



Immigrant Health Policy Paper

Authors: Susan Kunz, April Fernandez, Matt Gilleskie, Olivia Grondalski, Robert Guerrero, Sterling Haws, Ada Pariser, Prisci Quijada, Julie St. John and Myriam Torres

Disclaimer: This policy paper broadly explores the immensely nuanced and complex topic of rural immigrant health. The paper does not seek to address specific rural immigrant groups nor isolated health concerns facing rural immigrant groups. Subsequent papers that focus on specific issues within the domain of rural immigrant health are welcome.

I. Introduction

The National Rural Health Association is a national nonprofit membership organization comprised of a diverse assortment of nearly 21,000 individuals and organizations nationwide. Members share a commitment to our nation's rural health and strive to ensure rural America has access to quality and affordable health care, regardless of an individual's cultural background. Rural America is becoming increasingly diverse, so it is imperative that the rural safety net meets the needs of immigrant populations.

II. A Closer Look at the Rural Immigrant Population

Historically, the United States has been known as a “melting pot” of cultures, peoples and ethnicities. Contemporary perceptions dictate urban areas as the centers of immigration and culture, however, rural America has experienced increasing cultural and ethnic diversity as well. As Daniel Lichter puts it, “Rural and small town America have been largely excluded from...discussions [on diversity], despite the disproportionate potential influences of new minority populations...on small communities.”¹

As rural America becomes increasingly diverse, society must examine the particular health care disparities afflicting these groups. A 2011 policy brief adopted by the National Rural Health Association states, “while the largest number of the rural poor tend to be white, the highest rates of poverty tend to be among multiracial and multicultural populations.”² As supported in the literature, rural minority populations are disproportionately restrained in their ability to purchase health insurance, pay for transportation to medical appointments, and afford healthy food and other requisites of a healthy lifestyle.

So, who are these rural immigrants? They are young workers who hail from an array of nations and cultural backgrounds, as well as represent various racial and ethnic groups. While a majority of immigrants are Hispanic (54.2%), Asian and white immigrants



comprise 40.2% of the immigrant population. Rural immigrants are generally younger and of working age than nonimmigrant populations: 79.3% of the rural immigrant population is between the ages of 18 and 64. While the majority of the rural immigrant population has at most a high school diploma, almost 40% of rural immigrants attended college, graduated college, or obtained a graduate degree.³

III. Immigrants Economic Contributions to Rural America

Immigrants' contributions to American society and culture are often less visible in rural communities but are equally vital to immigrant contributions in urban areas. Rural immigrants infuse stagnant and struggling rural economies with new sources of labor, an increased consumer base, and entrepreneurial spirit, all while providing rural governments with additional tax revenue. In short, immigrants strengthen rural economies, as evidenced by the following examples.

Case: Immigration in Minnesota⁴

In the state of Minnesota, immigrants' economic contributions are noticeable. A larger proportion of immigrants are between the ages of 25 and 44 years (46%) compared to the native-born population (25%). Also, Minnesota has a greater proportion of Asian and African immigrants and a smaller proportion of Hispanics immigrants than the U.S. as a whole. Minnesotan immigrant households have a collective buying power (that is, disposable income after taxes) of over \$5 billion. By demanding goods that are not traditionally available in Minnesota, immigrants have spurred the inception of new businesses that cater specifically to immigrants' demands. Their presence and significant buying power are vehicles for noteworthy economic stimulation. Additionally, immigrants in Minnesota pay \$793 million annually in state and local taxes alone.

In Minnesota, immigrants comprise 37.2% of lower-skilled workers. Because of their labor contributions, they are viewed as a "complement to the native-born workforce." Additionally, immigrants work jobs that others simply do not desire. For example, Somali immigrants tend to live around and work for Minnesota's food processing manufacturers. The same trend is observed among Hmong and Latino populations in the state. Thus, immigrant populations are meeting demands for labor.

Case: Immigrants and Meat-Processing Industry⁵

During the 1980s and 1990s, the meat-processing industry started using mass production that led to increased hiring of immigrant laborers and the relocation of factories to rural areas. During that time, the percentage of the meat-processing workforce that was Hispanic increased from 10% to 30% and the percentage of foreign-born Hispanics increased from 50% to 82%.



