



# In the Literature

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October's issue of the *American Journal of Public Health* focused on eliminating racial and ethnic disparities in access to and quality of care. Contributors addressed such topics as the Veterans Health Administration's efforts to promote health equity; HIV infection, cancer, and diabetes among minority patients; and collection of data on race and ethnicity. One Fund-supported article included in this issue addressed health insurance among recent immigrants, and another examined how patient-physician relationships affect the quality of care for different racial and ethnic groups.

### Access: Immigration and Insurance

Lack of health insurance is a major problem among immigrant populations. A new study finds that, while the federal restrictions placed on coverage of immigrants in 1996 have not greatly worsened the crisis, they have shifted the costs of covering recent immigrants from the federal government to cash-strapped states. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), also known as the Welfare Reform Act, prevents states from using federal funds to cover immigrants who have resided in the United States for less than five years in Medicaid or the State Children's Health Insurance Program (CHIP). Some states choose to use "state-only" money to cover recently arrived immigrants, while others do not.

["Eligibility for Government Insurance if Immigrant Provisions of Welfare Reform Are Repealed,"](#) by Olveen Carrasquillo of Columbia University's College of Physicians and Surgeons and colleagues, estimates that between 100,000 to 140,000 children were barred from Medicaid or CHIP coverage because of the

1996 legislation. If CHIP were expanded to include parents and the immigrant restrictions were repealed, the researchers estimate that about 250,000 recently arrived uninsured adults would become eligible for coverage. The analysis draws on data from the March 1999 and 2000 Current Population Surveys to model eligibility for immigrant children and their parents.

The researchers found that, among the 17.2 million immigrants who were not U.S. citizens, 42.8 percent were uninsured and 13.7 had public health insurance coverage. One of five (21.3%) of the nation's uninsured population were noncitizen immigrants, and the majority of these uninsured immigrants—64 percent—were Hispanic.

### Results

Half (50%) of the 4.9 million immigrants who had been living in this country for less than five years during the study period were uninsured. But even in states with large immigrant populations, recent immigrants represented only small proportions of the overall uninsured: 8.8 percent in California, 9.2 percent in New York, 5.9 percent in Texas, 8.7 percent in Florida, 7.0 percent in New Jersey, and 6.9 percent in Illinois.

The authors calculated that, among the newly arrived immigrants, there were 1.1 million children, including 460,000 without health insurance, of which 310,000 were legal immigrants. The majority of this group—230,000 children—would qualify for Medicaid or CHIP based on income, including 110,000 who lived in a state that already allowed them to qualify for coverage. The number living in a state that

barred these recent immigrant children from coverage ranged from 100,000 to 140,000, depending on the number of undocumented children factored in to the study models.

Out of the 3.8 million noncitizen adults who had been in the United States for less than five years, 2 million lacked health insurance coverage. Of this 2 million, 1.4 million were in the country legally, and 330,000 had children. Among this group of parents, 50,000 qualified for Medicaid based on their incomes but lived in states barring recent immigrants from public coverage; 90,000 had children eligible for Medicaid or CHIP and lived in states that used their own funds to cover recent immigrants; and 100,000 would qualify for coverage only if immigration restrictions were repealed along with a CHIP expansion to parents. Together, 250,000 immigrant parents would benefit from a policy that expands CHIP coverage to parents and repeals restrictions on recent immigrants.

#### *Policy Implications*

The authors conclude that these findings support legislative initiatives to repeal PRWORA provisions preventing federal funding of insurance programs for recently arrived immigrant populations. The analysis was based on policies in place in 1998 and 1999. Current budget shortfalls may make it more difficult for states to bear the full burden of public health insurance for recent immigrants.

#### **Quality: Patient–Physician Relationships**

The root causes of disparities in the quality of care between minority Americans—including blacks, Hispanics, Asians, and Native Americans—and whites are not well understood, but a new study finds that patient–physician interactions contribute to the problem. Rather than viewing cultural competency training as a mastery of “facts” about different groups, the findings suggest that—in order to improve the quality of care across racial and ethnic lines—physicians should use a patient-centered approach based on fundamental skills, such as listening and treating patients with respect.

[“Patient–Physician Relationships and Racial Disparities in the Quality of Health Care,”](#) by Somnath Saha of the Portland Veterans Affairs Medical Center and Oregon Health and Science University and colleagues, examines the roles played by patient–physician interactions, physi-

cians’ cultural sensitivity, and patient–physician racial concordance in patients’ perspectives of quality of care. The researchers used data from the Commonwealth Fund 2001 Health Care Quality Survey, for which phone interviews were conducted in six different languages with 1,037 black, 1,153 Hispanic, 621 Asian, and 3,488 white respondents.

#### *Patient–Physician Care*

The survey revealed that the quality of patient–physician interactions was generally lower among minorities, particularly Hispanics and Asians. Specifically, physician behaviors such as spending adequate time with patients and showing them respect were reported less often by ethnic minorities than by white respondents. Of note, the reported differences in the quality of patient–physician interactions between Asians and whites were greater, on average, than reported differences between the insured and the uninsured. Race discordance between patients and physicians did not seem to explain such differences. Instead, contributing factors included physicians’ cultural sensitivity and patients’ health literacy.

#### *Satisfaction with Care*

Non-white respondents expressed lower levels of satisfaction with their care than did whites. However, adjustment for demographic factors and patient–physician interactions improved patient satisfaction across different racial and ethnic groups.

#### *Use of Services*

Racial differences in the use of health services varied by type of service. In general, blacks received more appropriate services. Among patients with hypertension and heart disease, Hispanics received fewer services than whites, while among patients with diabetes, Asians received fewer services than whites. Accounting for differences in patient–physician interactions, physician cultural sensitivity, and patient–physician race concordance did not explain racial and ethnic disparities in use of health services.

#### *Policy Implications*

The authors conclude that efforts to improve cross-cultural patient–physician interactions should be aimed at increasing patients’ health literacy as well as improving physicians’ cultural sensitivity and interpersonal skills.