

Children in Immigrant Families: Issues for California's Future

*Proceedings from Forums
Sponsored by the Board on Children, Youth, and Families
of the National Research Council/Institute of Medicine
and the UCLA Center for Health Policy Research*

**Published Jointly by the California Program on Access to Care
and the UCLA Center for Health Policy Research**

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About This Report

This report is based on proceedings of forums held in Los Angeles and Sacramento on December 10 and 11, 1998, co-sponsored by the UCLA Center for Health Policy Research (UCLA Center for Health Policy Research) and the Board on Children, Youth, and Families of the National Research Council/Institute of Medicine (NRC/IOM). E. Richard Brown, Director, UCLA Center for Health Policy Research, Deborah Phillips, Staff Officer, Board on Children, Youth, and Families of the NRC/IOM, and Delight Satter, Manager of Public Programs at the UCLA Center for Health Policy Research, organized the forums. The forums were funded by The California Wellness Foundation. At the forums, the NRC/IOM study *From Generation to Generation: Health and Well-Being of Children in Immigrant Families* served as a launching point for discussions about policies for health access for immigrant children. Participants included more than 200 policymakers, advocates, and researchers concerned with the health and well-being of immigrant children and U.S.-born children in immigrant families, whose access to health services was reduced as a result of federal welfare reform legislation in 1996, as well as lack of data on child endangerment as a result of barriers to health access. The report was prepared by Dan Gordon and Delight Satter from transcripts of the proceedings.

About the California Policy Research Center

The California Policy Research Center (CPRC) is a University of California program that applies the extensive research expertise of the UC system to the analysis, development, and implementation of state policy as well as federal policy on issues of statewide importance. CPRC provides technical assistance to policymakers, commissions policy-relevant research on statewide issues, and disseminates research findings and recommendations through publications and special briefings.

About the California Program on Access to Care

CPAC is an applied policy research program which the University established as a program of CPRC at the request of the state legislature to address issues related to access to health care for the state's working poor, focusing particularly on immigrant workers and their families as well as low-income households in agricultural and rural areas. The publication of these proceedings are supported by CPAC's Technical Assistance Program at the request of Assembly Member Gil Cedillo (Los Angeles). Gilbert Ojeda is CPAC project director. Maria Chacon was principal editor.

About the Center for Health Policy Research

The UCLA Center for Health Policy Research, sponsored by the School of Public Health and the School Public Policy and Social Research, conducts research on national, state, and local health policy issues; provides policy analyses, data, and training as a public service to policymakers and community leaders; and offers educational opportunities for graduate students and

post-doctoral fellows. The Center emphasizes a community- and population-based perspective to improve health outcomes for those who are at risk for adverse health conditions or are underserved by the health system.

The views and recommendations contained in this report are those of the speakers and the authors and do not necessarily represent those of CPRC, the UCLA Center for Health Policy Research, the Regents of the University of California, the Board on Children, Youth, and Families of the National Research Council/Institute of Medicine, or The California Wellness Foundation.

Contents

Introduction	1
Speakers: Sacramento and Los Angeles	4
<i>Deborah Phillips</i>	4
<i>Evan Charney (Committee Chair)</i>	5
<i>E. Richard Brown (Committee Member)</i>	7
<i>Michael Fix (Committee Member)</i>	8
<i>Nancy Landale (Committee Member)</i>	9
<i>Fernando Mendoza (Committee Member)</i>	11
Speakers: Sacramento	12
<i>Lewis H. Butler</i>	12
<i>Sherry Hirota</i>	14
<i>Lucy Quacinella</i>	15
<i>Sandra Shewry</i>	16
<i>Hon. Gilbert Cedillo</i>	17
<i>Jane Garcia</i>	20
<i>Claire Brindis</i>	21
<i>Calvin Freeman</i>	23
<i>George Flores</i>	25
<i>Stephen McCurdy</i>	27
Speakers: Los Angeles	28
<i>Hon. Xavier Becerra</i>	28
<i>Phil Ansell</i>	30
<i>Sylvia Drew Ivie</i>	31

<i>Robert Ross</i>	33
<i>Kazue Shibata</i>	34
<i>Nancy Bowen</i>	35
<i>Susan Drake</i>	36
<i>Paul Ong</i>	38
<i>James Smith</i>	39
Research Needs	40
<i>Data Collection and Epidemiology</i>	40
<i>Behavioral and Social Science Research</i>	41
<i>Community Health Education</i>	42
<i>Policy</i>	42
<i>Health Services</i>	42
Notes	45

Children in Immigrant Families: Issues for California's Future

Proceedings from Forums Sponsored by the Board on Children, Youth and Families of the National Research Council/Institute of Medicine and the UCLA Center for Health Policy Research

Introduction

On December 10–11, 1998, two public forums were held to discuss policies involving California's large population of immigrant children. More than 200 policy makers, advocates, and researchers were convened at back-to-back gatherings in Sacramento and Los Angeles. "Children in Immigrant Families: Issues for California's Future" was organized by the Board on Children, Youth, and Families of the National Research Council/Institute of Medicine and the UCLA Center for Health Policy Research. The NRC/IOM study *From Generation to Generation: Health and Well-Being of Children in Immigrant Families* served as a launching point for the discussions. Excerpts from the speakers' presentations are included in these proceedings.

One in three immigrant children in the United States lives in California. One in three children in the state—regardless of immigration status—speaks a language other than English at home. Yet, very few studies have documented the health of this population. This lack of data is of particular concern following the 1996 passage of federal welfare reform legislation, which reduced the access to health services for many children in immigrant families. Even where these children are entitled to services such as Medicaid or the new Children's Health Insurance Program (CHIP), perceived threats to immigration or

citizenship status have themselves created access barriers, endangering the health and well-being of immigrant children and U.S.-born children in immigrant families.

The National Research Council/Institute of Medicine study committee consisted of 19 members from a wide range of disciplines. The committee was charged with summarizing what is known about the demographics and characteristics of first- and second-generation immigrant children, including aspects of their development, risk factors, and their access to and utilization of health and social services. Both forums began with committee members discussing their findings.

One of the study's key conclusions was that first-generation immigrant children are as healthy as, and in many ways healthier than, children in U.S.-born families, but their health status declines as they become assimilated into American life. The committee recommended that longitudinal studies of immigrant groups be conducted to determine the reasons for this disturbing trend. It was also suggested that evidence that new immigrant children arrive in better health than U.S.-born children should be viewed with some skepticism, since it is based on subjective assessments by parents

One in three immigrant children in the United States lives in California.

. . . welfare reform barred new immigrant children from the Medicaid program, a crucial safety net, and excluded them from participation in CHIP.

who participate in health surveys, and new immigrant parents might answer the survey questions differently than U.S.-born parents.

Children in immigrant families are three times as likely to be uninsured as children in U.S.-born families. And even when they are insured, they face language and cultural barriers that may prevent them from receiving quality health care. But, as many of the presenters and other conference participants who followed the committee speakers pointed out, welfare reform barred new immigrant children from the Medicaid program, a crucial safety net, and excluded them from participation in CHIP. This marked the first time that legal immigrants were not entitled to the same public benefits as U.S. citizens.

While many of the lost benefits have since been restored, several speakers noted that in the aftermath of welfare reform and other policies that have been perceived as anti-immigrant, there has been a substantial reduction in immigrants' applications to public programs for which they are eligible.

Among the most striking examples are the initially disappointing enrollment figures for Healthy Families, California's CHIP program, which provides free or low-cost insurance for uninsured children in families whose incomes are above the eligibility levels for Medi-Cal (the state's Medicaid program). An estimated 328,000 children are eligible for Healthy Families, but at the time of the forums only 48,000 had enrolled. As of April 2000, the number enrolled was up to 262,473. Many

of the children not being enrolled are in immigrant families. Approximately half of the state's citizen children eligible for Medi-Cal or Healthy Families have at least one parent who is a noncitizen.

Several explanations for the low Healthy Families enrollment figures were offered, including the complicated application process, the use of co-payments, and inadequate publicity about the program. But participants at the forums were particularly concerned that families with mixed immigration statuses were opting not to insure their eligible children because of the perception that doing so would jeopardize the immigration status of other family members.

The large number of Medi-Cal- and Healthy Families-eligible children who are not being enrolled in the program due to their parents' concerns that signing them up will adversely affect their immigration or future citizenship status highlights a down side of the public charge issue. Conference participants related instances in which local jurisdictions such as San Diego County have posted signs that are intimidating to immigrants, giving them the impression that if their legal status is in question, they are not welcome.

One speaker told of a case in which a patient had to pay a \$5,000 bond to the Immigration and Naturalization Service to disprove the perception that the patient would become a public charge.¹ Word of a few such cases can travel quickly through immigrant communities, deterring many from seeking necessary services to which they are entitled.

Conference participants lamented the fact that concern over basic access issues such as these is impeding the important work of learning more about the many non-access issues that contribute, for better or worse, to the health status of children in immigrant families.

Data about the health of immigrant children are sparse. Barriers to collecting such data have included lack of funding and the small sample size of immigrant subpopulations within health surveys. In addition, one speaker noted, history suggests that immigrants will be undercounted in the 2000 U.S. Census, potentially undermining the ability of the Census to provide useful data on the influence of such variables as immigration status, country of origin, and generation of immigration on health.

Finally, research that includes questions about immigration status may deter immigrants from participating, given the evidence that many choose not to take part in programs for which they are entitled, such as Healthy Families and Medicaid, due to the public charge and similar issues. This, it was noted, makes it difficult for researchers to compile data that would support shifting resources or creating new programs that would benefit immigrant children.

There was general support for the report's call for longitudinal studies, but several conference participants also pointed to the need for more immediate data on the health of immigrant children, so that public health practitioners and community-based organizations can be responsive to emerging problems. In addition, they pointed to the urgent need among advocates for information that they can present to policy makers in order to make a difference in the current debate.

Many of the speakers offered specific recommendations regarding future research priorities. More information on the comparative social, economic and epidemiologic profiles of the areas from which people immigrate to California would assist providers in enhancing the health of this population, it was noted. To

that end, more data are also needed on aspects of healthy development unique to children in immigrant families. Concern over the report's finding that immigrants tend to be healthier upon arrival but become less healthy as they assimilate into American society led to the agreement that the causes of this trend—as well as interventions designed to reverse it—should be investigated in future studies.

Among other recommendations, conference participants called for research on how best to deliver interpretation services in the health care setting; on the impact of community health workers among recently immigrating populations; and on the role traditional practices and remedies that are brought by immigrants from their native countries, including alternative medicines, play in health and healing.

The need for operational measures of cultural competence and its role in achieving positive outcomes was identified, and one speaker urged that immigrants be asked to define cultural competence from their perspective. In addition, one speaker pointed to the shortage of information on immigrants as health care consumers, and recommended collecting data on the utilization patterns of various immigrant groups and how these patterns should influence both the types of benefit packages offered and the way these products are marketed.

Finally, more than one speaker argued that research on health issues pertaining to children of immigrant families should incorporate major participation from the community being studied, including input at the design, implementation, analysis, and dissemination phases. It was also suggested that researchers ask members of these communities how they feel about being the subjects of such studies.

There was also discussion about how best to make the case to policy makers that a commitment to the health of immigrant children is in everyone's interest. Speakers representing both the advocacy and legislative communities suggested that one of the most effective strategies is to highlight areas of "enlightened self-interest," including the future social security tax base represented by the current population of immigrant children and the potential consequences to the society as a whole if the lack of access to quality health care prevents these children from becoming productive future members of the work force.

Conference participants pointed out that shifting demographics, such as the growing Latino vote in California, Texas and other states, are creating a climate in which politicians will pay greater attention to the data and policy recommendations presented by researchers and advocates on the health of immigrant children.

Several speakers asserted that a dialogue must take place involving federal, state and local decision-makers. This discussion, they argued, must address larger questions such as what immigrants have meant to this country and what role they will play in the nation's future. Just as the Institute of Medicine report looks at the health of children in immigrant families from a perspective that encompasses social, educational, and economic factors, they contended, the future dialogue should consider the immigrant child as a whole, since health does not occur in a vacuum. For example, in addition to becoming less healthy the longer they live in this country, immigrant children's educa-

tional status also tends to worsen with time. And, it was noted, since income has been strongly correlated with health, any attempt to improve the health of children in immigrant families cannot ignore the issue of what economic opportunities exist for this population.

Indeed, several speakers argued, without a national consensus that immigrant families are an important part of the American fabric and deserve equal opportunities to succeed, any efforts to change public policy will merely be "tinkering on the margins."

Speakers: Sacramento and Los Angeles

Deborah Phillips

The Committee on the Health and Adjustment of Immigrant Children and Families was keenly aware of the immense gap between the research-based information that it had available to do its work and the kinds of issues that people in this room grapple with every day. Indeed, the primary goal of these forums is to make major strides in closing this gap. We feel very strongly that we need to identify information needs and gaps, or we will continue to have this problem of tremendous lack of data that really connects with the issues that people are facing. There's no better place to do this, of course, than in California.

The Board on Children, Youth, and Families, under whose auspices this study was conducted, is part of the National Research Council and the Institute of Medicine, which are working arms of the National Academy of Sciences. These working arms are focused on translating research-based knowledge pertaining to youths for practitioners, advocates and policy makers.

