to say that immigrants take jobs away from Americans who want them,
- less likely to say that recent immigrants do not pay their fair share of taxes, and
- less likely to say that the federal government is not tough enough when it comes to immigration (KFF 2004b).

The Minneapolis Foundation has long recognized a responsibility for maximizing the opportunities and minimizing the challenges presented by successive waves of immigrants in the state. As early as 1925, the foundation supported a community

Figure 11. *The Minneapolis Foundation's Minnesota, Nice or Not? Campaign Flyer*



Source: The Minneapolis Foundation 2005.

relations campaign on immigration, *Give Them a Welcome*, which sought to combat the hostility that immigrants were facing at that time. In 1999, the foundation supported another public information campaign on recent immigrants to Minnesota, *Minnesota, Nice or Not?*, which focused on educating Minnesotans on the growing numbers of Somalis, Russian Jews, Mexicans, and Hmong who were becoming a part of the community. The campaign included a brochure, a Web site, radio ads, bus shelter posters, and other dissemination vehicles (Figure 11). The foundation's current initiative, *Discovering Common Ground*, is a comprehensive effort by the foundation and its many partners to create a thoughtful state agenda on immigration based on factual information, rather than fear and false assumptions. What makes this effort more difficult than in the past, however, is that following the

tragedy of September 11th, immigration issues have become intertwined with legitimate concerns about national security. As part of this effort, the foundation developed a report to provide some basic facts on immigration in Minnesota and raise discussion points that will complement subsequent activities of the initiative. The report is the foundation's first step in an ongoing, multitiered, effort to begin candid discussions based on a common set of facts. Three meetings in 2005 focused on shaping the state agenda for immigration. Additionally, the foundation continues to provide funding support for creative efforts by communities, nonprofit organizations, and public institutions to develop strategies to improve the quality of life throughout the state and to help all residents rediscover their common ground (The Minneapolis Foundation 2005).

“We need to build a movement, not fragment ourselves. There are common themes in the problems that many of our communities face. We need to work together to recognize these commonalities and then tailor solutions to fit the needs of specific communities.”

LUELLA PENSERGA,
COMMUNITY VOICES
OAKLAND

FINDING COMMON GROUND

When working to improve immigrant health, it is important be aware of resentment and competition that may crop up from other vulnerable populations. When, through local tax increases, \$90 million dollars was made available in Alameda County, California for health projects, tensions arose between immigrant rights groups and advocates from native, minority populations about how to spend the money. African-American leaders pointed to persistent and prevalent health disparities in their communities, raising provocative questions for immigrant rights advocates about how to improve immigrant health without alienating other groups.

With financial resources dwindling at the federal, state, and local levels, tension among vulnerable populations are unlikely to go away without careful and concerted action. Communities may be hesitant, and even reticent, to acknowledge and openly discuss these tensions. But by promoting constructive and active dialogue, foundations can play an important role in helping to bring these groups together. Second, framing issues with a common goal and purpose can also help to move the agenda forward for all vulnerable populations. For example, conversations around improving health literacy (a problem in many low-income, native populations) should be broadened to include efforts to improve language and cultural barriers in health care, and vice versa. Lastly, it is important for grantmakers to be vigilant about programs and initiatives that exclusively target one group at the expense of others. When The Columbus Foundation began increasing funding for immigrant issues, it was careful not to shortchange native, minority populations and even prepared a memo for its board detailing funding levels between native and newcomer populations.

Addressing Cultural and Linguistic Barriers to Health Care

Health grantmakers are supporting several activities to reduce cultural and linguistic barriers in health care delivery settings. Many are focused on improving the linguistic and cultural skills of providers and staff, ensuring access in delivery settings, and translating written materials into various languages. Grantmakers are also funding activities to advance research on innovative delivery models.

Some foundations are working to make sure providers have a better understanding of their diverse patients, particularly in areas with new and emerging immigrant populations. The Moses Cone-Wesley Long Community Health Foundation in Greensboro, North Carolina funded the North Carolina Center for International Understanding in support of an initiative to take local health care providers to Mexico to study and observe the country's health care system and speak with Mexican residents about their beliefs toward medical care. These firsthand accounts enable health care workers to better

understand the needs of recent immigrants and how the U.S. and Mexican delivery systems differ.

