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

Personal Statement

This proposed dissertation study evaluates the effectiveness of state language policies in addressing disparities in access to health services between immigrant and US-born populations and reflects a culmination of both my professional and academic experience over the past decade. Professionally, I worked for seven years with a civil rights organization where I conducted policy advocacy and analysis around issues of immigration, welfare reform, language rights, and health care access—at both the legislative and implementation stages of the policymaking process. While I worked on policies at all levels of government, much of my work involved legislative and administrative advocacy around state policies and regulations. My research interests in immigrant populations and their access to services are mere extensions of this prior professional experience and have been the focus of my education and scholarship as a doctoral student.

To my knowledge, no study has empirically tested the effectiveness of state language policies in improving access to health services among immigrant populations. This is particularly an important question since federal civil rights law mandates state governments and agencies to ensure that their health systems are accessible to their limited English Proficient (LEP) residents. However, states are confronted with tremendous challenges in the face of rapidly changing demographics—largely due to immigration. Based on 2007 American Community Survey estimates, about 12.5% of the nation's population (or 38 million persons) are foreign-born. Moreover, the issue of immigration is no longer an isolated issue for just a handful of states. In the past decade, immigrant flows have begun to shift away from more traditional settlement states (e.g. California and New York) to so-called "new growth" states (e.g. Georgia, Arkansas, and Nevada).

For any state, the linguistic diversity resulting from increased immigration is a significant challenge. With over half of immigrant adults being LEP, many are likely to encounter language barriers when trying to navigate the health system. The importance of language assistance services, e.g. bilingual providers or interpreters, is well-documented in the literature. Due to the lack of enforcement and oversight, there is considerable state variation in the policies dealing with language barriers in the health system. Little empirical research exists as to whether any of these policies are actually effective in improving access. To date, studies have been largely based in a single setting, such as a hospital or clinic, and do not account for variations in state policies. Therefore, this proposed study could improve our understanding of the role that states can have in addressing immigrant disparities in health access.

State population estimates, based on the 2002 National Survey of America's Families, provide a cursory glimpse into the state variation in immigrant access to health care and the possible link between language policies and access. For example, immigrants residing in Minnesota and Washington, which have implemented policy mechanisms to fund language assistance services, tend to fare better than immigrants from states with no such policies. As shown in the table below, 17% of immigrants in the states with policies lack a usual source of care, compared to over a third of immigrants in the states with no policies. Immigrants also have a higher average number of doctor visits in states with policies than in states with no policies (1.95 versus 1.14, respectively). Finally, a lower level of dissatisfaction in one's health care is

observed among the immigrant populations in states with these policies. The disparities between the immigrant and US-born populations also seem to be smaller in the states with policies versus the states without policies. Most notably, in the states without policies, the proportion of immigrants who lack a usual source of care is 20 percentage points higher than the proportion of US-born persons. The difference is only 3 percentage points in the states with policies. Finally, in the states with policies, there is virtually no difference between immigrants and US-born persons in the proportion of those who were dissatisfied with their health care.

TABLE: State Policies to Fund Language Assistance Services and Immigrant Health Access

	US-born	Foreign-born	Difference
Percent lacking a usual source of care			
States with policies	13.5	16.5	3.0
States with no policies	16.6	36.6	20.0
Number of doctor visits (mean)			
States with policies	3.15	1.95	-1.20
State with no policies	2.65	1.14	-1.51
Percent dissatisfied with their health care			
States with policies	14.8	15.0	0.2
States with no policies	17.2	18.7	1.6

SOURCE: 2002 National Survey of America's Families (weighted).
NOTES: Based on sample of adults aged 18 and over. Refers to state policies that draw matching federal funds (through Medicaid or the State Children's Health Insurance Program) to reimburse for language assistance services. As of 2002, MN and WA were the only states with such policies. Non-policy states include CA, CO, FL, MA, MI, NJ, NW, TX, and WI.

My long-term goal is to engage in a career trajectory that deepens my involvement in policy-relevant research. I see my dissertation as a critical first step. Building on the lessons learned, I intend to seek additional resources to expand the study to include all fifty states and to also examine the effectiveness of other types of language policies. Eventually, I also hope to specifically look at the Hispanic and Asian American populations, which represent the fastest growing racial groups and whose growth is largely fueled by immigration. Finally, in order to examine the actual implementation of these policies, I also intend to seek additional funding to examine variations in access across counties (e.g. using data from the California Health Interview Survey) and to conduct interviews or focus groups with hospital administrators and other staff to explore the importance of specific state language policies at the institutional level. I hope that this research will help to inform organizations and policymakers regarding the effectiveness of language policies in addressing disparities in health access and how states can better address the linguistic needs of their growing immigrant populations.

My policy advocacy experience continues to inform and frame the way I perceive and do research. Therefore, I understand the gap that may exist between research and policy development. In order to ensure the policy relevance of my research, I hope to also collaborate throughout my career with stakeholder organizations directly involved in the policymaking process. Initially, I plan to discuss potential outreach strategies with former colleagues from some of the key health advocacy organizations, such as the California Endowment, National Health Law Program, Asian and Pacific Islander American Health Forum, National Immigration Law Center, Asian American Justice Center, and California Pan-Ethnic Health Network. Finally, in addition to the traditional academic routes, I intend to seek other ways to disseminate my research to policy makers and advocacy organizations. This could include translating my research into policy briefs, presenting at more policy-oriented conferences or meetings, and publishing in journals or periodicals that may reach a broader policy audience.