The study was born of a planning meeting that took place in 1994. The planning group felt that a major report on immigrant children

This discussion . . . must address larger questions such as what immigrants have meant to this country and what role they will play in the nation's future.

coming out of the Academy would, if nothing else, raise the consciousness about these children, who were invisible in national debates. The committee had 19 members, including representatives from child development, anthropology, psychiatry, history, sociology, public health, economics, law, and public policy.

The committee was charged with summarizing what is now known about the demographics and characteristics of first- and second-generation immigrant children: the trajectories that characterize the development of these children, risk factors that impinge on their lives, and what we know about the delivery of health and social services to these children and their families. Finally, the committee was charged with making recommendations for research and policy. We found that the science base was so weak that we were not able to make policy recommendations, only recommendations about research, which was tremendously disappointing to us.

That having been said, the report is simply a departure point for these discussions. The first panel will get out the information, but then we want to move beyond the report and hear through your state and local lenses what the issues are. Our big hope for this forum is that we can begin to close the gap between the knowledge base that's available and the information and data needs that you have in your daily work lives.

Deborah Phillips is Staff Officer, Board on Children, Youth, and Families, of the National Research Council and Institute of Medicine.

Evan Charney

The past two years have been uncertain ones for immigrant families in the United States. With the enactment of welfare reform in 1996, the relationship between these families

Since 1990, the number of children and adolescents in immigrant families has risen seven times faster than the number of those in U.S.-born families.

and the federal and state governments has changed dramatically. Thousands of legal immigrants who previously were eligible for a host of federal benefits are no longer eligible, and responsibility for deciding who is eligible has been delegated to the states.

Implementation of welfare reform underscored the importance of our task to clarify what is known about the health of children in immigrant families. It also made our work much more difficult, because as we were studying this, the entire landscape was changing. Even if appropriate monitoring programs were put in place when the law went into effect, the full effects of these far-reaching policy changes would not be known for a long time. And, of course, there are no such programs in place. One of our conclusions is that you need to monitor this process in order to understand it.

Why should we care about children of immigrants? First, they represent the future of the United States. Fourteen million children, one out of every five people under age 18, are immigrants or have parents who are immigrants. Three-fourths of these children have been U.S. citizens all their lives. Since 1990, the number of children and adolescents in immigrant families has risen seven times faster than the number of those in U.S.-born families. These youngsters will soon be a significant part of the labor force of this country, so it is in our narrow self-interest that these children be as fit and well educated as possible. Their health and productivity are a serious concern to the entire nation.

A second reason to study this population is so that we can fully understand the impact of welfare reform and other policy decisions on those most dramatically affected. Even after a series of modifications to the Balanced Budget Act of 1997, most immigrants who arrived later than August 22, 1996, are no longer eligible for Medicaid, the new Child Health Insurance Program (CHIP), food stamps or Supplemental Security Income (SSI) for their first five years in this country. We need to be able to track how these important policy decisions affect children so that we can make well-informed decisions in the future.

Perhaps our most surprising finding is that according to the limited data we have, children in immigrant families appear in many ways to be as healthy or even healthier than children in U.S.-born families. For reasons that are unclear, however, their health deteriorates as they assimilate into American life, and by the second and third generations it comes to resemble that of children and adolescents in non-immigrant families.

Second, it appears that for most ethnic groups, immigrant mothers give birth to fewer low birth-weight children than do U.S.-born mothers, and they have lower infant mortality rates than do U.S.-born women of comparable country of origin or ethnicity. These differences are substantial, though they vary by group. Third, immigrant adolescents are less likely to consider themselves in poor health, less likely to have school absences due to health or emotional problems, and less likely

to engage in risky health behaviors such as sexual intercourse at an early age, delinquent or violent behavior, and tobacco or illicit drug use.

There are reasons for concern as well. In 1995, immigrants accounted for one-third of the total U.S. tuberculosis cases. Certain subgroups of immigrant children, particularly Mexican-American children, have an increased prevalence of intestinal parasites, elevated blood lead levels and poor dental health. Children of migrant farm workers are likely to be exposed to damaging environmental toxins. Children in immigrant families are more likely than children with U.S.-born parents to live in poverty and less likely to have health insurance or receive regular medical care.

We also found that compared with children in similar socioeconomic and demographic circumstances, those in immigrant families are less likely to be receiving public assistance. Of particular concern to the committee are children from the former Soviet Union, Vietnam and Southeast Asia, Central America and Mexico, who account for half of all children in immigrant families in the United States.

On average, 35 percent of the children from these countries live in poverty. They also are more likely to have parents with little formal education and to live in overcrowded conditions. Despite these unfavorable conditions, there is substantial evidence that their overall health status is generally favorable. Disturbingly, we found that any health advantages immigrant families may enjoy tend to recede over time. By the third and later generations, for example, rates of adolescent risk-related behaviors approach or exceed those of white adolescents from U.S.-born families.

Disturbingly, we found that any health advantages immigrant families may enjoy tend to recede over time.

This project was not about immigration policy. It was of particular concern to the committee, though, that unlike any other group of children in the United States, many of those in immigrant families are now barred from eligibility for Medicaid and Supplemental Security Income, and may be excluded from participation in the new state Child Health Insurance Program. Our clear conclusion is that to exclude these children who are in the United States legally is shortsighted policy. The money saved will prove costly in the long run if preventive services such as immunization are curtailed or made more difficult to obtain, and chronic conditions such as childhood asthma are not cared for in an appropriate manner.

Evan Charney (Committee Chair), is Professor and Chairman Emeritus of the Department of Pediatrics, University of Massachusetts Medical Center/School.

E. Richard Brown

With funding from the Robert Wood Johnson Foundation, our center conducted a study of health insurance coverage and access to health care of children in immigrant families. We found that noncitizen children and citizen children with immigrant parents are much more likely to be uninsured than are citizen children in native-born families, and that the risk remains high even when we control for parents' education and the length of time that they've been in the country, as well as other important determinants of health insurance coverage.

The Medicaid program has been a critical safety net for immigrant children and children in immigrant families, and that is reflected in the very low rates of uninsurance among Southeast Asian children in refugee families.

With welfare reform, we have undermined the usefulness of this safety net for immigrant children, and especially new immigrant children.

They have among the lowest uninsured rates of any group of children in this country, because of Medicaid's generous eligibility provisions for refugee families and the intensive outreach to those families by refugee assistance programs.

With welfare reform, we have undermined the usefulness of this safety net for immigrant children, and especially new immigrant children. Such provisions translate into less coverage for children in immigrant families, and that means less financial access to health care services. Those who are uninsured consistently make fewer doctor visits than do children who have health insurance. They are less likely to have a usual source of care, which is an important connection to the health care system. We also found that immigrant children depend to a greater extent on safety net providers.

California has 1.85 million uninsured children, including more than 1.5 million uninsured children who are citizens and legal residents, making them eligible for a series of entitlement programs. We found that among these uninsured children, approximately 788,000 were eligible for Medi-Cal (California's Medicaid program) but not enrolled as 1998 began. Another 320,000 were eligible for Healthy Families, our CHIP program in California. But because of the structure of our Healthy Families program, as well as the limits imposed by federal law, about one-fourth of uninsured children in the state who are legal immigrants or citizens have family

Nine out of 10 uninsured children who are eligible for Medi-Cal are citizens. The same is true for the Healthy Families program . . .

incomes that exclude them from the Healthy Families and Medi-Cal programs. In addition, we estimated that 289,000 undocumented immigrant children in the state are uninsured but not eligible for any of these programs.

Nine out of 10 uninsured children who are eligible for Medi-Cal are citizens. The same is true for the Healthy Families program, and for those with incomes above the Healthy Families income-eligibility level. But about half of these children have at least one parent who is a noncitizen. Many of these children's parents have expressed fears that enrolling their children in either Medi-Cal or the Healthy Families program may adversely affect their immigration or future citizenship status. The Healthy Families and Medi-Cal programs, as well as many of the people in this room, are grappling with these issues.

E. Richard Brown (Committee Member), is Director of the UCLA Center for Health Policy Research and Professor, UCLA School of Public Health.

Michael Fix

I want to talk to you this morning about the policy context in which this report on the health and adjustment of immigrant children was written, and to provide you with an update on some developments that occurred after the report was completed.

There is a trade-off in public policy between the goal of promoting the health and adjustment of children of immigrants and other goals such as deterring illegal immigration and

restricting the entry of people who are likely to become public charges. With welfare reform, the nation struck out on a new path. Prior to the law's enactment, legal immigrants were entitled to health care and other benefits basically on the same terms as U.S. citizens. States played virtually no role in determining who would or wouldn't be eligible for federal programs and even for their own programs, and their role in funding many programs, such as SSI, was minimal. Undocumented immigrants were basically barred from public services, with some exceptions for emergency services, maternal and child health, and some infant nutrition programs.

Welfare reform has altered these formulations in three powerful ways. First, it makes citizenship increasingly important for receiving full access to public benefits. In the past, legal status was generally all that was required. Second, welfare reform puts the states in the position of determining which immigrants are eligible for federal, and for their own, public benefits. And third, immigrants who arrive after August 22, 1996 (post-enactment immigrants) are given far fewer rights to public benefits than immigrants who were here before that date (pre-enactment immigrants). An immigrant's date of entry and place of residence now determine membership within the society. Each of these changes represents a departure.

Viewed collectively, these changes represent a leap into the unknown, one that was taken with very little empirical evidence about the long-term health impacts on legal or undocumented immigrants. There are very few underlying data about the health of immigrant children in general. Moreover, given the fact that legal status is now the gate through which you have to pass to get public benefits, there are virtually no data that inform health and other outcomes on the basis of legal status.

The Urban Institute has been conducting a survey of what the states have been doing to respond to the immigrant-specific revisions of welfare reform. We have found that every state has extended Medicaid benefits to pre-enactment immigrants with the single exception of Alabama. But for post-enactment immigrants, the story is quite different. The states have been far less generous in extending Medicaid, CHIP and other benefits to these immigrants. Already, more than 2 million immigrants have entered the country since welfare reform was passed. That number is going to grow by 1 million a year.

The Urban Institute's survey found that the devolution of immigrant policy to the states has resulted in widening disparities in terms of immigrant access to health benefits. The survey also documents reduced overall access for immigrant families to health and other benefits. Further, we find increased state spending, as states move to fill the gap left by the federal government.

Surprisingly, California has proved to be among the most generous states in the nation in granting legal immigrants access to health and other public benefits. In contrast to virtually all other states, California is providing food stamps to working-age immigrants and is providing Medicaid to post-enactment immigrants. However, it strikes me that it doesn't take an expert panel at the National Academy of Sciences to conclude that those expenditures could be in danger if the economy declines.

Michael Fix (Committee Member), is Director of the Program on Immigrant Policy Studies at The Urban Institute.

Nancy Landale

I'm going to briefly summarize the findings of the committee with respect to the physical

Surprisingly, California has proved to be among the most generous states in the nation in granting legal immigrants access to health and other public benefits.

and mental health of children in immigrant families. Unfortunately, existing research on this topic is quite sparse. As Evan noted, studies suggest that along a number of important dimensions, children in immigrant families actually experience better health and adjustment than children in non-immigrant families, which is not what you'd expect, especially given their lower access to, and utilization of, the health care system.

One of the areas in which immigrants appear to do better than native-borns is infant health. The two most commonly used indicators of infant health are the rate of low birth-weight and the infant mortality rate. A number of studies report significantly lower rates of low birth-weight and infant mortality in the U.S. among the offspring of immigrant mothers than among the offspring of native-born mothers.

Some of the first studies identifying this epidemiological paradox focused on the Mexican-origin population, and it was noted that overall, Mexican-origin women have rates of low birth-weight and infant mortality that are comparable to, or even slightly better than, non-Latino white women. Subsequent studies attempted to disaggregate the Mexican-origin population into offspring of immigrants vs. offspring of the native-born, and again a paradoxical pattern was found:

One of the areas in which immigrants appear to do better than native-borns is infant health.

The offspring of the immigrant women actually did better than the offspring of the native-born women. Studies examining other immigrant groups have shown similar patterns, but the nativity differences are considerably smaller than they are for the Mexican-origin population.

These positive outcomes for immigrants are likely the result of a number of factors. For Asians, relatively high levels of educational and occupational attainment among immigrants may contribute to the positive outcomes of their offspring. But among Latin Americans, immigrants are generally not highly educated or in high-status occupations, so there must be some other explanation for this group. Most of the explanations in the literature focus on positive cultural influences on the behavior of pregnant women. Strong family bonds and more social support among immigrant women may translate into healthier behaviors, one of the most well-documented of which is a strikingly lower rate of cigarette smoking among immigrant women compared with native-born women.

We don't know a lot about the health of school-age children in immigrant families, and much of what we do know is based on parental self-reports and reports from the children themselves. According to parental reports in the 1994 National Health Interview Survey, first- and second-generation children have fewer specific acute and chronic health problems than third-and-higher generation children in the same age range. The acute problems we're talking about are things like ear infections and accidents; chronic problems include asthma, chronic hearing and speech problems, etc.