According to William Kandel, “the inflow of Hispanic labor transformed many rural communities, mitigating the decline of the population and stimulating local economies.” In fact, stemming the declining population led to economic stimulus. During the 1990s, Hispanic population growth in rural areas limited population decline in over one hundred non-metro counties throughout the Southeast. Immigrants “stimulated rural economies as consumers, in addition to contributing considerably to local sales, property and state tax revenues.” In Storm Lake, Iowa, the meatprocessing industry and a swell of the immigrant population has stimulated community development and the changing face of the community, where Whites now make up less than half of the population.⁶

Case: Immigrants and Rural Farming

Two million of the approximately 2.1 million farms in the United States, or 95%, are located in rural areas.⁷ Across the United States, immigrants are 1.5 times more likely to work in agriculture compared to a U.S.-born worker. In states such as Washington, Idaho, California, North Carolina and New Mexico, the ratio increases to 5.0, 4.7, 3.6, 3.0 and 2.6 respectively.⁸ In Southeastern Michigan alone, it is estimated that the farmworker population contributed about \$23.5 million dollars to the local economy, or \$18,000 per worker annually.⁹

Immigrant farmworkers are also vital to California’s economy and in particular, to the agricultural industry of the state. Devadoss and Luckstead demonstrated that “Immigrants have helped to expand labor-intensive agricultural commodities and to control production costs in recent years by providing the necessary supply of labor”.¹⁰

In summary, immigrants’ presence is a boon to the economy in the form of increased workforce, cash flow and spending; property ownership and tax paying; and entrepreneurship. However, as with any demographic group, there are certain factors that limit economic contribution. This paper aims to consider one of those factors—health. Recognizing immigrants’ unique and valuable contributions to rural economies, we must support the health of immigrants in order to foster their productivity and economic influence.

IV. Immigrant Health Care Access and Health Disparities

Overall, immigrants have lower rates of health insurance, use less health care and receive lower quality care than U.S.-born populations, however, there are differences among subgroups, depending on legal status, English proficiency residential location and stigma and marginalization. The two latter factors are relevant to immigrants living in rural areas where there may be fewer immigrants like themselves.¹¹

Some immigrants fear seeking care due to potential consequences for themselves or undocumented family members. The Kaiser Health News reports health center officials across the country describe how local, state and national law enforcement authorities



have staked out migrant clinics, detained staff members transporting patients to medical appointments and set up roadblocks near their facilities and health fairs as part of immigration crackdowns.¹² If immigrant populations fear accessing needed services, they risk suffering negative health outcomes, due to lack of pediatric vaccinations, infection prevention, and management of chronic disease.¹³

In conjunction with the aforementioned barriers to health care access in rural America, some immigrants also face severely limiting language barriers. Language and cultural barriers not only serve as a prohibitive factor for patients seeking care, but also result in poorer health outcomes upon receiving care. According to a study conducted by Georgetown University faculty, "...Spanish-speaking Latinos are less likely than whites to visit a physician or mental health provider, or receive preventative care, such as a mammography exam or influenza vaccination," and the inability to communicate effectively "...may lead to patient dissatisfaction, poor comprehension and adherence, and lower quality of care."¹⁴

The toxic stress that immigrant families experience due to fear of deportation and separation from loved ones is increasingly impacting daily life, health and wellbeing. A 2017 study conducted in five languages with 100 parents in immigrant families from countries of origin concludes that this toxic stress is particularly critical for children, many of whom are themselves citizens. The study points to potential long-term consequences for children in immigrant families, including poorer health outcomes over the lifespan associated with compromised growth and development and challenging social and environmental factors that influence health.¹⁵

V. Healthcare Facilities to Serve Immigrants

The health care organizations that form the rural safety net are the best resource to serve immigrant populations in rural areas. Primary among these are rural health clinics, health centers in rural areas and rural hospitals.

Rural Health Clinics

Rural health clinics (RHCs) are the second major safety net provider available to rural populations, including immigrants. They may be private or public practices but must be located in a health professional shortage area. A distinguishing characteristic of Rural Health Clinics is the requirement that they must employ at least a half-time midlevel practitioner (physician assistant, nurse practitioner, and/or a certified nurse midwife).¹⁶ The population of patients treated at Rural Health Clinics is generally older and more likely to be non-Hispanic White than Health Center patients.^{17, 18}