Foundations are also funding efforts to improve access for immigrants and their families in delivery settings. For example, the Medtronic Foundation in Minnesota provided a grant to the Center for International Health at Regions Hospital, a nationally recognized model of serving new immigrant and refugee populations. The center concentrates on bridging the cultural gaps that these groups may experience in accessing health care. Minnesota ranks number one in the nation for new refugee arrivals and is home to an estimated 30,000 Somalis. Funding was used to recruit professionally trained Somali interpreters to make the transition to Western health care easier for the hospital's Somali patients. The grant was also used to facilitate healthier, more productive relationships between health care professionals and the Somali community by educating both groups. The Somali community was educated on topics such as navigating the Western health care system, the importance of preventive care, and family planning. In turn, health care professionals were given lectures on Somali health beliefs and practices. As part of the project, a guidebook of Somali health phrases and culturally specific syndromes and conditions was developed.

Similarly, The Duke Endowment in Charlotte, North Carolina funded the *Immigrant Health Initiative* to assist hospitals and communities in addressing social and cultural issues that inhibit access to health care for Hispanic and Asian and Pacific Islander immigrants. The objectives were to encourage hospitals to provide

high quality accessible care to these populations, and to encourage other community service providers to work with each other and with local hospitals to provide a coordinated continuum of care. Funding was used to improve data collection on the health care needs of recent immigrants, bring together various agencies within a community to address immigrant health in a collaborative and cost-effective way, and allow different communities to develop customized approaches. The foundation also worked with medical and nursing schools, mid-level training programs, and allied health programs to incorporate cultural and language training into their curricula and to identify immigrant candidates who should be encouraged to seek training in medicine, nursing, or allied health professions.

Grantmakers are also working with immigrant communities to develop appropriate programs and training immigrants to educate and reach out to their peers. For example:

- The Moses Cone-Wesley Long Community Health Foundation funded the Center for New North Carolinians in support of the *Immigrant Health ACCESS Project*, a program that links immigrant populations with health services in the community through the training and deployment of lay health advisors. The program also works to increase health care providers' understanding of cultural differences, and helps immigrants understand the U.S. health care system. Specific areas of focus include nutrition, physical fitness, and adolescent pregnancy prevention. The next

stage of the program will to support and encourage lay advisors to become health care providers themselves.

- The Blue Cross and Blue Shield of Minnesota Foundation developed the *Critical Links* initiative, which supports bicultural, bilingual community health workers (CHWs), who offer health education tailored to the needs, experiences, expectations, and beliefs of diverse communities. CHWs also work with health care organizations to increase cultural competence, improve access to care, and educate families about health care coverage. The collective goal of these initiatives is to improve health among recent immigrant populations, strengthen community health, and build stronger communities for all.
- The Annie E. Casey Foundation developed the *Cultural Case Managers* program to improve health services for immigrants and refugee families. The program draws on data from the target population to design culturally acceptable approaches to services and care, and focused initially on tuberculosis, but eventually expanded to meet other family needs. The program started in Seattle and is currently being replicated in Boston, San Diego, and Washington, DC. The foundation used the knowledge, talent, and skills within the community to design appropriate interventions and build trust with the community.

Written materials serve multiple purposes in health care settings, including relaying health education and prevention guidelines, surveying a patient's medical history,

stating dietary restrictions, giving pre- and post-operative instructions, approving advanced directives, and other important tasks. The translation of certain documents, when done thoughtfully, can be a valuable means of relaying important health messages to LEP individuals and their families. The Hogg Foundation for Mental Health has supported the translation of brief, standardized, self-reported procedures to identify and monitor mental health problems among a variety of ethnic populations in the Houston area. The measures were used to identify new refugees with potential disorders and to monitor their symptoms until mental functioning is restored. Refugees in the program speak Arabic, Serbo-Croatian, Spanish, and Vietnamese.

Finally, The Robert Wood Johnson Foundation has made a \$10 million dollar investment in developing affordable models for health care organizations to offer language services. Launched in 2002, *Hablamos Juntos: Improving Patient-Provider Communication for Latinos* is funding ten demonstration sites in regions with new and fast-growing Latino populations. These organizations, which include two health plans, four hospital-based programs, two community-based organizations, and two educational institutions, are working to design and test innovative approaches that improve health care services for Latino patients. Demonstration sites are focused on three essential benchmarks for improving health care services:

- *Increasing the availability and quality of interpreter services for Spanish speaking patients in health care facilities.* This includes developing community run

college-level training programs for training interpreters, piloting tools to assess language proficiency and interpreter readiness, and supporting system-wide changes in health care organizations, including the use of technology and in-person interpretation.