Children in immigrant families are also reported to have fewer health problems that limit their activities than third-and-higher

generation children, and fewer accidents and injuries. At the same time, if you take parents' reports of their children's overall health status, first- and second-generation children are reported to have a somewhat worse overall health status than third-and-higher generation children, so there is some inconsistency in the data. Children in immigrant families also have higher risks of some infectious diseases, such as tuberculosis, hepatitis B and parasitic infections.

Because much of the evidence comes from parental reports, the extent to which we want to believe these findings is an open question. Parents could report fewer chronic and acute conditions, for example, because they aren't aware of those conditions given that they are less likely to see a medical provider and less likely to have certain conditions diagnosed. They may understand some of the conditions differently or, alternatively, they may not choose to report when their child has these conditions. While the evidence does suggest that these children have better health, we should be cautious and a little bit skeptical, and try to understand in more detail what's going on when parents answer surveys.

Data from the National Longitudinal Study of Adolescent Health show that among adolescents, first-generation immigrants are less likely to consider themselves in poor health or to have school absences due to health or emotional problems than second-and-higher generation U.S.-born youths. First-generation adolescents are also less likely than higher-generation youths to report that they engage in risky behaviors such as sexual intercourse at an early age, delinquent or violent behaviors, smoking, and substance abuse.

By the third generation, risk behaviors among immigrant groups are similar to, or more common than, those of U.S.-born white ado-

lescents. These findings are consistent with additional research that I'm currently conducting on a sample of Puerto Rican mothers reporting on stressful life events—such as homelessness, partner/spousal abuse, and financial problems—during their pregnancies. A much higher percentage of U.S.-born Puerto Rican women have experienced these stressful life events during pregnancy than recent migrants from Puerto Rico.

Nancy Landale (Committee Member), is Professor, Department of Sociology, Pennsylvania State University.

Fernando Mendoza

If we examine the growth patterns of children around the world, those living in socio-economic standards that are similar to middle-class whites in the United States achieve the same growth status as children in the United States—that is, their heights and weights are the same as the average U.S. child's. However, when children live in poverty, their growth is impaired, with height more permanently impaired than weight. In China, for example, the average height for children is equal to the 10th to 5th percentiles of U.S. children. This means that poverty has a major impact on growth, particularly height. Thus, for immigrant children it is important to understand their prior nutritional circumstances—that is, their prior nutritional and health environment.

For example, how is the immigrant child from Cambodia similar to the immigrant child from Japan? The family of the child from Japan is typically coming from and going to a middle or upper-middle class environment, whereas the family of the child from Cambodia may come from a very underprivileged background, and may continue to live in an

Understanding the nutritional status of immigrant children requires understanding the economic standards of the countries they're coming from, and within those countries, where is that family's position in the overall social standing.

underprivileged environment because of low parental education, among other factors. Both of these children are immigrant children, but if we look at their nutritional and health status, they're clearly going to be different.

Understanding the nutritional status of immigrant children requires understanding the economic standards of the countries they're coming from, and within those countries, where is that family's position in the overall social standing. It also requires an understanding of the opportunities for the family in the United States, and the degree these circumstances will allow for economic mobility.

Dr. Katherine Dewey, from UC Davis, has done studies in the Sacramento area and found that among children from Vietnam, Cambodia and Laos, 34 percent were in the 5th percentile or less in height, but only 7 percent were low in their weight. We usually don't think of obesity as malnutrition, but this is a form of malnourishment. It's one that's not easily visible, because we don't think "malnourishment" when we see a short, overweight child. However, the effects of obesity on these children may be as detrimental to their future health as being severely underweight. Understanding the nutritional needs of immigrant children is an important challenge for practitioners and researchers.

Studies have also found that immigrant children's diets initially tend to be traditional, but

The assimilated diets appear to have more fat, and less fruits and vegetables.

then they acculturate to the fast-food diet. Our Hispanic Health and Nutrition Examination Survey study from the early 1980s found that first-generation Mexican American children had better diets in terms of the four food groups than the second or later generations. It appears that the first generation may be more likely to maintain a traditional diet, whereas second and third generations seem to become more assimilated into the overall American diet. The assimilated diets appear to have more fat, and less fruits and vegetables.

Maintaining good dietary intakes among immigrant children, particularly those who are living in poverty, is important for their overall health. How to keep well-balanced traditional diets from changing to the American fast-food diet is a challenge that will require the cooperation of the health, nutrition, and public policy sectors.

Whether one discusses immigrant or U.S.-born children, both suffer from an increased prevalence of obesity. Among Mexican American children, many of whom are new immigrants, obesity is the major public health problem. As these obese children become obese adolescents and obese adults, they are at greater risk for obesity-related illnesses, such as diabetes and cardiovascular disease. Diet and exercise, therefore, is a major public health issue for children, and it's one on which we're currently making little impact.

Prior to welfare reform, immigrant children were getting access to some health and nutritional programs directed at obesity. They could access WIC and other nutritional programs, along with some health programs. The

question arises, what's going to happen when welfare reform starts cutting out some of these programs? Can we as a state and nation afford not to provide services to children, including immigrant children, that will maintain their health and well-being?

Fernando Mendoza (Committee Member), is Associate Professor of Pediatrics and Chief of the Division of General Pediatrics, Stanford University School of Medicine.

Speakers: Sacramento²

Lewis H. Butler

We all know that the correlation between educational status and health is very direct, as is the correlation between economic status and health. This Institute of Medicine study is helpful because it is telling us all to look in a holistic way at what is happening to immigrant kids.

When we started this work in 1986, nobody knew how many immigrant kids there were in the California schools. Estimates that we made, which have been confirmed by others, are that at that time, one in six children in California schools was born in another country. These are not the *children* of immigrant parents; I'm just talking about kids born in another country. Now, it's probably one in five.

One in three children in the state—regardless of immigrant status—speaks a language other than English at home. And, of course, a great majority of those speak fluent English, but that still gives you some idea of the demographic revolution that's been going on. Nationally, about one in eight kids in the United States lives in California, and one in three immigrants is here. This is a huge issue for California, and for the country.

We found that there was no state policy of any sort to address the educational experience of immigrant children. Not only did the state not collect the statistics, but also, with a few exceptions, the state did not even want to reflect on the demographic changes that were going on, particularly in the 1980s and early 1990s. You can see signs of what's happening. If there's a growing number of limited-English-proficient students who have been in that category from the early grades and remain in that category in high school, you have to ask what has kept them there. It's very clear that there has been no focus on what it would really take to have those kids succeed.

One of the major problems we have run into, and I think it may be understandable, is that schools have tended not to want to disaggregate data that they were collecting about their own students. There was this myth that the civil rights movement said we should all be color-blind, everybody should be treated the same. Of course, since 80 percent of the teachers and administrators are white, people have said—quite defensively in many instances—that they don't see black faces, they don't see immigrant faces. They just see kids and treat them individually.

Well, whatever you think about that, it's a disaster if you're trying to improve the education of different groups of children in the schools—groups of children who are having different experiences. So we have been pushing people to start looking at this data and to be thinking about why certain kids aren't doing well. Is the education appropriate? Presumably, the reason you see the same paradox in education as this report shows in health—the longer immigrant kids are in this country, the worse off they are—is that something is happening in this country that is not good.

As immigrants were coming into the schools and as the schools were going from 15 percent so-called minority to 60 percent Latino, Asian, and African American, the funding of California schools was going from the top fifth in the nation to 39th in the nation—and, in relation to wealth, 49th.

On this count, there's no way to characterize at least the last 15 years in California as being anything other than a complete policy disaster. As immigrants were coming into the schools and as the schools were going from 15 percent so-called minority to 60 percent Latino, Asian, and African American, the funding of California schools was going from the top fifth in the nation to 39th in the nation—and, in relation to wealth, 49th. It's not a political accident that all of that happened at a time when there was an 80-percent white voting population and the kids in school didn't look like the voting population. When the voting population looked exactly like the parents of kids in the schools—and in fact *were* the parents of kids in the schools—California schools reached their peak. If we can't do something about that, I wonder if we can conceivably do anything about the health status of immigrant children.

Speaking as a politician, suddenly candidates for elected office are discovering that education is important and that maybe kids—particularly Latino kids—aren't getting the best treatment. You have to say there's only one reason for that: Somebody woke up and found the Latino vote was a big vote. George W. Bush found that out in Texas. People are beginning to find that out in California. We're getting to a point where the political climate is such that politicians will pay attention when

we have information. Now, the question is how to produce the kind of solid research and solid policy recommendations that will move us forward.

Lewis H. Butler is Chair of the Board of Directors, California Tomorrow.

Sherry Hirota

I'd like to take a few minutes to highlight some of the issues that were in the report. Immigrant children are three times more likely to be uninsured. It seems obvious that if we hope to expand health coverage to all children in California, we need to know what is happening with the immigrant population. It astounded me that in California we were moving to implement Healthy Families without having a refined sense of who are the uninsured in our state and how our policies would be fashioned to address these gaps. I think this report and the analysis that's being put forth provides our state with rich information about how to go about insuring the rest of the children.

Aside from data, we also have some big policy issues that are standing in the way of covering our children. Many counties are not using their indigent care programs to serve either newly arrived or undocumented immigrants. We have a Healthy Families program for which we have not chosen to expand coverage to new immigrants, with or without a federal match. We have the issue of the public charge. We've had cases in which patients have

been told to put up a \$5,000 bond to the INS because even though our lawyers helped prove that they were eligible for the services under Medi-Cal laws, the Immigration and Naturalization Service (INS) decided that they were a potential public charge, and needed to prove that they were going to take care of themselves. Needless to say, just a few cases in a community will make it very difficult to tell people that they are eligible and nothing will happen to them. These and other policy issues are standing in the way of our goal of covering all children.

If we don't rely on the public side, then the issue is whether the private market will take up the slack. The Institute of Medicine report provides some very important baseline information on immigrant health. If our communities are going to have to pay for it out of pocket, or our small businesses have to absorb it, at least we'll have the data to show that immigrants should be given some affordable health insurance and not the high end of the rates. Without information on these populations' health status and utilization, they're probably paying the most for the worst kinds of health coverage.

Even when people are insured, we have major problems when we create all of these different rules and regulations about who should be eligible for care. We recently had a mother who took her 3-year-old to the emergency room and received a \$1,000 bill. Two months later, her three-month-old baby was choking. She hesitated to call 911 because of the emergency room cost. She called various family members and relatives and finally one of them suggested that she call our clinic. Our doctor said, "Get off the phone and call 911." By the time she did, it was too late and the baby died. Ironically, the baby was still covered under Medi-Cal, but the mother hesitated because

Without information on these populations' health status and utilization, they're probably paying the most for the worst kinds of health coverage.

she wasn't sure. Even the experts in this room might have a hard time determining the ins and outs of who's eligible at any given time.

Sherry Hirota is Executive Director of Asian Health Services.

Lucy Quacinella

As a health policy analyst and advocate, the first question that popped into my mind was how can advocates for immigrant children use this report. I have a few observations about how the report would have helped us in the past three years, when we were all struggling with the implications of federal changes in public benefits for immigrants, and with the implementation of devolution here in our state.

The first thing that jumped out at me was almost a throw-away line early in the executive summary, but for me as a policy advocate, it was so important: This generation of immigrant children represents our future social security tax base. This is the kind of hard, cold fact that will enable all of us to build bridges.

I have found in the past three years that probably the most effective strategy employed by advocates, at least at the state level, is to find areas of enlightened self-interest and present them in such a way that the broader human and political connotations are not lost. That, of course, has been extremely important because, as Secretary Johnson and others have noted, we live in an anti-immigrant era, and, despite positive signs on the horizon, I don't think anyone believes that aspect of our political climate is going to change overnight.

I would like to see a lot more data and research about how—and why—immigrant children are the future social security tax base, and other areas of common interest. It never

This generation of immigrant children represents our future social security tax base.

hurts to have the flesh put on the bones. Any area of enlightened self-interest that can be amplified and used for advocacy in the policy arena is very important.

I want to thank many of the people in this room not only for their expertise, but also for their willingness to help the advocacy community make these points in the political arena. A lot goes on behind the scenes, and you hope you get a better chance behind the scenes to really make the case. But at the end of the day, if the decision-makers don't have a public sound bite that fits in with their district and their assessment about what they have to do to survive and thrive in the political environment, then the most well-thought-out research is unavailing.

It's also important to stress that in our state we came through almost completely unscathed in terms of changes in eligibility for immigrants for essential public benefits programs in health care. I'm happy to hear California is more generous than other parts of the country. But it's been distressing to learn how many people in clinics and local policy-making positions, and even at the state level, are unaware that Medi-Cal really hasn't changed, that the laws governing county health services haven't changed. Quite understandably, folks are confused given all of the publicity about what's happened with immigrants. The information about where we've held the line isn't getting through.

That's another area for research: If you really want to ensure that immigrant children have access to services, how do you deal with that

information gap? The answer, of course, is related to a very important point that's already been made. Preserving eligibility in public benefits programs is almost meaningless if we don't get back the initiative in reassuring families that it's safe and OK to use these benefits programs. Unfortunately, there are ongoing problems with the public charge policy at the federal level.

