

## Strangers in a Strange Land: Health Care Experiences for Recent Latino Immigrants in Midwest Communities

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**Abstract:** Latino immigrants in recent years are moving to U.S. communities that have little experience with immigration from Latin America. Although public health initiatives have been created to expand health care services to uninsured adults and children, little is known about whether and to what extent new immigrants benefit from such resources.

**Methods.** We conducted 50 in-depth, semi-structured interviews with recent Latino immigrants residing in the Ann Arbor/Ypsilanti area of southeast Michigan to explore (a) these immigrants' perceptions of access to public health resources; (b) their assessments of their own health status, social and health needs, and patterns of use of health care services; (c) barriers to health care utilization; (d) strategies they have adopted to approach these barriers; and (e) how best to address the needs of growing immigrant communities. **Results.** Latino immigrants often are not using and are unaware of local public health programs and other health resources. The principal barriers to care noted included lack of insurance, language barriers, and isolation in new communities. Many strategies, both effective and ineffective, have been adopted to overcome these barriers. **Conclusion.** With the dynamic flux of new immigrants into many communities, outreach efforts must be continuously renewed and re-oriented to reach new arrivals.

**Key words:** Health care accessibility, Hispanic Americans, emigration, immigration, vulnerable populations, health services, community-institutional relations, qualitative research, interviews, adults.

Latinos are now the largest minority group in the United States, constituting more than 14% of the U.S. population.<sup>1</sup> As this population has grown, health disparities between Latinos/Hispanics and non-Hispanic Whites in the U.S. have been well documented.<sup>2-8</sup> Limited access to health care for immigrants has exacerbated these health

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disparities.<sup>9-10</sup> Barriers to health care have been shown to differ among subgroups of the Latino population.<sup>11,12</sup>

Mortality and prevalence of chronic illness varies among Latinos from different countries of origin.<sup>13-16</sup> Barriers to health also differ among different subgroups of the Latino population.<sup>11</sup> Language fluency, immigration status, and degree of acculturation all influence health behaviors.<sup>17</sup> Recent Latino immigrants are less likely than their more acculturated peers to use preventive services,<sup>18,19</sup> and also have a worse self-perception of health.<sup>20,21</sup>

Currently, approximately 45% of the Latino population living in the United States is foreign-born.<sup>22</sup> Communities that historically have not been significant destinations for Latino immigrants, such as many Midwest communities, have become such destinations.<sup>23</sup> Whereas the total U.S. Hispanic population increased by 58% between 1990 and 2000, the greatest growth (81%) occurred in the five Midwestern states of Illinois, Indiana, Michigan, Ohio, and Wisconsin.<sup>24</sup> This growth has been associated with the expansion of low-wage jobs, primarily in non-metropolitan areas.<sup>25</sup> Studies in urban communities have noted barriers to health care such as lack of health insurance, language barriers, and immigration status.<sup>26-29</sup> Public health initiatives have been set up to address such barriers in many communities. However, we know little about the health status, perceived health needs, and barriers to health care of this most recent wave of Latino immigrants in Midwest suburban and rural areas.

In our community in southeast Michigan, a county health plan specifically targets uninsured residents of Washtenaw County who have incomes at or below 200% of the federal poverty level (FPL), but are not eligible for Medicaid or Medicare. Medicaid eligibility levels are particularly low in Michigan (working parents are only eligible if they earn less than 61% of the federal poverty level; childless adults are eligible only if they earn less than 35% of federal poverty level).

To apply to this plan, one must show proof of residence in Washtenaw County (e.g., a copy of an electric bill or an ID card) and proof of income (a pay stub or a letter from an employer stating weekly or monthly salary) and have no access to affordable health insurance. This basic health plan covers the costs of primary health care: x-rays, laboratory tests, and other diagnostic tests and procedures; inpatient hospital services and/or emergency services; and some pre-approved specialty services. In addition, a supplementary prescription drug plan provides basic medications for a minimal co-payment. No evidence of immigration status is necessary to be eligible for this program. Participants are encouraged to apply for Emergency Only Medicaid and Medicaid Spend Down, if eligible, to help defray the county's costs.

