Elderly Immigrants: Emerging Challenge for the U.S. Healthcare System

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Citation

E Gorospe. *Elderly Immigrants: Emerging Challenge for the U.S. Healthcare System*. The Internet Journal of Healthcare Administration. 2005 Volume 4 Number 1.

Abstract

Elderly legal immigrants contribute significantly to the growth of America's aging population. They bring with them their diverse culture, health beliefs and practices which challenge U.S. healthcare providers in rendering accessible and culturally-acceptable health services. But as non-U.S. citizens, these elderly individuals are ineligible for federal health and welfare benefits despite their lawful presence in the U.S. Thus, the task of providing healthcare services for elderly immigrants fall on local community, family and individual responsibilities. Multisectoral cooperation is needed to harness the limited resources for the immigrant elderly in view of the ever increasing demand for publicly-financed healthcare resources.

INTRODUCTION

Immigration shapes the diverse character of American society. Through the years, immigrants have richly contributed to the growth of the U.S. population. They comprise a significant workforce with a yearly contribution of $10 Billion to the economy [1]. As they get older, immigrants represent a substantial fraction of America's aging population. As of 2000, 9.5 % of the U.S. population are immigrants age 65 years and older [2]. Moreover, they continue to grow with the influx of elderly immigrants who are entering the US through lawful immigration programs, sponsored by their family members under the Family Reunification Act [3]. These elderly immigrants will face the problems of adapting to a new environment, culture, and a complex healthcare delivery system. In these terms, they are disadvantaged compared to elderly non-immigrants in accessing and utilizing healthcare services.

Unfortunately, public welfare programs for non-US citizens have been curtailed. The enactment of the Personal Responsibility & Work Opportunity Reconciliation Act (PRWORA), stopped legally admitted immigrants beginning August 22, 1996 from receiving federal cash assistance and food stamps. Furthermore, the Supplemental Security Income (SSI) and Medicaid benefits of poor elderly immigrants have also been abolished [4]. These laws have caused and will continue to have significant implications in the provision of healthcare services for legal immigrants.

In this paper, I intend to present examples of health-related problems that beset the elderly legal immigrants and review possible solutions with respect to the elderly's special circumstances. I shall limit the discussion to legal elderly immigrants, also referred to as, lawful permanent residents. The issue of illegal immigrants is too complicated and political to be dealt adequately in this brief review. This problem, albeit interesting, merits a separate discussion.

REVIEW OF LITERATURE

By 2010, the elderly immigrant population is expected to reach 4.5 million. Approximately 60% of this increase is attributed to the growing number of elderly immigrants admitted as relatives of U.S. citizens, permanent residents and refugees [5]. On average, these immigrants enter the U.S. at 60-79 years of age [6]. Upon arrival, elderly immigrants settle in neighborhoods established by earlier immigrants. They tend to stay among family members or in ethnically-concentrated communities like Chinatowns. These settlements are mostly found in urban and suburban communities [2]. These provide a sense of belonging, access to ethnic foods and other cultural paraphernalia.

Elderly immigrants are different from their younger counterparts. Their process of acculturation to U.S. society varies depending on their ethnic background, socioeconomic status, and prior experience with American culture. Limited exposure beyond their ethnically-concentrated communities and strong cultural beliefs can become barriers to successful

acculturation [7]. However, acculturation to the American culture is not entirely ideal [6]. The shift to high fat, high salt, low fiber diet may even be detrimental [8]. Acculturation to the fast-paced American way of life is even associated with obesity, smoking, and sedentary lifestyle [9, 10].

Immigration can be a stressful life event for the elderly. It can bring about new financial, medical and psychosocial issues. Newly arrived elderly immigrants can become entirely dependent on their families because of their ineligibility for government healthcare funds and supplementary social benefits. They may not have sufficient savings or insurance coverage from their previous employment from their countries of origin.

In terms of health, they may lack the basic preventive care services such as immunizations, dental care, and cancer screening [7]. Coming from developing countries, they may have been exposed to harsh working and living conditions detrimental to their aging health. For example, newly immigrated elderly Mexicans have poorer health status compared to their Mexican counterparts who have lived and aged in the U.S. [11]. In terms of mental health, there have been documented cases of migratory grief and depression among elderly immigrant Latinos[12], Chinese[13], Indians[14] and other Asian/Pacific Islanders[15]. Even if the stringent medical examinations required by U.S. immigration laws have been efficient in screening and barring elderly applicants who may have active diseases of public health significance [16], newly arrived elderly immigrants still have poorer overall health and well-being compared to their American-born and U.S. naturalized elderly counterparts.

Access and utilization of healthcare services can also be challenging. The complex U.S. healthcare delivery system and its bureaucratic procedures are difficult to understand for new immigrants. In addition to financial issues, language and culture could hinder healthcare utilization. Older immigrants tenaciously hold to their cultural practices and health beliefs [17]. Communication with the elderly immigrant is an important consideration in providing health services. In a Minnesota program that aimed to improve the access of elderly immigrants to health services, limited ability to communicate in English was a significant factor. Latino, Somali and Cambodian elderly who spoke little or no English at all were heavily dependent on family and community members in accessing health services [7]. In choosing healthcare services, some groups of elderly immigrants still seek their traditional medical practices [18]. These services are not reimbursed by most insurance plans. Nevertheless, they are generally regarded as cheaper and readily available in their ethnically-concentrated communities such as the herb pharmacies in Chinatowns.