In addition, the state Department of Health Services has engaged in disastrous activities over the last three to four years, aggressively working with the INS to entrap families in the public charge situation. The state has seen the error of its way, but we still need the Feds to clarify their policy,¹ and we also need the State of California, once federal clarification has been gotten, to use whatever credibility it has left in the community to convey new messages. The right people in key positions in the new administration should deliver these messages and work with community-based organizations to deliver them. That is essential if we're ever going to be able to reassure immigrants that it's OK to return to public benefits.

Lucy Quacinella is Staff Attorney of the Western Center on Law and Poverty.

Sandra Shewry

I work for a small state agency, the Managed Risk Medical Insurance Board, that has the mission of trying to increase access to affordable coverage for uninsured Californians. We were honored these last 18 months to be asked to administer a new Healthy Families program. Healthy Families, as I'm sure most of you know, provides low-cost insurance for children in low-wage families. It's for children above Medi-Cal income levels who are uninsured. Pursuant to federal law, they need to be citizens or legal immigrants; recent immi-

grants are not covered. The federal law does not provide federal matching funds for recent immigrant children and undocumented immigrants.

As Rick Brown pointed out in his remarks, about 328,000 children are eligible for Healthy Families. From statistics that Rick has been able to extrapolate from large national databases, six in 10 children are Latino, two in 10 are Anglo, and two in 10 are either Asian-American or African American. That is similar to the ethnicity of children eligible for Medi-Cal. The Healthy Families population is also similar to the Medi-Cal populations in that the majority of parents are employed full-time for the full year.

Nine in 10 Healthy Families-eligible children are U.S. citizens, but four or five in 10 have an immigrant parent. Approximately 48,000 children are enrolled in Healthy Families as of this morning. About 40 percent of the children are Latino. I want to talk today about how our national policies are keeping us from achieving our goal in the state—our goal, again, being to get children in the state who are uninsured and eligible for these programs enrolled.

Because Healthy Families is a new program, after we had it operating for three months we stepped back and talked to a lot of stakeholders in the community who talked about what wasn't working. We were told the application process was overwhelming, and we're making revisions based on that feedback.

The second concern that surfaced early was the need to create a safe environment for the eligible children. This is the issue of the public charge. There are things that we can say to families today based on what we know. We can say we won't share information with the INS except in situations of fraud. We don't

need to know about the parents' citizenship or immigration status, and we won't collect that information. We won't ask for repayment of any benefits that were legally received. Those are the things that we think we can do today to create a safe environment, but we feel very stymied on the issues surrounding public charge.

Half of the children live in what are called "mixed families" in which the child might be a citizen, but the parent is an immigrant. At this point, we don't have clear information that we can provide to these families.

Grantland very articulately identified that we are tinkering on the margins until we have a national consensus on how welcome our programs are going to be for immigrant families.

We really want to get to the point where these eligibility issues are off the table so we can turn to the more important work, which is looking at utilization of services and health status indicators. The epidemiological paradox that was identified in the report, in which immigrant children's health regresses to the U.S. mean after they've been here for a period of time, is a very important factor. We need to figure out how to reckon with that, because Congress put \$24 billion on the table, and lots of other interest groups want that money.

We will need to be able to demonstrate to Congress and to legislatures everywhere that we are making a difference in the lives of children. To the extent we have a lot of immigrant children in the program, we need to understand this paradox, because if we set up cohort studies to look at children's health status and find that for immigrant kids it's regressing to the mean for the first three or four years and getting worse, this is not the kind of information that is going to help Congress want to keep that \$24 billion on the table. We need to think about what sort of

We are tinkering on the margins until we have a national consensus on how welcome our programs are going to be for immigrant families.

health care intervention would respond to the phenomenon.

Sandra Shewry is Executive Director of the California Managed Risk Medical Insurance Board.

Hon. Gilbert Cedillo

In this country and in this state, we have a growing divide between rich and poor. One percent of the population owns 40 percent of the resources; 5 percent owns 50 percent. We hear that the economy is successful and unemployment is down. The problem is that 20 percent of Californians live in poverty and 7 million don't have access to health care.

We read in the paper that we have this robust economy, and yet our children, the future of our state, live in poverty, and most who don't have access to health care are working people. We have children of immigrants born into poverty who, through no fault of their own, have no access to health care, which diminishes their potential to participate, do well in school and become integral elements of our society. When we have 7 million people without access to health care, that's a societal problem.

When I visited Mexico, I witnessed a system where everybody who works has access to health care. Mexico is a poor country in many respects, and it has tremendous poverty. But the people who work, even at a low minimum wage of 30 pesos a day, should they get sick, have an ability to see a doctor without a co-payment. If somebody in their family is sick, they go to the doctor. And if they need

surgery, they don't have to check with an accountant to see if it fits within the plan; they get their surgery and they get the medicine they need.

The problems that we have with health care in this country are so dramatic that if we're just tinkering around the edges, we're really not going to address the core, fundamental issues. We've experienced a radical transformation of the global economy, and in the United States we've moved from heavy manufacturing to a service economy. The unionized sectors of the economy have given many people access to health care. When those industries lose members, those families are without access to health care.

The other problem is that we have changing demographics and emerging economies in which we don't have a unionized work force. In important sectors of our economy, the work is done by an immigrant work force, and these sectors are not unionized.

The good news is that this is the focus of labor's organizing efforts. Unions like Service Employees International Union are organizing janitors. The carpenters are bringing in the drywall workers and hotel and restaurant employees are organizing their workers. Obviously, the farm workers are in a renaissance in their efforts to organize in the fields.

But the labor movement is still not in a position to partner with us in terms of using their collective resources to buttress the public-sector health care system, bringing their tremendous pension and trust funds to the public-sector side of the market toward the purchase of health care. They're not at that point because they represent only 9 percent of the work force in the private sector. When you combine that with the public sector, they're at about 13 percent. Organized labor is

in crisis over whether or not it's going to survive as a viable and important institution within the framework of American society. We should applaud and support its efforts to organize, because when there is a unionized work force, it brings a score of additional benefits that enhance society at large.

With the leadership we now have in Sacramento, the possibilities for what we can do are tremendous. I don't know the specifics of how we go forward. That's why all of you are here. I'm simply here to cheer you on and say that we will work with you and be your allies in the state legislature.

We need to figure out what we do with \$2 billion from the federal government that we haven't been spending, which is really obscene. We need to plan how we will spend \$25 billion that we will receive from the tobacco settlement and ensure that that money does not go into any other area outside of health care. We have a legislature that's going to be particularly sensitive to immigrants and their health care needs, and a governor who is frugal. The governor will be forced to make hard decisions. Our job is to force him to make the right decisions. I think the efforts to make Healthy Families everything that it should be represent both good politics and good policy for the State of California.

Here is what I think we should do with Healthy Families. I would like to see us merge Medi-Cal and Healthy Families and move to insure 1 million uninsured kids in California who aren't enrolled. I would like to do that by automatically enrolling any person who is qualified for any means-tested program. If our kids qualify for free and reduced school lunch, WIC, Head Start, or similar programs, we should enroll them in a health care program that will meet their needs.

I've had it with the arguments used by opponents. They call broader and more successful health care programs socialized medicine. They never say it's socialized highways. They never say it's a socialized public education system. They never say it's socialized unemployment insurance, or socialized workers' comp. They don't say these things because we've made a commitment that we need an infrastructure in our society that maintains both commerce and people. We could have toll roads everywhere, privatize our roads. I hear people say they want others to have dignity, so everyone should pay for his or her own health care.

I say you can't have dignity if you don't have health. I never saw a corporate lobbyist who felt stigmatized about getting a tax break. We should enroll people in Healthy Families automatically. Let's have a postcard-size application. I get applications for credit cards, and all they want is my name. Yet, we can't enroll poor people and we have \$2 billion sitting untouched.

Eliminate the cost-sharing measures of Healthy Families. You know how I feel about these co-payments—they've got to go. We've got to expand the coverage for legal immigrants. Particularly when we're talking about documented children, they should be eligible for health care. It's absurd. We also need to engage in massive public education of people about what resources are available. I think we will have partners in the media, particularly in the non-English-speaking media.

Obviously, I believe we should expand the Healthy Families program for children and working families who cannot afford the full cost of insurance—at least move up to people with incomes at 300 percent of the poverty level. (*The fiscal year 1999–2000 budget passed*

I say you can't have dignity if you don't have health. I never saw a corporate lobbyist who felt stigmatized about getting a tax break.

by the legislature will increase eligibility of children for the Health Families program to 250% of poverty, allow deductions from income that are used in the Medi-Cal program, and provide one year of state funding for a program to cover recent immigrant children—i.e., those who immigrated to the U.S. after August 22, 1996).

I believe we need to restructure state agencies to integrate all of the state health care coverage programs. We need to be strategic, to think in broader terms about who our allies are. What are the social interests that we have in keeping people healthy? I think there are people who will understand that, at the bottom line, it makes no sense to have a state in which people are physically unhealthy, and that there is enormous benefit to having a healthy California.

In fact, I think that if we invested in the public health care system, invested in research and teaching and preventative efforts, made it school-based in addition to community-based and subsidized it with the tobacco money and available federal dollars, then brought in additional consumers from the unions that are organizing low-income workers, we could build a world-class public health care system.

We could then challenge the private sector to compete with the services that we provide. You would see a market-force reform of health care and HMOs, because everybody would be flocking to this world-class public health care system. They would see that every person in the state has a right to quality education, a right to affordable housing, and a

right to quality health care, and that those are the foundations of a life of dignity and respect. We should fight, struggle and organize to ensure nothing less.

Gilbert Cedillo is a Member of the California State Assembly.

Jane Garcia

I wholeheartedly agree with the statement, made earlier, that no database has enough information on aspects of healthy development unique to children in immigrant families. We need much more information on immigrants as “consumers” of health care. We are not used to thinking of immigrants as purchasers of products, especially health care insurance. This is not surprising, since immigrants have been largely uninsured, resulting in lower utilization; or have access to public services such as Medi-Cal, which has a fixed and prescribed package of benefits. There is a lack of information on what Latinos as consumers are willing to buy. I’m not sure how many people predicted that so many families legitimately eligible for Medi-Cal would opt, when given a choice, for Healthy Families instead. As you know, the package under Medi-Cal is much richer and more comprehensive, so we were really surprised by this dynamic. On the other hand, families that have mixed immigration statuses opted not to insure some of their children when they perceived that by doing so, other members of the family would jeopardize their immigration standing.

Will utilization be lower because immigrants are healthier, or is lower utilization a result of access barriers such as cost, language and fear of the INS?

As we explore the issue of immigrants as consumers, we have many unanswered questions. Will utilization be lower because immigrants are healthier, or is lower utilization a result of access barriers such as cost, language and fear of the INS? We’ve made some assumptions that it has to do with just being healthier, but I’m not sure that we know precisely the answer. How do parents make decisions about programs that treat their noncitizen children differently from their citizen children, and what other kinds of health care decisions are families with mixed immigration statuses making?

The other data that we need is on what role alternative medicine plays in the well being of immigrant families. That is a significant part of their lives, and yet you hear very little about it. What is the definition of cultural competence from the perspective of immigrant families—not from the perspective of HMO bureaucrats? Currently we have only anecdotal information. Better documentation must be available for policy makers and providers who want to increase access to health care for children and families.

We need data and research that will lead to real-life solutions, research that will help us to know what an insurance product for immigrants should look like, and how that will differ from ethnic group to ethnic group. What benefits would such a package offer? What benefits do immigrants want? How should we market that product? How much are immigrants willing to pay for health insurance for their children?

We don’t know any of these answers, and we certainly need better documentation on the cost of insuring immigrant families, but also, perhaps more importantly, on the cost of not insuring immigrant families. As Lucy said earlier, so much of our policy is driven by the

almighty dollar, and so we need data that will help us make arguments that come down to dollars and cents.

Jane Garcia is Executive Director of La Clinica De La Raza.

Claire Brindis

While I will specifically focus on adolescents in my remarks, I believe it is also important to consider the level and meaning of acculturation and the necessity of understanding its cultural and contextual meaning. In a 1954 Social Science Research Council Seminar, four levels of acculturation were outlined:

1. *Assimilation*—wherein the individual relinquishes cultural identity and assumes the cultural attributes of the dominant group.
2. *Integration*—wherein the individual adopts a bicultural existence, utilizing both cultures (the new and the old) in a complementary manner.
3. *Rejection*—wherein the individual refuses to assimilate.
4. *Deculturation*—wherein individuals find themselves marginalized and out of cultural and psychological contact with both their original culture and the dominant or mainstream culture. This is more often seen in second-generation groups of immigrants when parents fail to transmit their own cultural background, yet the group is unable to access the mainstream culture.

This framework is important because we need to recognize several different aspects of acculturation.

First, acculturation is not a linear process; its direction can be reversed, accelerated, or slowed.

Second, it can occur simultaneously, at several different levels, with an individual rejecting some aspects of the mainstream culture, integrating other aspects, and assimilating others.

Third, it can vary between generations, by gender, as well as by age. Fluctuations in acculturation occur often as a result of the types of opportunities that exist.

Fourth, contextual issues affect the process and one needs to take into account the prevailing sociopolitical and economic conditions, access to quality and higher education, as well as the type of attitudes that exist regarding immigrants. For example, the lack of access to quality education, combined with a punitive environment directed at immigrants, is more likely to lead to deculturation.