We conducted in-depth, face-to-face, semi-structured interviews with Latino immigrants residing in the Ann Arbor/Ypsilanti, Michigan area to explore (a) this population's perception of its access to public health resources; (b) their assessment of their health status, social and health needs, and patterns of use of health care services; (c) barriers to health care utilization; (d) strategies they have adopted to approach these barriers; and (e) their understanding of how best to address the needs of new waves of immigrant communities.

## Methods

**Study setting.** Washtenaw County is located in southeast Michigan, covering an area of 720 square miles. Its 27 cities, villages, and townships are home to about 325,000 citizens in suburban and rural settings. The 2 largest cities are Ann Arbor and Ypsilanti, located 40 miles west of Detroit. In the last 5 years, Washtenaw County has experienced a rapid influx of Latino immigrants. We conducted face-to-face, semi-structured interviews lasting 30–90 minutes with Latino adults residing in the Ypsilanti/Ann Arbor area, in the participant's preferred language (English or Spanish).

**Sample.** In order to reach a broad community-based sample with a variety of health needs and different levels of access to health services, we recruited participants from diverse community settings frequented or inhabited by Latino populations. Points of entry into the community included produce markets, churches, apartment complexes, trailer parks, a community festival for the local Latino population, restaurants, and English-as-second-language classes. At each of these locations, participation was solicited face-to-face to generate a list of willing participants. People on the list of 86 names and phone numbers gathered were invited by telephone to schedule interviews. Six percent (5 individuals) of the 86 had numbers that were disconnected. Three individuals declined to participate. The research team reached the remaining 78, either directly by phone or by leaving a message on an answering machine. Interviews were conducted based on the first 50 individuals who were available to schedule an interview. Interviews took place at the respondents' residence and lasted between 30–90 minutes.

Inclusion criteria included being a Latino immigrant (someone born in Central or South America, or Mexico, Puerto Rico, the Dominican Republic, Spain, or Cuba), aged 18 to 64 years.

**Study instrument, data collection and analysis.** The semi-structured interview guide consisted of a combination of closed-ended and open-ended items, compiled by the investigators based on their health services research expertise, their clinical experiences with the Latino community, their familiarity with likely community barriers to access, and their knowledge about community programs. The interview guide was reviewed and refined by the three investigators in an iterative process, in order to achieve phrasing of nonjudgmental, non-leading questions. The instrument included items to permit collection of basic demographic data, and focused chiefly on participants' perception of health care needs, utilization of health services, interactions with health care providers, and current barriers to access to care.

A total of 50 interviews were conducted, 48 in Spanish. Participants had considerable latitude to comment on points or topics they considered relevant. If a respondent had children, the interview was longer, to explore perceived pediatric health care needs and barriers. The investigators audio-recorded and then transcribed the interviews, with the permission of the participants.

Data collection and analysis occurred in tandem throughout the data collection period. We analyzed the interviews thematically, following the *Editing Analysis Style*, which contains both deductive and inductive elements.<sup>30</sup> Deductive codes were derived from analysis frameworks based on our literature review on health care obstacles faced

by prior waves of Latino immigrants.<sup>31-35</sup> Inductive codes were derived from the interviews to create new categories and refine framework categories.

The principal investigator (NH) coded all transcripts, with a second coder coding a subset to verify code reliability. Coded transcripts allowed cross-case comparison and analysis of patterns and themes. We increased the credibility of this analysis through rigorous and systematic data collection and analysis, the use of multiple readers (including the other authors) and coders, and by documenting the reasons for analytic decisions.<sup>36</sup> All authors were involved in refining the thematic analysis.

The Institutional Review Board of the University of Michigan approved the study. We obtained written informed consent from all study participants.

## Results

Demographic characteristics of the participants appear in Table 1. The majority of participants (78%) were under 40 years old, 88% were recent immigrants (living in the United States for less than 6 years), and 72% came to Michigan directly from their countries of origin.