- *Providing useful health care related materials in Spanish.* This includes guidelines for developing materials that account for cultural nuances, as well as literal translations, in conveying health information to Spanish-speaking patients.
- *Developing easy-to-understand ways for non-English speaking patients to navigate health care facilities.* This includes developing and testing symbols and signs that guide patients through health care facilities, such as those currently present at airports and other public facilities.

Reflections from Grantmakers

Grantmakers working to improve immigrant health and well-being have learned some lessons along the way and share the following reflections for developing or strengthening grantmaking in this area.

Understanding and Working with Immigrant Communities

- Build meaningful relationships within the immigrant community and develop the trust of respected leaders. While

true relationship building takes time, it pays off. Do not underestimate the value face-to-face contact brings through site visits, community forums, or even sharing a meal with someone.

- Be open to learning from immigrants firsthand about their needs and work with them to develop programs and interventions that are beneficial to their families and communities.
- Recognize the significant diversity in immigrant populations, both between different immigrant groups and among groups from the same country of origin. Be cognizant of socioeconomic or generational differences within immigrant groups and how these nuances have an impact on program design and effectiveness.

Engaging the Public and Other Vulnerable Populations

- Separate fact from fiction when it comes to immigration, particularly recent immigrants that may come from areas unfamiliar to many Americans. Support and foster dialogue to overcome the many misperceptions about immigrants, such as the proportion of illegal immigrants, participation in the workforce, and willingness to pay for health insurance coverage.
- Emphasize the common issues, values, and principles that all vulnerable populations face, both native and foreign-born. Finding and developing solutions for these common problems (such as health literacy and access to care) may help to minimize feelings of resentment from nonimmigrant

IDENTIFYING POTENTIAL PARTNERS

Health grantmakers may benefit from working with partners outside the health sector, particularly when relationships with the immigrant community have already been established. For example, the fastest growing credit union in America is a Latino credit union in North Carolina that was started by the coming together of a self-help financial institution, the North Carolina Employees Credit Union, the police, and a group of Latino leaders. Using a person's Individual Taxpayer Identification Number (ITIN), immigrants are able to open checking and savings accounts.* The credit union currently has over 30,000 members in six different cities in North Carolina. Services have been expanded and now include automobile, mortgage, and homeowner loans (Martinez 2005). Organizations such as these that work to build capacity in immigrant communities may be important partners when developing health initiatives targeting immigrants and their families.

* An ITIN is a tax processing number issued by the Internal Revenue Service to individuals who are required to have a U.S. taxpayer identification number but who do not have, and are not eligible to obtain a Social Security Number. ITINs are issued regardless of immigration status because both residents and nonresidents may have U.S. tax return and payment responsibilities under the Internal Revenue Code.

populations who may feel as if resources are being diverted from them.

- Recognize that strengthening one part of the community will ultimately benefit entire the community, and find ways to put this notion into action. For example, efforts to expand health care coverage in California have focused on covering all residents and refrain from using the terms “citizens” or “Americans”.
- Emphasize the contributions that immigrants have made both throughout history and today. Encourage acceptance and integration of cultural traditions that may benefit receiving communities such as healthy behaviors and diets, and strong family ties.

Fostering Broader Change

- Recognize the connection between poverty, economic opportunity, and health, and think about solutions outside the health box. Working from common goals, identify opportunities for broader change and collaborate with nonhealth stakeholders when and where it makes sense.
- In addition to advocating for the availability of public coverage for immigrants, look for ways to expand private or employer-sponsored health coverage to low-wage, immigrant workers and their families.

- Support advocacy and policy change, since local efforts are often not sustainable without public financing. Stimulate discussion on current tax policies, and how they ultimately have an impact on the provision of services to immigrants and other low-income populations.
- Explore opportunities to promote immigrant integration in your own community. Support capacity building of immigrant-led organizations, but also work to engage mainstream institutions (such as local businesses, churches, hospitals, labor unions, schools, libraries, credit unions, police departments, and other community stakeholders) in ensuring immigrant health and well being.

Conclusion

The issue of immigrant health and well-being has traditionally been viewed as pertinent to a handful of states and major urban areas, rather than a matter of widespread national importance. This is due in part to the relatively low levels of immigration for several decades prior to the 1980s and the concentration of immigrant populations in California, New York, and a few other states. But major increases in immigration over the last 20 years and the increasing dispersal of immigrant populations to new growth states amplify the issue to one of national significance. As immigrants and their families continue to become a part of communities across the United States, foundations play an important role in ensuring their health and well-being. Recognizing newcomers' unique contributions, while addressing their myriad health and social needs, will be critical for keeping communities healthy, vibrant, and inclusive.

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