California is on the verge of a baby boomlet—there will be a 34 percent increase in the number of adolescents ages 10–19 living in this state by the year 2005; the rest of the country will experience a 13 percent increase. Latino adolescents will increase by 58 percent. Thus, the issue of acculturation, particularly of adolescents, will play an important role in the coming decade. I concur with the report's primary recommendations that we need additional nationally representative, longitudinal databases, as well as qualitative ethnographic studies to further understand the context of immigrants' lives. I would like to build my own dimensions to these recommendations and ascertain what stereotypes this research will confront.

First, what protective factors are important at the individual, family, community, and policy environment level? What assets do immigrants have and how are these threatened by the economic disparity evident in the society? How does the political environment, including

policies such as Propositions 209 and 187, impact the immigrant's experience? (*Proposition 209 was a ballot initiative passed by California voters prohibiting the state, local governments, universities and other government entities from discriminating against or giving preferential treatment to any individual or group in public employment, public education or public contracting on the basis of race, sex, color, ethnicity or national origin. Proposition 187, also passed by California voters, proposed to make undocumented residents ineligible for non-emergency, publicly funded health care services, public social services, and public education.*)

Second, what contributes to the dilution of the protective factors initially experienced by immigrants? How do we “immunize” immigrants or provide them with the necessary “booster” shots?

Third, how does acculturation shape adolescent attitudes and behavior, for example, in the areas of STD, HIV, and pregnancy? Given the data demonstrating that higher acculturation is linked to poorer self-esteem and poor pregnancy outcomes, what can be done to ensure that the connectivity that migrants have remains an important protective factor?

Adolescents confront particular challenges. Their social and sexual norms evolve from the influence of multiple cultures, as well as their sense of future and perceived risks and vulnerabilities. Adolescent behavior must be understood in terms of it being part of a cluster

of risk-taking behaviors, as well as resiliency factors.

It is important to shift away from conducting categorical, problem-focused research—for example, research that focuses only on sexual behavior, HIV behavior, alcohol behavior or violence behavior. It's very important to recognize the multiplicity of the worlds that adolescents live in and how the clusters of behaviors—risk-taking behaviors as well as protective factors—intersect. Researchers, policy makers, and funders have traditionally sought “answers” to adolescent behavior by focusing on individual sets of behaviors, rather than examining the inter-relation between a health problem and other social, health, and educational issues.

In San Jose, where we have previously conducted an evaluation regarding adolescents' access to contraceptives, we learned about a young Latina girl who came in for a pregnancy test. When the nurse told her she wasn't pregnant, the girl started to cry. She told the nurse that her boyfriend had been putting a lot of pressure on her to have a baby, because he was worried about being killed and he wanted to have a baby who could grow up to take care of his mother. In this case, the young man was anticipating that he would not be able to fulfill the tradition of taking care of an elderly parent, but wanted to ensure continuity of his heritage by providing what he considered to be a viable option.

No matter how good we are as program developers in the area of adolescent pregnancy prevention, if we don't think about violence and lack of life opportunities and hope for the future, we're not going to be creating comprehensive approaches for solving some of these dilemmas. We also need to fully recognize the subpopulations of adolescent groups, the tremendous differences between rural and

Researchers, policy makers, and funders have traditionally sought “answers” to adolescent behavior by focusing on individual sets of behaviors, rather than examining the inter-relation between a health problem and other social, health, and educational issues.

urban youth and the tremendous differences by country of origin, as well as the impact of acculturation.

We need to be thinking about developing and conducting outcome studies. Improving adolescent health is not just about having access to care. Rather, it is more about understanding what is going on in the interaction between health care utilization and outcomes, particularly for young people. Another area that bears further study has to do with the influence of media. We know how important media is for adolescents, but we do not fully know the impact of media on health outcomes. It's interesting to see *People* magazine in Spanish, to see all of the soap operas on TV. We need to do a content analysis about the kinds of media messages that young people are receiving. We know that in many of these environments, young women still feel that they don't have the right to bring up the issue of contraceptive utilization with their partners, nor the negotiation skills to delay having sex while maintaining the relationship.

Finally, I'm deeply concerned about the amount of the time that it will take us to create national databases that reflect the different groups of immigrants that we have in our country, their level of acculturation, and their own patterns of health and health care utilization. Given the delays in establishing databases, and the necessity of creating policy and action based on the research findings, we may need to consider the use of sentinel research. Another way of thinking about sentinel studies is to consider them as the fire alarms that attract people's attention because they may represent the early warning signs of future findings.

We need to collect the types of patient stories that we have heard today, and bring them to the attention of policy makers. Sometimes a

We also need studies that focus on the cultural and social norms of the region from which the family has immigrated

good story goes farther in telling a case than even some of the best national data, which up to now has often failed to adequately tell the tale of immigrants' experiences. A group that has received relatively little mention is the group of immigrants for whom borders are invisible—those returning to and from Mexico and Central America on a frequent basis. Thus, we also need studies that focus on the cultural and social norms of the region from which the family has immigrated. Much as we recognize differences between East, West, North, and South in the U.S., we must also recognize the differences between subgroups within countries and recognize the diverse communities.

In all of these points, I feel it's valuable to be thinking not only about immigrants, but also about other children. The understanding that we gain from studying the experiences of immigrants will be valuable in our understanding of adolescent risk-taking behavior as a whole. This is particularly true in terms of studying the protective factors that ensure positive outcomes for immigrants when they initially arrive in this country.

Claire Brindis is Adjunct Professor and Director of the Center for Reproductive Health Policy Research, as well as Executive Director of the National Adolescent Health Information Center, University of California, San Francisco.

Calvin Freeman

Paraphrasing Surgeon General David Satcher, promoting social justice for the most vulnerable of us ensures social justice for us all. Social

justice is not a zero sum game. Moreover, the health of children is a critical element of social justice and is important to all of us. Ultimately, the health of our children is a critical indicator of the moral health of our society.

California's children are the most diverse segment of our state's population, as well as our most important asset. I came to realize, first through my work in hypertension control and especially in my role in the Office of Multicultural Health, that it is essential to adopt a multicultural approach to public health and health care issues here in California. I had to learn to identify the ways that our diversity affects how we approach health and health systems for ourselves and our families. And not incidentally, this diversity also affects the way health systems respond to our needs.

I would like to focus my remarks first on cultural competence, then on how we do research in communities, and finally on their intersection. Regarding cultural competence, I want to focus on the interactions between immigrant families and the programs, organizations and institutions that seek to serve them. I am including not only the provision of health care but also health promotion and prevention services delivered to immigrant communities by our public health agencies and providers.

I believe there are four distinct types of relationships that we need to consider in assessing these interactions: (1) *The relationship between individual providers and clients and families.* Most often, this is characterized by physician-patient relationships. (2) *The relationship between organi-*

zations and clients and families. This relationship is characterized in part by the provision or lack of enabling services such as child care, interpreting services and extended business hours. (3) *The relationship between organizations and their own diverse staff,* which influences the number and roles of staff members, and whether their backgrounds reflect the characteristics of the community being served. (4) *The relationship between organizations and communities as a whole,* characterized by the degree of community participation in the decisions of the organization.

How organizations and providers define and develop these relationships with diverse communities affects how successful they are in promoting service utilization, consumer satisfaction, quality of care and, ultimately, health outcomes. How they address these relationships defines the organizations' cultural competence. Put simply, cultural competence is the ability of individuals and organizations to achieve positive outcomes while working across differences, and especially how successful they are in reducing the power inequities in these transactions.

I urge that research conducted concerning children of immigrant families be community-based. By that I mean research that incorporates substantial participation in the design, implementation, data analysis, and information dissemination phases of the project by members of the communities being studied. This participation should not be limited to professional researchers, but should also include practitioners and consumers who can provide critical context for, and ensure the relevance of, research efforts. They can help to develop dissemination strategies that are specifically designed to ensure maximum use of research results by the communities being studied. And finally, community-based research provides learning and practice opportunities

Put simply, cultural competence is the ability of individuals and organizations to achieve positive outcomes while working across differences . . .

for researchers from those communities to develop and improve research skills as well as to inform the research of others. Although we are moving in this direction, research partnerships with communities remain rare. Community involvement can help to increase survey response rates and data accuracy, as well as helping to maintain good community relationships between the researchers and those with whom they are working.

For the purpose of our discussion, let me highlight the related research and data needs that I believe are important. We know with certainty that effective interpretation is critical when provider and consumer do not speak the same language with sufficient fluency to eliminate the risk of health-threatening miscommunications. We have a hard enough time when provider and patient speak the *same* language. We do need to know more about the style of interpretation that delivers the best results and the level of training needed by interpreters. This work is ongoing in a number of places.

In regard to issues of non-linguistic cultural competence, we are not nearly as well informed. There are many theories about how to promote cultural competence. Some emphasize individual transformation; others focus more on organizational practices and policies. Some emphasize ethnic-specific approaches, while others subscribe to more generic approaches to cross-cultural interactions. We do have important anecdotal evidence of the consequences of cultural ignorance, but have not yet validated operational measures of cultural competence in terms of utilization, patient satisfaction, quality of care, and health outcomes.

We must be extremely careful with this responsibility. We should not shy away from truth, but we should recognize that even sci-

We do have important anecdotal evidence of the consequences of cultural ignorance, but have not yet validated operational measures of cultural competence in terms of utilization, patient satisfaction, quality of care, and health outcomes.

entifically valid research can reveal only parts of the truth and can actually obscure larger truths about the people with whom you are working. In California's recent past, the focus of the policy debate on immigration has been on the degree to which the state's economic and cultural problems could be laid at the feet of those from other countries. This report, this forum and, hopefully, this new administration can help to change the focus to one of how do we maximize the potential of immigrant populations by ensuring the healthy development of their children.

Calvin Freeman, of Freeman and Associates, is former Director of the Office of Multicultural Health, California Department of Health Services.

George Flores

We all bring to our jobs unique values and beliefs that influence the way we carry out research and programs. To this extent, at the local level we find that there can be great variability in how policies affecting the health of immigrant children are translated into practice. For example, many children who are referred to local California Children's Services programs are immigrants without health insurance. Decisions are made on a daily basis by staff who must decide how far to go to help certain immigrants with coverage for extraordinary medical cost. Some go farther than others. Another example has to do with symbols that represent bias. Some local jurisdictions

post signs that are intimidating and hostile toward immigrants, giving people the impression that if their legal status is in question, they are not welcome. Variations in local interpretation of federal or state policies toward immigrants clearly have profound health and social implications.

Local campaigns to get kids into Healthy Families or Medi-Cal are highly variable in the way they may, or may not, accommodate immigrants. In particular, the way the public charge issue is handled makes a big difference in terms of whether children are enrolled. If a child is found not to be eligible for these two programs, is there a next step, or does the child just remain uninsured? In my county, we are pushing efforts to get *all* kids into one program or another: if not Medi-Cal or Healthy Families, then Kaiser Kids or Cal Kids; and if not that, then a physician volunteer program.

Another fundamental problem is the likely undercount of immigrants in the year 2000 census. The epidemiologic impact is meaningful on a broad basis, but it may be even greater within smaller populations. In regards to the Healthy People 2010 objectives, there would be great advantage to distinguishing the influence of immigration status, country of origin, and generation of immigration on health. But with incomplete census data, the usefulness of health data for immigrant populations will be diminished.

We must also weigh the implications of both the process and results of research on immi-

grant children's health. Asking people about immigration status itself may create a deterrent to services, such as that which has been acknowledged in the Healthy Families program by Sandra Shewry. Indeed, if people stay away because they are intimidated by the process for service determination, data to support shifting resources or creating new programs cannot be compiled. We are unable to identify gaps if we don't have the data to support that there *is* a gap. We must be creative in our strategies to determine the health needs of immigrant children, without adversely affecting participation, and ultimately health status, in the process.

I would also like to call for the study of traditional remedies regarding their impact on health. Habits, practices, and traditional medicines that people bring from their native countries may be of some therapeutic or palliative value, or could do harm. The use of lead in traditional remedies sometimes given to children is just one example. There are many others.

We need to know more about the comparative social and epidemiologic profiles of the areas from which people emigrate. Most practitioners are unaware of the specific circumstances in which people live before they arrive in our country. Impressions are based on broad notions of disease and economic conditions, often times out of date. There is very little known about community issues, child rearing, occupational or environmental characteristics. Getting those issues into the medical mindset would be valuable for improving cross-cultural technical skills, leading to better quality health care.

We also need to study the impact of community health workers among recently immigrating populations. Many immigrants feel a familiarity and trust with such community

Variations in local interpretation of federal or state policies toward immigrants clearly have profound health and social implications.

workers—people who look and speak like them and many times live within their own neighborhoods. We need to research the impact of community health outreach and how it can best be employed in a variety of settings.

Lastly, we need to ask the people we're investigating how they feel about our intrusion. We've experienced the conditions of research fatigue among these communities. Clearly, people get tired and intimidated from being asked repeatedly whether they're undocumented, even if it is from a friendly face and voice. Eventually, the answers may become rote or guarded, not at all representative of true conditions. Ultimately, we must respect the people represented in the numbers.

George Flores is Public Health Division Director and Health Officer, Sonoma County.