**Table 1.**  
**DEMOGRAPHICS OF PARTICIPANTS**

Characteristics	Number of subjects	Percent
Gender		
Female	32	64%
Male	18	36%
Age		
18-29	25	50%
30-39	14	28%
40 and older	11	22%
Country of origin		
Mexico	22	44%
Honduras	11	22%
Guatemala	7	14%
Costa Rica	4	8%
Nicaragua	2	4%
Other Latin America	4	8%
Number of years in United States		
<2 years	20	40%
3-6 years	24	48%
>7 years	6	12%

(Continued on p. 1354)

**Table 1. (continued)**

Characteristics	Number of subjects	Percent
Family income per year		
<\$20,000	35	70%
\$20,000-\$30,000	9	18%
>\$30,000	6	12%
Occupation		
Housekeeping (hotel, offices, personal homes)	22	44%
Restaurant service	14	28%
Landscaping/construction	3	6%
Nanny	2	4%
Driver/chauffer	1	2%
Self-employed (owns restaurant)	1	2%
Student	1	2%
Not in paid work force	6	12%
Self-rated health status		
Excellent/Very Good	8	16%
Good	26	52%
Fair/Poor	16	32%
Postponed care in last 12 months		
Yes	24	48%
No	26	52%
Seen health professional in last 12 months		
Yes	29	58%
No	21	42%
Has a regular clinic for care		
Yes	15	30%
No	35	70%
Insurance coverage		
None	36	72%
County Health Plan <sup>a</sup>	8	16%
Emergency Medicaid	4	8%
Private Insurance	2	4%

<sup>a</sup>One respondent had both county health plan and emergency Medicaid.

**Health status and access to health care.** The self-rated health status of our sample was significantly below national averages for Latino adults. Nearly a third (32%) of respondents rated their health status as fair/poor, compared with only 13.8% of Latinos in a recent national sample.<sup>37</sup> This lower self-perception of health may reflect our study

population's status as recent immigrants. More acculturated Latinos have a better self-perception of health than do the less acculturated.<sup>38</sup>

Most of the respondents (74%) were uninsured. Only 28% had a regular source of care, and 48% had postponed care for a specific medical condition or ailment within the previous 12 months. For a variety of reasons (e.g., frequent turnaround of providers at free clinics, miscommunication due to language, postponing care), less than 30% of the respondents believed they were receiving necessary medical attention.

### **Principal Barriers to Health Care Access Among New Immigrants**

The barriers to care noted most frequently included lack of insurance, language barriers, and isolation in new communities. More specific sub-themes emerged in each area, and are discussed below.

#### ***Lack of Insurance***

**Fear of costs and unfamiliarity with local coverage.** The majority of respondents (50%) cited lack of insurance as their primary barrier to care. Fear of the costs of health care predominated (Box 1). Although the majority of respondents (94%) qualified on the basis of their income for the free local county health plan, many were unaware of the program. Forty-five percent of respondents claimed that they had heard of the county health plan, specifically that they had heard the name of the program. When probed further, most (92%) answered that they were not aware of what the plan offered, of the eligibility criteria for the program, or that they were eligible.

Of the few respondents (eight) who were enrolled in the plan, only half understood that it provided primary health care services and knew how to use it. One respondent, who had been enrolled in the county plan during a hospitalization six months previously, still had a bag at home full of unfilled prescriptions, discharge paperwork, an unused glucometer, and diabetes education material. She was unaware of how to get services, how to use the plan, and how to fill the prescriptions. Six of the eight respondents who were enrolled in the county health plan had been enrolled by social workers as a result of an inpatient hospitalization or an emergency room visit.

**Feelings of inferiority within health care system.** Lack of health insurance led to hesitation in seeking care not only because of fears of costs, but also because of beliefs that lack of health insurance would result in receiving inferior health care: "Ellos no lo atienden bien a uno si uno no tiene seguro./They don't treat you properly when you don't have insurance" (Respondent 28). Some respondents believed that certain medical services were not rendered to those who were uninsured and that they "me despachaban rapido, despues de poco [cuando no tenía seguro]/try to quickly get rid of you [if you do not have insurance]" (Respondent 14). Several respondents believed that those with insurance received preferential treatment. For example, they believed that the uninsured were kept waiting longer and given the hallway cots (rather than rooms) in the emergency room. One respondent believed that only those with insurance had the right to ask for an interpreter.

