

## **STATE VARIATIONS IN LINGUISTIC COMPETENCY POLICIES AND THE EFFECTS ON IMMIGRANT ACCESS TO HEALTH SERVICES**

### **Executive Summary**

#### **Background**

Despite exponential growth in the past several decades, immigrants continue to have less access to the health system than the US-born population. For example, immigrants are less likely to have a usual source of care (1), have fewer visits to the doctor or nurse (2), and are less likely to be satisfied with their health services (3). With over half of immigrant adults being limited English proficient (LEP), or speaking English less than “very well,” language barriers are likely to play a significant role in hindering many immigrants from accessing services. The literature clearly shows that LEP individuals face difficulties in accessing health services, compared to persons with higher English proficiency (4-10).

The availability of language assistance services—such as bilingual providers or competent interpretation services—may help to diminish these disparities in access to health services between immigrants and US-born persons. Pairing patients with language concordant providers (or those who speak the same language) can lead to higher rates of satisfaction (4) and improve their understanding of a medical situation (11). The use of professional interpreters can also result in increased physician visits, greater patient satisfaction, and fewer medical errors, compared to using “ad hoc” interpreters, such as family members, friends, or even untrained staff (4, 12-15). However, for most hospitals and providers, the additional time or costs associated with the provision of language services are a significant barrier (16, 17). Currently, almost two-thirds of hospitals encounter LEP patients either daily or weekly (16) while two-thirds of direct practice physicians have active LEP patients (17).

States play an important role in the provision of health services and under federal civil rights law, are required to ensure that their health systems are accessible to LEP persons. However, with the lack of enforcement and oversight, a “patchwork” of state policies has emerged, with considerable variation in how states address language barriers in the health setting. In the literature, efforts have been made to describe and catalogue the broad array of state policies—as well as to highlight specific state models, such as California or Washington (18-23). However, little empirical research exists as to whether these policies are actually effective. Past studies examining the effectiveness of language service interventions have been largely based in a single setting (such as a hospital or clinic) and do not account for state variation.

#### **Specific Aims**

The proposed dissertation study evaluates the effectiveness of state language policies in addressing disparities in access to health services between immigrant and US-born populations.

The specific aims of the study are to:

- Examine changes in demographic characteristics for states with varying language policies;
- Determine whether the disparities in access to health services between immigrant and US-born populations vary from state to state
- Test whether the disparities in access to health services between immigrant and US-born populations vary between states with and without specific language policies.

Three types of state language policies will be assessed, including: policy allocating funding or reimbursement for language services, policies dealing with health interpreter competency, and

mandates for hospitals and other health care provider organizations (such as managed care plans).

## Methodology

This study draws on a secondary data source, the National Survey of America's Families (NSAF)—a large representative survey of households conducted by the Urban Institute. Unlike other national health surveys (e.g. National Health Interview Survey), the NSAF is designed to provide state-specific estimates and allows for comparisons between a cross-section of thirteen states (see table below). Of these, eleven states have sufficient immigrant samples (defined as 100 or more). The final sample consists of 36,149 adults aged 18 and over, with 15% of the sample being foreign-born or immigrants (n = 5,459).

**TABLE: Study Sample Linked with State Policies and Demographic Characteristics**

NSAF States	Sample		State Policies				State Demographics	
	Total	FB	Funding	Interpreter competency	Hospital mandates	HMO mandates	% FB <sup>a</sup>	% LEP <sup>a,b</sup>
Alabama	2,484	73	--	--	--	--	--	--
California	3,574	1,195	No	No	Yes	Yes	26.9%	21.4%
Colorado	3,345	377	No	No	No	Yes	9.8%	7.5%
Florida	2,454	510	No	No	No	No	17.9%	11.5%
Massachusetts	3,026	502	No	Yes	Yes	Yes	13.1%	8.9%
Michigan	3,895	221	No	No	No	No	5.5%	3.3%
Minnesota	4,459	246	Yes	No	No	Yes	6.4%	4.2%
Mississippi	2,226	35	--	--	--	--	--	--
New Jersey	3,353	782	No	Yes	Yes	Yes	18.9%	13.2%
New York	2,621	588	No	No	Yes	Yes	20.9%	14.2%
Texas	2,568	556	No	No	No	No	15.2%	14.7%
Washington	3,027	322	Yes	Yes	No	Yes	10.7%	6.9%
Wisconsin	3,837	160	No	No	No	Yes	4.0%	3.0%
Initial sample	40,869	5,567	--	--	--	--	--	--
Analysis sample (not including AL or MS)	36,159	5,459	--	--	--	--	--	--

SOURCE: 2002 National Survey of America's Families (NSAF).

NOTES. FB = foreign-born; LEP = limited English proficient; HMO = health maintenance organization; "--" = not applicable. Shaded cells indicated states with samples of foreign-born persons greater than 100.

<sup>a</sup> Estimates based on 2002 American Community Survey.

<sup>b</sup> Population aged 18 and over.

The individual-level data will be linked to state policy information and demographics (based on the 2002 American Community Survey); these are also summarized in the table above. Outcome measures for access to health services include: whether or not a person has a usual source of care; the self-reported number of physician visits in the past year; and overall satisfaction with one's health care. A broad range of individual- and state-level characteristics known to affect access to services will also be included as control variables. Individual-level variables include: age, race/ethnicity, educational attainment, citizenship status, family income, employment status, marital status, household size, health insurance coverage, and self-reported health status. State-level variables include the proportions of foreign-born and LEP persons.

The preliminary analysis will involve both descriptive and bivariate statistics. To account for the hierarchical nature of the data (i.e. individual nested in states), multilevel modeling techniques will be used to test differences in immigrant access to health services in states with the specific language policies versus states without such policies (24, 25). Each state language policy will be tested separately and then altogether in the same model in order to determine their relative importance.

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