Stephen McCurdy

One of the major recommendations of the report was that there be longitudinal studies done on immigrant groups to document their health status and access to care, and that this should include studies of specific ethnic and interest groups. I agree with that completely and want to urge that one of those groups be farm workers, because they are so important here in California. Basic data—even knowing how many farm workers there are in California—are very hard to come by. The National Agricultural Survey suggests that there are approximately 700,000 farm workers in California. This is based on inference, in that we know the amount of various crops and how much person-power is required to harvest them. By comparison, the census estimate is about 183,000. That's quite an undercount.

Clearly, we're at a very early stage with respect to understanding the health of farm workers. I

Everything that we can do to support people in getting a chance to succeed, to come in from the cold, to no longer be marginalized, works to the advantage of all of us.

would request that research in this area include two infectious diseases: tuberculosis and HIV. I know from my own work and work with advisory groups of farm workers that these are important issues to this community. These studies should also include health maintenance issues, in particular dental health. One of the few studies of farmworker children, conducted by the California Department of Health Services, showed how prevalent dental problems were among children. It's hard to concentrate at school when your teeth hurt. And lastly, mental health problems are prevalent in this community and others, and they can't be ignored.

I want to finish with two sets of comments that aren't in my area of expertise. The first is the importance of economics. When all is said and done, one of the most important influences on health is income. Everything that we can do to support people in getting a chance to succeed, to come in from the cold, to no longer be marginalized, works to the advantage of all of us. That means supporting institutions that support, maintain, and develop strong bodies and healthy minds.

Finally, I think the most important reason for working in this area is spiritual. What kind of a society do we want to live in? We learned from the UCLA report this morning that there are 1.85 million uninsured kids in California, yet the programs that we're talking about really cover only a little more than half of them. What about the other 40 percent? We need to put that to the public. We're also

learning about barriers that are put up by our government, barriers put up in our name even for these 60 percent of uninsured children who are eligible, to minimize the number that can actually come into the program. I realize we have to be realistic. This is a political process that we have to deal with. But we can't lose the vision, can't forget about the children who aren't being covered.

Stephen McCurdy is Associate Professor of Medicine, Department of Epidemiology and Preventive Medicine, University of California, Davis.

Speakers: Los Angeles

Hon. Xavier Becerra

With the report "From Generation to Generation," we finally have something that can be conveyed to policy makers that comes not just from a politician, a Latino, or a son of immigrants. Now, I hope, we have something that can help us make policy changes. If we don't make them soon, we're going to face the consequences into the future.

This report does a tremendous job of setting forth the issues, the dilemma, the facts, the benefits of immigrants and children. But so much is missed behind the doors where policy is made. Let me give you an example of what I mean. Last night our three-and-a-half-year-old asked for some candy, and she'd been very good so we decided to give her some. She took a few licks and then she said, "This candy is too salty. I want another one." I said, "That's the candy you chose so that's the candy you should finish." My daughter started crying. I could see my wife wanted me to give her another candy. Finally, I broke down. I wasn't happy. I remember when I was young. *Any* candy was a treat. You would never discard the candy, because you didn't

know when you'd have a chance to buy another piece.

Too often in this country, we discard our treats too quickly. We say we like what we see, but once we take off the wrapper, we don't like it and we discard it, and think we can get something else. How many people only get one chance at that piece of candy? What you see reflected in attitudes as simple as that piece of candy reaches all the way to the halls of Washington, D.C.

When I first got elected in 1992, my first experience with an issue in which I was immersed and had a stake had to do with unemployment benefits. We had a new Democratic president, and Democrats still controlled the House and Senate. We were still recovering from the recession of the late '80s and early '90s, and a good portion of the people who were receiving unemployment benefits had exhausted not just their initial take of benefits, but their second supplemental take of benefits, and they were about to lose all access to unemployment benefits without any recourse.

We needed \$4 billion to cover them for another four months, so we pieced together legislation. One of the components of that legislation was to temporarily strip legal immigrants of Supplemental Security Income. We were going to strip SSI from aged, blind, and disabled people to the tune of \$1 billion to help fund people who were on unemployment. But it wasn't just *any* recipient of SSI, it was only legal immigrant recipients of SSI. So I went to the Democratic leadership and said, "How can you take from Peter to give to Paul? Paul is in need, but so is Peter." Ultimately, we cut \$1 billion in SSI benefits to legal immigrants for the first time in U.S. history. It had nothing to do with making policy; it was politics.

And in 1996, it happened again. Under the guise of reforming welfare, which most people think of as Aid for Families with Dependent Children, the Congress, now under Republican control, decided to include programs that have not been categorized as welfare—Medicaid, which is Medi-Cal here in California; SSI, which is for the aged, blind, and disabled; and food stamps. Forty percent of the money they saved by reforming welfare came out of the hides of legal immigrants. Not only were they being denied SSI, but there was a proposal to deny them access to Medicaid and food stamps as well.

A total of \$25 billion out of the \$42 billion or so that was saved in welfare reform in 1996 came out of 5 percent of the population, most of whom had never served a day on welfare—legal immigrants. The president signed the bill, because it was an election year and he had talked for so long about reforming the welfare system, and not signing the bill would have hurt his party. Fortunately, in 1997, we were able to recoup about 40 percent of those cuts, and fortunately this year we were able to get another \$800 million restored for food stamps for legal immigrants, but that still leaves a large population out there in the cold. That is politics, and that's what we must take into account when we talk about immigrant children.

But remember something else: The 1990 U.S. Census, we know, missed some 5 million people. More than half of those people not counted were children. A great number of those not counted, we also know, were immigrants. Immigrants were not counted well and children weren't counted well, so how do you think children of immigrants were counted? Remember, also, that when we talk about "children of immigrants," for the most part we're talking about U.S.-citizen children whom the census did not count, to whom

Forty percent of the money they saved by reforming welfare came out of the hides of legal immigrants.

policy makers don't wish to provide services, and, for the most part, whom American people quickly discard.

Policy making for children of immigrants is very difficult, even though for the most part we're talking about U.S. citizens with every right that you or I have, but because they're not yet 18, they can't vote to express themselves. And because their parents aren't citizens, they can't vote to express themselves for their children. That's why in 1993, a Democratic majority was willing to take \$1 billion out of SSI for legal immigrants, and in 1996, the Republican majority was willing to take \$25 billion out of SSI, food stamps, and AFDC for legal immigrants.

The Immigration and Naturalization Service recently came out with regulations that are meant to construe the 1996 Immigration Reform Bill. In these regulations, they define a public charge. Remember, if you come to this country you have certified that you will not become a public charge. If you do become a public charge, you are subject to deportation. The regulations that the INS has issued seem to indicate that if you receive Medicaid, which has never been considered welfare, you are now considered a public charge and, therefore, subject to deportation. So, especially in places like L.A. County, many immigrant families are keeping their U.S.-citizen children out of the hospital and out of the community clinic because they're afraid that if they take their children to these clinics or hospitals, they will become subject to deportation.

Perhaps the most important thing as you start to discuss how to move forward with this report is to talk politics. I don't mean Democratic or Republican politics, I mean simply how we can change what goes on in Washington, D.C., which discards so easily the immigrant child or the child of immigrant parents. If we don't do that, we're going to continue meeting and talking about the problem, but we'll never have all of the ammunition we need to make sure the policy makers put the money where it should go.

My children will never have to worry about just one piece of candy, what school they'll go to, having access to health care. But I want my children to recognize that I never had a chance to discard a piece of candy when I was small, and that there are still generations of children who can't discard the candy. We have to make sure that people understand, especially in Washington, D.C., that you cannot discard the child. There's a lot of money out there, and it doesn't take a whole lot. But sometimes we discard too quickly. This is an opportunity to discuss what we need to package within that wrapper, and then how to sell it. I hope you'll discuss some politics in the truest sense of the word so that we can all do that.

Xavier Becerra is a Member of the U.S. House of Representatives.

Phil Ansell

I would like to start by making three foundational points. If children don't have enough to eat, their health status will not be good. If children's families do not have access to a basic source of income to maintain adequate housing, the health status of those children will not be good. So point number one is that if we're concerned about the health status of children of immigrants, we have to ensure that they have access to basic public benefits.

Foundational point number two is that children do not live by themselves; they have parents. Though self-evident, it's important to understand that we cannot segregate the issue of access to public benefits for children from access to public benefits for their parents and then expect that lack of access for their parents will have no impact on the health status of those children.

There was an effort to do that in California with regard to food stamps. On September 1, 1997, 120,000 legal immigrants in Los Angeles County lost federal food stamps. In Sacramento, a state food stamps program was created, but the state program applied only to seniors and children. So of this group of 120,000 people who lost federal food stamps in L.A. County, 30,000 had them replaced by the state, and 90,000 didn't. Los Angeles County worked closely with the California Food Policy Advocates to document the impact of the termination of food stamps for 90,000 legal immigrants, ages 18 to 64, in the county on September 1, 1997.

The study dramatized in an extremely clear way that children and parents live together—they eat from the same refrigerator, cook on the same stove, and sit at the same table. If parents don't have food stamps, their children go hungry. It's public policy fiction to maintain access to benefits for children and not for their parents and expect that children will not be adversely affected.

The third foundational point is that most children of immigrants are not immigrants themselves, but United States citizens. They live in mixed households, which underscores how impossible it is to segregate the immigrant community from the citizen community because, in fact, many people live in households of mixed statuses and particularly children tend to be U.S. citizens even though their

parents may be either legal or undocumented immigrants.

What are the implications of these three premises? Based on our experience here in Los Angeles County, there are two. One, it's important to do everything we can to maintain eligibility for public benefits for legal immigrants. And two, eligibility by itself is not enough. We have to take the next step to ensure that eligibility translates into real access and utilization. Let me talk about these two points separately: eligibility and actual utilization.

When the Personal Responsibility Act was enacted on August 22, 1996, we in Los Angeles County said that we faced an impending regional emergency. At the time, we faced the prospect of 100,000 elderly and disabled legal immigrants losing SSI. Another 100,000 legal immigrants, in addition to the first 100,000, would be losing food stamps. And if the state took full advantage of its new discretion under federal law, more than 300,000 legal immigrants would lose Medi-Cal and more than 100,000 would lose AFDC. As many of you know, Los Angeles County has been at the forefront of the effort to restore federal eligibility for benefits, to ensure that the state would maintain federal benefits where it had the option to do so, and to exercise further discretion to replace lost federal benefits with state benefits. We have been extraordinarily successful in California in maintaining eligibility for legal immigrants to public benefits.

If eligibility meant that immigrant children and their parents would continue to utilize public benefits, as they had before both welfare and immigration reform, maintaining eligibility would be sufficient. But there has in fact been a substantial reduction in immigrant applications for public benefits in Los Angeles County. Michael Fix mentioned the most

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striking statistic, a 71 percent reduction in applications for Temporary Assistance for Needy Families (TANF), which means Medi-Cal and Food Stamps as well, from households headed by legal immigrants—during a period in which there was no change in eligibility.

On another front, Los Angeles County has embarked on an aggressive effort to enroll 100,000 children in Medi-Cal in over a two-year period. The biggest obstacle to the success of that effort is the fear that both legal and undocumented immigrant parents have of enrolling their mostly citizen children. If we are to preserve actual access and utilization of basic public benefits for the children of immigrants, we must address and overcome the fears that are so prevalent today in immigrant communities regarding the utilization of public benefits. Fundamental to that effort is federal clarification that utilization of health benefits by citizen children is not related to a public charge determination. But even if we get that from the INS and the federal government, it will not be sufficient. We'll then have to take the next step in an aggressive community outreach campaign assuring immigrant parents that utilization of benefits for their children will have no adverse impact on their immigration status.

Phil Ansell is Chief, Strategic Planning and Government Relations Division, Los Angeles County.

Sylvia Drew Ivie

The subject of the conference today is immigrant children, but I want to take my few minutes to share with you what is happening

to a typical provider of care for immigrant children. Our providers and our communities have been hit twice, first by managed care and then by welfare reform. Before those two trains hit us, our facility had 60 percent uninsured, 40 percent Medi-Cal reimbursement. We now have 75 percent uninsured, 25 percent Medi-Cal reimbursement. The problem with the loss of that Medi-Cal support in a community clinic is, how do you take care of the uninsured? This is a monumental problem, and I think it threatens the viability of all of the community clinics because, with very few exceptions, this is the pattern.

Another big issue resulting from these changes is that, while we lost those patients, we gained large numbers of uninsured whom we care for under various patchwork programs such as Expanded Access to Primary Care, Child Health and Disability Program (CHDP) and the Public-Private Partnership (PPP) in L.A. County. The PPP program has really been a godsend to us. But the income that we get, which is from federal bailout dollars to L.A. County, covers only a small part of the cost. The uninsured patient is a sicker patient than the Medicaid patient. So we are spending half of the money that we get for PPP for the medications and the lab and X-ray work that the patients require. We are also taking care of new populations that we didn't serve in volume before, like General Relief patients who are very sick. This puts a tremendous burden on the clinic to redirect our efforts.