**Box 1.****RESPONDENT ATTITUDES TOWARDS  
PRINCIPAL BARRIERS TO CARE****Lack of health insurance***Leads to fear of cost/bill*

- There were multiple times that I wanted to go to a doctor here, but didn't. My back causes me many problems. I never go to the doctor in the U.S. It's too expensive." (Respondent 1)
- "I think [my husband] has a hernia. Yes, he can go to a free clinic. But, what if he needs surgery? It is too expensive. Hernias can strangulate and it is scary. It's different when one has insurance." (Respondent 19)
- "When things are simple, I can get care . . . but, when things are serious, I am not able to get what I need. It is too expensive and I have no insurance." (Respondent 2)

*Leads to feeling of inferiority within health care system*

- "It's known that when you go to the hospital, the nurses know if you have insurance or not. I think that they know if somebody is not paying and they treat them with much indifference. The last time that I went to the ER, I told them that I had insurance (Emergency Medicaid) and they treated me completely different." (Respondent 14)
- "They don't treat you properly when you don't have insurance; they give you prescriptions and send you back home." (Respondent 28)
- "The [ER] receptionist seemed bothered by our inquiring how much longer we needed to wait . . . I think they left us waiting there [in the hall] because we don't have insurance . . . The others, with insurance, were seen more promptly. They made me feel really bad, like trash, waiting in the hall. I never went back." (Respondent 19)
- "They wanted me to get a colonoscopy, but they didn't do it because I don't have insurance." (Respondent 19)

*Leads to feeling unwelcome*

- "They have poor service. Mean. We didn't have insurance at that time. Poorly respected . . . the staff was rude. They kept asking if we have insurance. It's difficult to make an appointment without insurance." (Respondent 5)
- "What's difficult is not having insurance . . . Without insurance, you cannot make an appointment. And, it doesn't matter if you're sick, The first thing they do when you arrive (and all you want is to be seen), is ask if you have insurance." (Respondent 11)
- "Three clinics said that they do not accept new patients once they understood that I didn't have insurance." (Respondent 47)

*(Continued on p. 1357)*

## Box 1. (continued)

### Language barrier

#### *Leads to delay in seeking health care*

- “He was scared to go to the ER alone because he could not communicate. He finally found me via another friend. I know a little English. By that time, his hand was swollen, infected, needed an operation. The doctor asked why he didn’t come sooner. He said that he didn’t have anybody to come with . . .” (Respondent 44)
- “I wanted to go to the doctor for my stomach pains, but I didn’t go. I was afraid, afraid because I don’t speak any English.” (Respondent 43)

#### *Leads to lack of confidence and confusion when care is sought*

- “We speak basic, limited English at work. But, when you go to the doctor, you barely understand their language. You are already dazed in the hospital or emergency room and sometimes you don’t understand what they are telling you. Really, it is necessary to have a person that can speak your language for you to understand clearly what they are asking you.” (Respondent 14)
- “It’s really difficult when you don’t know English that well to explain what you really feel and try to convey your emotions and feelings. It is possible that we confuse the situation more and are less understood.” (respondent 14)
- “Sometimes I feel like I’m receiving the care I need . . . and sometimes I’m not sure. Maybe it’s due to language because they may understand you or maybe they don’t understand you.” (Respondent 11)
- “At times, when I can’t speak the language, I can’t ask my questions.” (Respondent 3)
- “When I went for a mammogram, I didn’t bring anybody with me to translate. They told me it wasn’t necessary to have a translator. But I felt very bad because I couldn’t understand. Very uncomfortable.” (respondent 3)
- “Sometimes I say, ‘I’m sorry, I don’t understand.’ And they try to explain it again. But, it’s difficult. They want to help you, but they don’t know your language. If they can’t understand, they can’t help.” (Respondent 19)
- “The ambulance [staff] was very annoyed . . . and because they did not know that I understood a bit of English, they acted in a very rough and crude manner. They said that there was a ‘barrier in communication’ and that they could not attend to me. It was very frustrating to know how people react in a crisis . . . it’s almost best for my husband to take me rather than have a crisis in an ambulance where I cannot communicate” (Respondent 14).
- “I took my friend with me to translate. But, it’s difficult because he can’t explain exactly what I’m saying. He tries. The doctor doesn’t exactly understand . . . and each time there are things that one cannot say . . . My friend speaks quite a bit of English, but not perfect.” (Respondent 46)