The challenge for healthcare providers is how to render services that are culturally-acceptable to elderly immigrants. Simply providing access to health services does not always guarantee that the elderly will avail themselves to such services. Another challenge is how to finance the healthcare of the uninsured elderly immigrants who are not eligible to Medicare or Medicaid. Free care should not be the only option. Recent data suggest that the incoming aged immigrants are becoming more financially capable due to their supporting families who have successfully established in the U.S [19]. However, there is still a need for insurance coverage. A study among elderly Korean immigrants prove that insurance coverage increases healthcare utilization [20]. The lack of regular health services to the aged could result to catastrophic medical conditions that are more costly to finance. In addition, chronically debilitating diseases in the elderly such as stroke, cardiovascular disease, osteoarthritis, and other chronic degenerative conditions could financially overwhelm families supporting the healthcare of their elderly.

DISCUSSION

STRATEGIES FOR ELDERLY IMMIGRANTS

Given the current legal restrictions for public funding of non-citizen residents, the best solution for the elderly immigrants would be to immediately apply for U.S. naturalization after five years of continuous residence in the U.S. Upon attaining U.S. citizenship, elderly immigrants instantly gain eligibility to Medicare and if qualified, including Medicaid, Supplemental Security Income (SSI), food stamps and other state administered programs. Since Medicare and Medicaid provide similar services to all beneficiaries, these government services are instrumental in reducing health disparities and enhancing the quality of lives of elderly Americans regardless of ethnic origin [21]. However, the process of naturalization requires the ability to read, write and speak English and knowledge of American history which could be difficult for aged immigrants with disadvantaged social and educational background. Fortunately, there are exemptions on certain meritorious cases which waive these requirements.

Aged immigrants who are still capable of working should

seek employment opportunities as a means to earn Social Security contributions and possibly even employer-paid health insurance. Employment is also a means to facilitate acculturation, possibly improve language skills, and to broaden social networks. However, because of possible language barriers and physical frailty, elderly immigrants are likely to have limited employment prospects.

Another option is for sponsoring families to procure private health insurance plans for their elderly members. This should not be regarded as unnecessary burden. Besides, federal regulations for immigrant sponsorship require that the sponsoring family member makes at least 125% above poverty level as a proof of his financial capability to support the elderly [4]. Although enrolling an elderly immigrant in a private insurance plan would significantly have high premium cost, financing the newly immigrated elderly is only temporary while they wait to qualify for US naturalization and to receive Medicare benefits.

Utilizing community and non-governmental resources will be helpful for the aged immigrants and their families. They should learn to organize themselves and create links with institutions, non-governmental organizations and community health centers that specialize in migrant health issues. Their joint mobilization and campaign have been very effective even in the past. After the PROWORA enactment, community organizers and advocates for the elderly successfully lobbied to restore SSI benefits to non-citizen elderly individuals who have resided in the U.S. before the Aug. 22, 1996 cut-off in spite of political resistance and prevailing anti-immigration sentiments during that time [4]. Advocates for the elderly minorities must take advantage of the growing influence of naturalized U.S. citizens and minority lobbying groups in both elections and legislative processes to support the cause of disadvantaged elderly.

STRATEGIES FOR HEALTHCARE INSTITUTIONS

Healthcare institutions operating in communities with substantial immigrant population should learn to establish links among the different ethnic communities. It is becoming popular among hospitals to provide medical interpreters and clinicians who are bilingual. In this regard, we can appreciate the advantage of diversifying our healthcare professionals. The trend of employing more foreign nurses and physicians might be an unexpected benefit which can answer the growing needs of a culturally-diverse elderly population. Cultural competency training is increasing among healthcare institutions as well as in the educational setting [22].

Providing healthcare to a culturally diverse and elderly population could be very challenging. Not all elderly immigrants are the same. Even among Hispanic immigrants, there are great differences among various South American ethnic groups. Health programs must consider these differences and not be quick to generalize all minorities. Clinicians must understand that older immigrants expect providers to be respectful of their culture, customs and even social status [17]. In terms of services, providers should optimize preventive services such as cancer screening, preventive cardiology and immunizations. The rational use of preventive services could forestall major illnesses that could deplete the limited financial resources of elderly immigrants and their families.

CONCLUSION

Meeting the challenges of the growing number of elderly legal immigrant requires multisectoral cooperation. Policy makers and the general public should avoid the assumption that immigrants disproportionately consume healthcare resources. On the contrary, healthcare spending for both legal and illegal immigrants is even 55% lower than the healthcare expenditures of US-born citizens [1].

Ten years after the enactment of PROWORA, health and social workers realize that elderly legal immigrants are indeed deserving of federal financial aid [4]. Unfortunately, there is no upcoming resolution for this issue. The current budgetary constraints, the costly implementation of the Medicare prescription drug plan, and the general mood of the U.S. government to cut spending do not show any signs of possible change on present welfare policies. Like most elderly Americans, aged immigrants and their families should plan ahead. Uncertainties in the future of Medicare and Medicaid suggest increasing reliance for private plans [23] and use of personal resources in the care of the elderly.

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