Historically, we have tried to follow a formula for taking care of at-risk multiethnic, multiracial populations that involves 80 percent support, 20 percent medical care. Now the ratio is

reversed: 80 percent medical care, 20 percent support. Our patients require a lot of time, a lot of one-on-one assistance, a lot of education from multiple team members. It's not just the physician, not just the nurse practitioner from whom they learn; they get information from the financial screener, from the appointment desk clerk, from the health educator, from the outreach workers. This is crucial to the quality of care that we provide.

When all of your energy goes into taking care of sicker people, that educational and supportive interaction falls by the wayside. Those people who used to sit down with the mother and the child to talk about general life management issues are now on the telephone trying to get specialty referrals set up with county facilities or one of 10 different HMOs. In many cases, instead of sitting down with and talking with our patients about their health problems, our staff is helping them navigate the system.

In addition to those problems, we have Healthy Families. Healthy Families was going to be the solution to many of our problems. But, guess what folks, people are not signing up. We've had only 9,000 people signed up in L.A. County, which is a pitiful number given all of the children who are uninsured. We've done such a good job of saying people are bad if they sign up for any public benefit program that it's not just the public charge issue, it's the stigma that affects people of all races equally. We need to let people know there has been a shift.

The State of California needs to say, "We are now embracing preventive primary health care for children and putting a program in place to take care of that. We want you to come in and get health care early. We want you to take advantage of state-subsidized care, even though we were demonizing

The uninsured patient is a sicker patient than the Medicaid patient.

undocumented immigrants and welfare recipients only a short while ago.” People would respond to that kind of candor.

Sylvia Drew Ivie is Executive Director, T.H.E. (To Help Everyone) Clinic, Inc.

Robert Ross

Let me begin by telling you a little bit about San Diego County. We are a geographically isolated cul-de-sac, surrounded by the ocean on the west, the desert on the east, the Mexican border on the south, and Camp Pendleton on the north. The running joke in San Diego is that although we have a six-foot fence that separates us from Mexico, we need a whole slew of Marines at Pendleton to protect us from Los Angeles.

The reason I mention this is that San Diego County really does have its own political, cultural, and social mentality. Tip O’Neill said, “All politics is local,” and the same holds true in our business: All public health is local. Protecting the health of the community is our mission, but how we achieve this is shaped by local influences. This being said, we must be reminded that protecting the public’s health is an “all or none” phenomenon. Either you do it, or you don’t.

As has been mentioned by previous speakers, both communicable and behavioral disease issues confront immigrant communities. Tuberculosis is one example: 65 percent of our cases in the county are in foreign-born individuals. The State of California and San Diego County have done a reasonably good job of controlling TB because we’ve learned to be busy and aggressive, identifying and tracking cases with public health nurses and outreach workers, and doing DOT (directly observed therapy). This is basic, nuts-and-bolts public health, akin to blocking and tackling in football.

We must be reminded that protecting the public’s health is an “all or none” phenomenon.

Well, along came the 1996 federal welfare reform legislation, with the following language:

... no state or local government entity may in any way be restricted from sending or receiving from the INS information regarding the immigration status, lawful or unlawful, of an alien in the United States.

As a health officer, I felt sick when I read this language. One county supervisor was ready to plaster this language in every health clinic and Medi-Cal office throughout San Diego County. The majority of supervisors realized that this was unwise when I said the following: “Look, we’ve been able to cut TB case rates by 14 percent last year, 29 percent over the past three years, and our community is better protected as a result. So if we start plastering these signs everywhere we are going to scare active TB cases away, and this is going to head in the wrong direction.”

So, even in California’s most politically conservative county, elected officials respect the need to prioritize public health, even if it occasionally runs counterintuitive to political ideologies.

Also, the need for good data has been mentioned. When I asked my epidemiologist for data on the health of immigrant children in San Diego County, all I got back was a blank stare. Longitudinal studies are nice, but we need organic, real-time data, relevant not only to public health practitioners but also to community-based organizations, so that we can be responsive and manage emerging problems.

So, here's the "To Do" list. First, we need to establish relevant, real-time data on the health of immigrant children nationwide and statewide. Second, outreach and eligibility information is mission critical, and especially now; in San Diego County, we are creating a Center for Health Education and Consumer Advocacy in a contract with the Legal Aid Society. Third, we must push the envelope on a multicultural health agenda, not because it's politically correct, but because we are a diverse society and public health is an "all or none" phenomenon. Finally, the time is ripe for federal-state-local dialogue around how immigration issues impact on public health. There are some lessons that some folks inside the Beltway need to hear.

Robert Ross is Director of the San Diego County Health and Human Services Agency.

Kazue Shibata

Much of today's discussion has been focused on the financing aspect of health care—who's going to pay for it. I think we also need to look at what's the best and most cost-effective health care for people in a community. One of the presenters this morning was talking about looking at the strengths of a community—including, for example, herbal medicine usage and nutritional habits that people have brought from the countries from which they came. Integrated medicine considers the different strategies of a community for healing, staying healthy, and becoming healthier.

Professor Brown asked me to focus on barriers for immigrant communities other than entitlements. I like to focus on language and culture. Everyone can be insured today, but if

we don't have language access and cultural access, people won't have a good place to go to get the best care. At the Asian Pacific Health Care Venture, 90 percent of our patients are monolingual. We need to understand that we're dealing with people who are linguistically isolated in the community, who may be isolated from the large family network that they had in the countries they came from. These patients need the skills to be able to understand what's going on in health care for them and their children. A lot of times government agencies and programs find an excuse at the bottom line to say we have to do translation on our own. There's no political realm to recognize that California has a very diverse population and we all need to start taking responsibility for it.

I used to be one of those people who couldn't speak English very well. The impact was that I couldn't understand what was going on in the medical setting. And the impact of managed care is that now community-based clinics have to deal with "panel" providers. We and our patients are limited in choosing providers with whom the patients will feel comfortable. Under the fee-for-service system, clinics had some freedom to plug those monolingual patients into bilingual/bicultural providers in a community. Now, we basically have no choice.

The other impact on lack of language is the access issue—not just to health care, but to information. We have to ensure outreach to hard-to-reach populations. We shouldn't allow ourselves to entertain excuses that this particular population is too small or we don't have enough money. I think there has to be a clearly stated policy that we recognize all of these diverse populations and must find some way to do the outreach.

Kazue Shibata is Executive Director of Asian Pacific Health Care Venture.

Nancy Bowen

What I'm going to talk about is in the context of our goals for public health. To achieve our goals we need to eliminate disparities in health status between groups; therefore, we need information for those subpopulations. I'd like to touch on a few of the major barriers to moving forward and addressing our information needs—including one of my pet peeves, sample size, and the most important one, funding. Finally, I'll touch on what I think are the priorities among information needs, and specifically, what are the priorities related to information on immigration status.

What is it going to take to eliminate the disparities? All of you are involved in working with communities to identify culturally appropriate strategies for improving health. Healthy People 2010 calls for improving collection and use of standardized data, and they're not even talking about information about immigrants when they say that presently, data are sparse about subpopulations.

Second, it calls for monitoring the effectiveness of interventions targeting these groups. We need to be very careful with our dollars. This is because we're probably not getting much more money than we have right now. When we try something, we need to see whether it's working and change course if it's not.

And the final strategy is to look at the different subpopulations and understand how different variables interact and influence health status. We're moving forward to the year 2010 and we're changing data systems to be able to follow information on selected populations, but we would need to add a few more data elements so that we'll be able to also follow our immigrant populations.

To achieve our goals we need to eliminate disparities in health status between groups; therefore, we need information for those subpopulations.

What are the barriers to addressing information needs? Now, when we start getting very specific about subgroups that have different problems, we sometimes end up with very small numbers. For example, in San Diego County, if you're an Asian, a female, and a teenager and you're in poverty, it makes a difference if you're a second-generation immigrant and if your parents happen to come from Vietnam vs. another country, and if you are able to speak English and your parents aren't. All of that makes a difference, but you end up with maybe 25 people—if you can find them—in the whole county whom you could look at and measure your area of interest, such as whether they are smoking, or enrolled in a program for which they're eligible. How are we going to address that?

Sometimes in studies you can increase the sample size. Obviously, for a population-based data set like I just went through you can't do that, so we combine many years of data so that the size accumulates. We would also look at more than just San Diego County. We would determine what are the other parts of the state that are similar to us and combine our data with them. There are also statistical tests that can help determine, out of that long list of variables that I gave you, which ones really aren't going to influence the smoking status, or enrollment in a program. No matter what, you also need to use caution when you interpret the data. I find that once people have a rate, they don't care what the sample size was, they just go with it.

The next barrier has to do with funding. Obviously, not everything that's in this report is

going to be able to be accomplished. All of us are forced to set priorities. I want us to think not just about which information projects to fund, but to also realize we need to be investing more money of all general funding in information-type projects. Why? One reason is the principle that health is a shared responsibility. We need to work in partnerships involving all of the stakeholders, including the public. I'm involved in a lot of public-private partnerships. The key to those being successful is to get information that people can come together around, establish some goals and move beyond their biases and agendas to work together.

The other key reason we need to be investing more in information is that the mantra nowadays is accountability, outcomes, etc. In government we've heard from the taxpayers, who want proof that what we're doing is effective. This requires a lot of thought, and then resources must go into building the infrastructure to be able to produce that information on outcomes.

What are the information priorities? First, let's look at what we already have. We have reports, and we're not necessarily making them accessible, disseminating them, explaining them. Let's get out the information that we have right now and make it more timely. Next, with regard to new information, we need the ability to look at different subpopulations, and immigrants are at the top of the list. Third, we need to establish the infrastructure for measuring performance. Finally, we need to increase the epidemiologic infrastructure—that is, the science behind figuring out the information we're going to collect and, once we do, whether it really means something or not.

When investing in immigrant information priorities, first let's look at where we have existing data systems and then add a few

elements. Practically speaking, there's not really a lot to it. You ask the clients of interest their country of birth, their parents' countries of birth, and then citizenship status. As the report points out, immigrants who are citizens are in different situations than immigrants who are not citizens. Second, we also need qualitative information. To understand what the data means, we need focus groups and interviews and surveys. Third, longitudinal studies take a long time to produce results, but it's fascinating to see whether, for instance, an infant program is still making a difference when the child is in kindergarten, or a teenager. And finally, when we're doing surveys we need to make sure we have enough immigrants in our samples so that we'll be able to draw conclusions about what's going on with that population.

Nancy Bowen is Chief of Child, Youth, and Family Health Planning, San Diego County Department of Health Services.

Susan Drake

I'd like to discuss changes affecting the immigrant population that have implications for the arguments people need to make and, therefore, the kind of data they need. It's amazing, when you look at the report's recommendations, that there are four or five major studies on the impact of welfare reform being funded in the country, and none of them is bothering to look at these issues.

We cannot let immigration law and immigration law enforcement undermine other values in American society. That is basically what happened with the 1996 bill. That law and its enforcement are preventing us from providing health care to people who need health care. We cannot reassure them, even when they are eligible, that it is safe to come in. In the public charge debate, I cannot tell you how powerful

the participation of the health care community has been in making it possible for politicians at the federal, state, and county levels to begin to see the question in a different way. It is not a question of who are those people using our system, but how can we be sure that public health is provided to everybody.

We want to get back to a situation in which people who are here legally are on parity with citizens, the way it was before 1996. It's a value in American society that people who are in the same situation should be treated equally, and we're not there yet. For example, newly entering legal kids are not eligible for CHIP at the federal level. They're under the federal five-year bar, and they're not eligible here in California. I'll talk in a minute about barriers to enrollment of kids who are eligible for Healthy Families, but let's also remember the ones who *should* be eligible and aren't.

This is an intergenerational issue. If you want to bring in your parents, they're not going to be eligible for SSI, and you probably won't be able to get health insurance for them. We had a horrible time trying to explain why those grandparents in immigrant families who hadn't yet worked for 10 years in the United States really were making contributions to American society. Maybe they had worked for 20 years back in their home countries, and now they're here taking care of the kids while the parents are working.

Longitudinal studies addressing the intergenerational strengths of having those grandparents in the families would be helpful. Are they providing some of the cultural norms and support systems that are making those kids healthier? If a grandparent needs long-term care and you can't afford it because you couldn't buy insurance, what impact does that have on the health of the entire family?

If we help everyone in the family, that helps the child.

On the public charge issue, there's been a lot of restoration of benefits, and yet people are still afraid to take them. The General Accounting Office found that one-third of the nation's children who are eligible for Medicaid but not enrolled are kids in immigrant-headed households. In California, it's 70 percent. That's a lot of kids who could be on Medicaid but are not for various reasons, public charge being one of them. Among other things, the issue of reporting is very worrisome. There's a lot of concern in the advocacy community about wanting to collect data so we can monitor and being worried about how those questions are asked. There's this tension between what we need to collect in order to know what's happening and what questions might actually create fear in the community about seeking services.

A key to finding language to talk about people who do not yet have legal status in a way that resonates with policy makers is going to be how we collect information about these kids and their family members. We need to show that not only are we harming *them*, but we're also harming the rest of us. The front-line arguments are going to be the arguments made by people in the health care community. I'm happy you are out there doing what you're doing and delighted that researchers are beginning to ask some of these questions.

Susan Drake is Executive Director of the National Immigration Law Center.

We cannot let immigration law and immigration law enforcement undermine other values in American society.