(Continued on p. 1358)



**Box 1. (continued)***Unaware of interpreter services*

- “They do not request an interpreter because they do not know that this service exists, at no cost. One women that I helped asked me if she had to pay something and I said, ‘no, nothing’” (Respondent 27)
- “They don’t have interpreters here” (Respondent 18).
- “When I go to the University of Michigan, I bring my grandkids to translate. One can ask for an interpreter, but I can’t because I don’t have insurance.” (Respondent 19)

*Lack of training of interpreters leads to further insecurity within the community*

- “We waited 2–3 hours for an interpreter who in the end knew minimal Spanish and didn’t help.” (Respondent 2)
- “Sometimes they give you a translator doesn’t know how to ask questions well and has difficulty in translating and if you know a little English, it makes you nervous. The translator was asking my husband about my medical history, but he didn’t understand because he was using a very different language. . . . This also happened to my sister that the interpreter didn’t know how to respond. So now my sister does not have confidence in the interpreters at the hospital and when she has to go to the hospital we look for someone we know that can help us translate before going to the hospital.” (respondent 14)
- “They ask if I want an interpreter and that I can use one to communicate through him. But, I had a bad experience with an interpreter, and I prefer to speak directly to the doctor. My impression is that interpreter services is quite poor and I prefer to make do as best as I can on my own. The other way you end up more confused. You know that you don’t have the best means to communicate one-on-one.” (Respondent 14)
- “It’s not the same with an interpreter. The interpreter needs to be very professional because it is difficult to translate properly. He has be very proficient in order to help one . . . the best thing is if the doctor speaks Spanish.” (Respondent 19)
- “Well, later an interpreter came. But, he spoke minimal [Spanish]. The first time I went, the doctor spoke Spanish, the second time there was nobody. When the doctor spoke Spanish, I understood everything. The second time, I hardly understood what was going on.” (Respondent 46)

*(Continued on p. 1359)***Language Barriers**

Twenty percent of respondents reported that the language barrier was the main obstacle to care that they faced. The majority of respondents (86%) were unaware of interpreter services; 82% of respondents stated that they had difficulty communicating with the doctor during their last medical visit. Several respondents (8%) reported traveling

## Box 1. (continued)

### Isolation

#### *From others in community*

- “My sister and I are here in the house. I work at home. We don’t visit many people and also many people do not visit us.” (Respondent 10)
- “We have no friends here and we don’t visit anyone. I think many are like this. Everyone in his/her separate house. It’s strange, no?” (Respondent 28)
- “When you have a baby, they explain things to you like feeding and basic things, but they should include more general instructions such as recognizing symptoms when babies don’t feel well. In our countries we have relatives and friends, but here it’s different. They do not instruct you on basic things. How do you learn?” (Respondent 14)
- “There are no places where to go, no one to ask. There’s no information.” (Respondent 8)
- “I only have my sister and husband here. Nobody really visits us.” (Respondent 50)

#### *Unaware of services available*

- “The reality is that one is ignorant of the system. If I advise them (about the county health plan), they are not going to believe me, because I am not a doctor, just a common person.” (Respondent 27)
- “Where do I receive information on health? “De dios” (from G-d), I don’t know where to go.” (Respondent 11)
- “From the point of view of the patient, it seems to me that people are not informed. They are waiting for somebody to help them. I have mentioned to my friends that they have to fill out the applications and that it is not very difficult.” (Respondent 27)
- “I need to know where to go. We don’t have any information.” (respondent 24)
- “In the beginning, it’s difficult to learn the system. They recommended that I go speak to the [finance department] to get insurance and other medical services. I went from one place to the next. I had to continue searching out services.” (Respondent 14)
- “In California, I went to a ‘government clinic for women’ for my annual check-up. Here, I don’t know where to go, where to access services.” (Respondent 41)
- “I had heard of the [free] clinic and when to look for it, but couldn’t find it. So, in the end, I never went.” (Respondent 42)
- “One does not know where to go exactly. It would be best to post specific addresses and maps. With an address, map then you can go and try to obtain what you need.” (Respondent 11)