Health Centers in Rural Areas



Approximately one half (49%) of Health Centers are located in rural areas, which serve one in seven rural residents.¹⁹ Federally Qualified Health Centers (FQHCs) that receive federal Health Center Program funding and FQHC Look-Alikes that do not receive the same federal funding both must offer services to all persons, regardless of ability to pay.²⁰ Health Centers may only charge a nominal fee for individuals under 100% of the federal poverty level and offer a sliding fee scale for individuals from 101%-200% of FPL.¹⁹ Since by law these Health Centers may not turn anyone away, it enables them to serve uninsured individuals. According to CMS, Health Centers do not account for the legal status of immigrants when providing care.²¹ In addition to primary care, health centers must provide the following services directly or indirectly via another provider: dental care, behavioral health, transportation and hospital and specialty care. The health centers that are funded to serve special populations—such as migrant and seasonal farmworkers, homeless and public housing residents—may offer services especially relevant to some immigrant groups in rural areas.²²

Rural Hospitals

Rural Hospitals, including Critical Access Hospitals, are a vital but increasingly vulnerable part of the health safety net for rural residents, including immigrants. As such, they may be the only source of emergency department for treatment of true emergencies or provision of routine care for uninsured immigrants, as well as inpatient care, outpatient care, and care coordination services.²²

VI. Service Strategies of Benefit to Immigrants

A number of health care delivery strategies may help address barriers to health care access for immigrants, as well as make health care more culturally and linguistically appropriate.

Community Health Workers (CHW)

CHWs are an invaluable workforce to combat access barriers and provide culturally and linguistically appropriate care. When working with vulnerable populations, accounting for cultural barriers and fears towards seeking health care remains important. A CHW can help minimize this restraint because she/he is a “trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.”²³ The bond that CHWs have with the members of the community allows them not only physical access to the patients, but also to obtain pertinent health information that the patient may not feel comfortable disclosing to a lesser known health professional. Furthermore, many CHWs are “members of the communities in which they work.”²⁴ Because CHWs live in the community, they have a



holistic understanding of what resources are available for a healthy lifestyle; CHWs understand the barriers to accessing healthy food, getting to the nearest hospital, and preventing injury in local industries.

In regards to immigrant health specifically, it is worthy of note that “many Community Health Workers are immigrants themselves.” This trend applies to a variety of immigrant populations. Thus, CHWs have first-hand experience with the health risks associated with immigration and the challenges to accessing care once having crossed the border. The CHW is likely able to connect with community members around this common experience, resulting in increased trust amongst community members.²⁴

Finally, “Community Health Workers are the most cost-effective addition to a health team...” When investing in Community Health Workers, “the net result is a reduction in urgent care or hospitalizations,” so much so that “for every dollar that’s invested in the Community Health Worker, the savings is as much as \$7.”²⁴

National CLAS Standards

The United States Department of Health and Human Services Office of Minority Health has developed The National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards).²⁵ With an underlying theme that “dignity and quality of care are rights of all and not the privileges of a few,” the National CLAS Standards provide a blueprint for providers and agencies to be able to administer services that meet both the cultural and linguistic needs of the patient community. The National CLAS Standards may be accessed for free, so they are affordable and accessible for rural practices.²⁵ The NIH states “...cultural respect enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and healthcare—or participating in research—in an inclusive partnership where the provider and the user of the information meet on common ground.”²⁶ As helpful as CHWs can be, doctors, nurses, therapists, healthcare agencies, and other providers must be able to optimize their communications with the patient because having a positive experience with a provider leads to better health outcomes.

Language Translation

Although CHWs often speak the language of local immigrants and other community members, other health care professionals must still be able to communicate directly with patients without the assistance of a CHW or other staff member. According to the Bureau of Labor Statistics, interpreters and translators working in medical settings earn an average annual salary of nearly \$50,000 and few are available in rural areas.²⁷ For small rural practices and hospitals, employing sufficient translators to accommodate multiple languages is not financially or logistically feasible. Contracting with companies that provide medical translation in numerous languages over the phone is a realistic



solution for rural health care providers to address immigrants' linguistic barriers to health.

VII. Recommendations

1. Support the health of rural immigrants, which as a group, contribute greatly to the economic health of Rural America.
2. Promote the use of Rural Health Clinics, Federally Qualified Health Centers and FQHC Look-Alikes, and Rural Hospitals as safety net providers to serve uninsured and underinsured immigrant patients.
3. Promote the use of CLAS standards among rural providers in order to meet the cultural and linguistic needs of immigrant patients and their families.
4. Increase the utilization of Community Health Workers as a culturally and linguistically appropriate workforce for immigrant outreach, education and case management in order to increase access to care, improve health care compliance and enhance overall health and wellness of immigrants in rural America.
5. Explore the specific needs of refugees as a special subgroup of immigrants living in the United States.



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