Paul Ong

I want to make a modest suggestion about what can be done to help us understand some of the issues raised in the report. That modest recommendation is to expand our time horizon in thinking about these problems. In looking at the percentage of the total U.S. population that is foreign born—the immigrant population—from the year 1810 to the present and beyond, with projections into the year 2050, this nation over a very long period of time has gone through two massive waves of immigration. I think there's much to be learned by looking at how this country, through its politics and policy, has historically treated the immigrant population, as well as children of immigrants. That helps to place into context what's happening currently.

But I also want to turn my attention to the future. I think it's important for us to think about the future as a way of framing what we do today, to become aware of what are some of the problems that might be on the horizon and to understand the magnitude of those problems. There are two ways of doing this. One is the very simple way; that is, you take the projections of the forecast and think about the implications. What will the population look like 20 years from now, 30 years from now? And even more important, what will that population look like by age cohort? If you knew that composition, it would tell you a lot about how you should think about policies today.

I think there's much to be learned by looking at how this country, through its politics and policy, has historically treated the immigrant population, as well as children of immigrants.

Part of what we try to do as planners, given all of the flaws in population projections and the problems in making assumptions, is to peer into the future and think about how we allocate our resources. That's a simple projection. The one thing you can't do, and there should be some pressure put on the Census Bureau, is take the bureau's estimates and break them down by nativity and by generation. The capability is there to do this sort of work, and it should be done.

The more difficult part, however, is when you probe a little deeper into the assumptions that go into the cohorts of survival models that we use. I think the most critical assumption, for example, is the assumption about the rate of immigration over the next decade, over the next two decades, over the next half century. It seems innocuous. You work it out, and you do the best job possible by having the detailed information on survival rates. You need to break that down by ethnicity as well as nativity, and you do that as a good demographer. The tricky part is not so much making assumptions or getting estimates of survival and death rates, but what do you assume will be that rate of immigration over the next decade, two decades, three decades? It's not a mechanical exercise.

The middle series for the census is a status quo assumption; that is, we will have immigration roughly at the rate we're seeing in this last decade of the century, taking out some of the usual fluctuations in refugees. But the census' low series says that immigration drops by half; therefore, the number of children of immigrants will be smaller. It is a statement about what policy we will accept in the future. If we say that immigration increases, that's another set of assumptions. Those policies deeply reflect our assumptions about this nation's willingness to remain a nation of immigrants. They reflect not just our

immigration policy, but also our policy toward immigrants.

When you start doing this population projection exercise, which is technically very difficult but do-able and insightful, and then you probe more deeply into the assumptions, you begin to confront the questions about what this nation ought to do about its immigrants and about immigration. If you can answer that, you can answer questions about what will be the health services available. Unfortunately, that is not a very easy thing to discern. In part, we can't discern that because it's not written yet. The good news, however, is that doing this exercise puts us in a position in which we must think about how we as researchers and how we as citizens begin to act on those policies through the political arena.

Paul Ong is Professor of Urban Planning and Social Welfare, UCLA School of Public Policy and Social Research.

James Smith

It's often said that we are a nation of immigrants and that is one of the things that makes this country unique. But in spite of the fact that immigration is so fundamental to who we are, there has never been any nationally representative sample that allows us to study the process of immigration from beginning to end—to look at immigrants when they come, observe what fraction of them succeed, what fraction of them do not succeed, and why. We have no data to enable us to study that process. That is one of the things wrong with current data on immigration.

The second fundamental problem is we never ask the right questions. That's because typically we've added immigrants to surveys on a different topic. In these studies, life begins when

the survey starts, or, at best, after people come to the United States. For example, you have a 40-year-old who comes to the United States and you're not going to ask anything about life before he or she came to this country. That's a limitation.

The third problem is that the designs of all of these surveys are fundamentally flawed. You have to follow the immigrants as they arrive. In surveys, it is a sample of people who happen to be out there. We may be getting immigrants who have been in this country for 20 years or 10 years, and we don't know what's happened before that. It's like looking at the NBA and making a statement about the average talent of boys in elementary school in basketball. That's the *end* of the process. You have to see the beginning.

At RAND, we're trying to rectify this by doing a new study of immigrants in which the sample consists of new green card recipients. This is when that process of being a legal immigrant actually begins. They get a green card, the next thing they do is hear from me asking them questions about their lives. There are legitimate questions about whether such a survey is feasible.

Immigrants are a highly mobile population, even after they get here. One of the concerns, given their mobility, is that this is the time period of distrust with people asking them questions. Many of these people have transited from undocumented status. Given that level of distrust, we wanted to know whether we would get response rates consistent with what we want in high-quality surveys and whether we could follow these people over time and have them answer our questions. We are now at the end of that pilot and the answer to all of those questions is yes. It's clearly feasible.

They answer questions about things I wouldn't answer questions about, including their

prior illegal status. You have to have some sensitivity about how you ask these questions and not be threatening, and certainly you should be using people that they respond to. All of our interviewers are dealing, obviously, in the language that they speak, but many are also immigrants themselves, so there's a lot of conversation that goes on besides the questions that they could ask. You can build up that level of trust.

We've done a study on a small population to see if it's feasible, and we believe it is. We'll be proposing to do this study on a much larger population to deal with the sample-size issues. Data allow us to separate ourselves from opinion and get down into facts. Whether the facts are favorable to immigrants or unfavorable, I really don't care. I think the truth will always be the basis for how we should make decisions. I trust the truth.

James Smith is a Senior Economist at RAND.

Research Needs

The following research agenda related to children in immigrant families represents a summary of the combined priorities of the presenters at the December 10–11 public forums. The agenda items have been grouped into the following categories: Data Collection and Epidemiology, Behavioral and Social Science Research, Policy, and Health Services. Many of the research suggestions cross categories, but have been listed in only one section.

Data Collection and Epidemiology

- ▶ Conduct research specifically on the health status of immigrant children.
- ▶ Establish relevant, real-time data on the health of immigrant children nationwide and statewide.

- ▶ Develop new census survey techniques in order to collect information on immigrants and their children.
- ▶ Add data elements to existing surveys to enable researchers to follow immigrant populations. For example: country of birth, parents' countries of birth, and citizenship status.
- ▶ Increase database information on aspects of healthy development unique to children in immigrant families.
- ▶ Conduct longitudinal evaluations of existing programs.
- ▶ Develop additional nationally representative, longitudinal databases.
- ▶ Include research on the lives of immigrant populations before entry to this country. Current information is limited to U.S. residency only.
- ▶ Develop comparative social and epidemiologic profiles of the areas from which people emigrate.
- ▶ Conduct qualitative ethnographic studies to further understand the context of immigrants' lives.
- ▶ Conduct qualitative research, such as focus groups and interviews, in order to inform quantitative research.
- ▶ Develop strategies to increase participation by immigrants in studies.
- ▶ Find ways to overcome small sample-size issues related to specific immigrant populations by combining years of data or combining the data from similar areas.
- ▶ Conduct research on the epidemiological paradox identified in this report, in which immigrant children's health regresses to the U.S. mean.
- ▶ Increase the overall epidemiologic infrastructure.

- ▶ Conduct research on migrant agricultural workers, particularly related to two infectious diseases: tuberculosis and HIV/AIDS.
- ▶ Conduct demographic studies on population projections.

Behavioral and Social Science Research

General

- ▶ Examine clustered risk-taking behaviors as well as protective factors.
- ▶ Study the subpopulation of people who are in a continual migration pattern between the U.S. and Mexico and Central America.
- ▶ Incorporate substantial community participation in the design, implementation, data analysis and information dissemination phases of research.
- ▶ Improve dissemination efforts and the accessibility of reports.

Culture

- ▶ Provide cross-cultural training for those in the medical field, including knowledge of their patient populations' countries of origin and the health conditions that exist in those countries.
- ▶ Define the appropriate definition of cultural competence from the perspective of immigrant families.
- ▶ Conduct research on valid operational measures of cultural competence in terms of utilization, patient satisfaction, quality of care and health outcomes.
- ▶ Identify the protective factors that are important at the individual, family, community, and policy levels.
- ▶ Determine what contributes to the dilution of the protective factors initially experienced by immigrants, and how immigrants can best

be “immunized” or provided with the necessary “booster” shots.

- ▶ Identify the assets immigrants have and how these assets are threatened by the economic disparity in American society.
- ▶ Conduct research on effective interpretation/translation services, including the style of interpretation that delivers the best results and the level of training needed by interpreters.
- ▶ Given that asking people about immigration status may itself create a deterrent to services, find the best way to avoid this problem in research designs, and learn more about the conditions of research fatigue among these communities.
- ▶ Conduct research on language access and cultural access issues.
- ▶ Conduct studies addressing the intergenerational strengths of grandparents in immigrant families. Are they providing some of the cultural norms and support systems that are making children healthier? If a grandparent needs long-term care and the family cannot afford it, what impact does that have on the health of the entire family?
- ▶ Examine the role alternative medicine plays in the well-being of immigrant families.
- ▶ Study the use of traditional remedies among immigrant families and how this usage impacts health.

Education

- ▶ Conduct research on effective English-as-a-Second-Language teaching methods.
- ▶ Look into why children are having varying educational experiences, and identify the differences between the high and low academic achievers.

Media

- ▶ Conduct content analysis on the types of media messages that young people are receiving.
- ▶ Conduct research on the most effective ways to translate scientific findings into public sound bites.

Community Health Education

- ▶ Study the impact of community health workers among recently immigrating populations.
- ▶ Examine the impact of community health outreach to immigrant populations and how it can best be employed in a variety of settings.
- ▶ Develop a strategic plan for spending the tobacco settlement dollars and ensuring that these dollars do not go into any area outside of health care.
- ▶ Given the data demonstrating that higher acculturation is linked to poorer self-esteem and poor pregnancy outcomes, determine what can be done to ensure that the connectivity migrants have remains an important protective factor.

Policy

- ▶ Determine why families eligible for Medi-Cal have opted, when given a choice, for Healthy Families instead.
- ▶ Given the political climate, look into areas of enlightened self-interest, such as immigrant children's importance to the future social security tax base. Through research, find other areas of common interest for advocacy in the policy arena.
- ▶ Through research, demonstrate to Congress and legislatures everywhere that researchers and advocates are making a difference in the lives of children.

- ▶ Identify the social interests that society has in keeping people healthy.
- ▶ Determine how the political environment, including policies such as Propositions 209 and 187, affects the immigrant's experience.
- ▶ Collect case studies—individual patients' stories—and bring them to the attention of policy makers.
- ▶ Develop a community outreach campaign assuring immigrant parents that utilization of benefits for their children will have no adverse impact on their immigration status.
- ▶ Create opportunities for federal-state-local dialogue in regard to how immigration issues affect public health.
- ▶ Conduct research that will push the envelope on a multicultural health agenda.

Health Services

- ▶ Conduct research on why many counties are not using their indigent care programs to serve either newly arrived or undocumented immigrants.
- ▶ Conduct research on utilization of services and health status indicators.
- ▶ Gather more information on immigrants as consumers of health care.
- ▶ Determine whether utilization of health care services is lower because immigrants are healthier, or whether it's a result of access barriers such as cost, language and fear of the Immigration and Naturalization Service.
- ▶ Determine what an insurance product for immigrants should look like. Does it need to be different across ethnic groups?
- ▶ Identify the health insurance benefits immigrants want.
- ▶ Determine the most effective strategies for marketing health insurance products to immigrant families.

- ▶ Quantify the cost of insuring vs. the cost of *not* insuring immigrant families.
- ▶ Study the interactions between health care utilization and outcomes, particularly for young people.
- ▶ Conduct research on providing dental care to the children of migrant agricultural workers.
- ▶ Conduct research on mental health problems faced by migrant agricultural workers and how to provide services to them.
- ▶ Identify the best and most cost-effective health care for immigrant populations.
- ▶ Pursue research to determine whether the barrier to health care involves not only access issues, but also a lack of information.
- ▶ Gain a clear understanding of what a community-based public administration strategy should look like in order to deal with devolution and to develop the capacity to provide necessary services.
- ▶ Develop research that will establish the infrastructure for measuring performance.
- ▶ Determine how parents make decisions about programs that treat their noncitizen children differently from their citizen children. Identify the other types of health care decisions that families with mixed immigration statuses are making.
- ▶ Examine how the diminished capability within the HMO system of sending a patient to a bilingual/bicultural provider has affected health care delivery to immigrant populations.

NOTES

1. Many noncitizen families have avoided the Medi-Cal and Healthy Families programs due to concerns of being labeled a “public charge.” They fear that enrolling even their citizen children in these or other means-tested programs may be used against them when they try to renew their visas, return to the United States after traveling abroad, or apply for citizenship. The fears of some immigrants may be allayed by recent policy changes concerning Medicaid enrollment and immigration status. The INS and the State Department ruled in May 1999 that noncitizens will not be classified as “public charges” if they or their children enroll in Medicaid or CHIP (except those who receive long-term care under Medicaid). This policy change, if effectively communicated to parents, should help assure families that they do not have to fear these programs.

2. In addition to the speakers whose excerpts are featured here, the sponsors wish to gratefully acknowledge the contributions of Grantland Johnson—then Regional Director of the U.S. Department of Health and Human Services and current Secretary of the California Department of Health and Human Services—to the Sacramento policy forum.

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