approximately 35 miles to the Detroit area to seek care at clinics with Spanish-speaking personnel.

**Need to bring somebody to interpret contributing to delays in seeking health care.** Many respondents (56%) noted that they did not feel comfortable going to the doctor without finding somebody to help them communicate. As a result, respondents noted postponing care for days while they found somebody with necessary English skills who was willing to accompany them to the doctor (Box 1).

**Lack of confidence and confusion when care is sought.** With *ad hoc* or lack of interpreters, some respondents (22%) left appointments confused about the exact diagnosis or treatment or with other questions unanswered. Some respondents perceived that not being able to speak directly to the doctor in his or her own language impaired the doctor-patient relationship.

**Impediments to social services.** Lack of bilingual staff at government and non-profit social service agencies makes it more difficult for immigrants to get services. “Mucho gente no va a FIA porque no hay información en español. Es mejor me voy y busco un trabajadora social./Many people do not go to the Family Independence Agency because they do not have information in Spanish. It’s better to go look for a social worker” (Respondent 27). In Michigan, bilingual personnel answer Medicaid phone lines only during certain hours. Several respondents reported having difficulty renewing children’s health benefits due to such barriers in communication.

### **Social Isolation**

Many respondents (48%) reported a feeling of isolation and lack of strong social or information networks. Most of these respondents did not know where to access information, something that may differ in urban areas where the immigrant community is more well-established.<sup>39,40</sup> Ten percent of respondents stated that not knowing where to go was their primary barrier to care. When asked, “Where do you get general health information?” 58% of participants responded, “Ningun lado/ Nowhere.” As one respondent described, “No hay lugares donde ir, nadie para preguntar. No hay información./There are no places where to go, no one to ask. There’s no information” (Respondent 8). Respondents who were involved in church activities felt less isolated, but many still noted not knowing where to turn for health information.

## **Respondents’ Strategies to Overcome Barriers**

### **Effective Strategies**

**Use of informed community members (social workers, neighbors, friends at work).** Despite the isolation that many recent immigrants feel, some respondents had managed effectively to use informants to help access services. Social workers were particularly helpful for enrollment in the county health plan, which provides preventive, primary care. Respondents viewed social workers as their advocates. Most initial contact with social workers was made in health care settings (e.g., hospital, emergency room). Thereafter, social workers made themselves available to help make appointments in order to overcome linguistic barriers and to tell people in need of care where to go.

Other respondents used English-speaking friends and neighbors to help navigate the

system and fill out forms. Such outside assistance was valuable, almost vital, for several respondents. As one said, "Si uno no tiene alguien te ayudo, no se puede conseguir servicios./If you don't have somebody to help you, you won't be able to get services [referring to the county health plan]" (Respondent 35).

**Actively requesting interpreter services.** Some respondents (14%) had used interpreter services before and knew specifically to request them. Their experiences varied based on the level of training and testing of the interpreters. Those who were satisfied sought interpreter services again. On the other hand, negative experiences with poor interpreters led to distrust and hesitation to use an interpreter in the future: "Esperamos por 2-3 horas para un traductor y por fin él no sabía mucho español y no ayudó./We waited 2-3 hours for an interpreter who in the end knew minimal Spanish and didn't help" (Respondent 2).

Only a small minority of respondents (8%) were satisfied with interpreter services. These respondents were able to use interpreter services effectively to help schedule appointments and also to request interpreters for future doctors' visits. Particular respondents learned to leave a message on a specific Spanish line and to be available for a return call to help make appointments.

**Flexible payment arrangements.** The majority of respondents (94%) found the sliding-fee scale available at several local nurse-managed primary health care centers and Planned Parenthood appealing. Reasonable fees made them more willing to seek services: "Necesito saber a donde ir y saber cuanto cuesta./I need to know where to go, but also how much it would cost to go" (Respondent 42). In addition, a few respondents were aware of payment options available at larger institutions, though these payment arrangements are only available upon request. As one respondent recalled, "Le llamé y le dije que no podía pagar de golpe y me dijo que puedo pagar cada mes lo que pueda 5 o 10 dolares./I called them and said that I cannot pay it all in one payment. They told me that I can pay monthly what I can, \$5 or \$10" (Respondent 27).

**Enrolling in local clinics and health plans.** All of the women interviewed were aware of Medicaid benefits for pregnancy. In addition, all but two respondents with children were aware of Women, Infants, and Children (WIC) assistance programs. Over half (54%) of the women interviewed were aware of family planning services at Planned Parenthood.

### *Other Strategies*

**Self-medicating.** Some respondents indicated that they contact relatives in their home countries regularly to request remedies for various maladies via the mail. Relatives abroad send oral medications, injections, and home remedies: "Mi prima inyecta a las demás personas Latinas. Consigue sus jeringas y antibiótico de todo de su país./My cousin does injections for many of the Latinos here. We obtain syringes and antibiotics and everything from our country" (Respondent 10).

**Using friends and family as interpreters.** Due to lack of awareness of interpreter services, many respondents continue to use relatives and friends to help translate. "Mira, que a mi es difícil ir al doctor porque aquí pues uno tiene que buscar quien le traduzca y esto es bien difícil . . . y si uno encuentra alguien, uno tiene que darle algo a esta persona./Listen, here it's quite difficult to go to the doctor. One has to look for

somebody to translate, and it's quite difficult . . . and if you find somebody, you have to compensate them somehow" (Respondent 36). Respondents recognized that using *ad hoc* interpreters was not ideal. "Muchas personas que visitan llevan a una persona que es traduzca. Pero es dificil cuando muchachas tienen enfermedades que no quieren que otra persona sepa./Most people bring somebody to translate with them. But, it's difficult when women have illnesses that they don't want another to know" (Respondent 11).

In addition, poor training of interpreters leads people to bring their own translator along. "A veces te dan un traductor que no sabe preguntar bien o tiene dificultad en traducir y como uno esta escuchando, se da cuenta . . . ahora mi hermana no se confia de traductor del hospital y cuando tiene que ir al hospital buscamos algun conocido que nos ayude con la traduccion antes de ir al hospital./Sometimes they give you a translator that doesn't know how to ask questions well . . . it makes you nervous . . . Now my sister does not have confidence in the interpreters at the hospital and when she has to go to the hospital we look for someone we know that can help us translate before going to the hospital" (Respondent 14).

**Getting primary care from home countries.** Due to lower costs and familiarity with home health systems, some respondents obtain primary care services during visits to their native countries. Women often noted this strategy when discussing women's preventive health services.

## Discussion

Midwestern U.S. communities with little history of Latino presence are now sites of substantial Latino immigration. Our findings suggest that, although communities may have attempted to respond to the health needs of new Latino immigrants with new programs, many Latinos are neither familiar with nor fully using these programs.

Recent Latino immigrants are more susceptible to barriers to access to care than more acculturated Latinos.<sup>41-44</sup> They are particularly vulnerable due to lack of networks in rural and suburban communities in addition to their lack of knowledge of available services.<sup>45,39</sup> Such isolation may affect the relatively good health and longer life span that has been observed among foreign-born Latinos in urban communities.<sup>46-48</sup> Recent work shows that the health advantage experienced by foreign-born Latinos may be attributable to enclave-like settings (neighborhoods with high percentages of foreign-born residents) and that such contexts may provide the cohesiveness critical for effective prevention.<sup>49</sup> As Latino immigrants choose to settle in more suburban and rural areas, the Latino health profile may need to be reexamined.

Latino immigrants have also been noted to have the highest rate of uninsurance of any major population group in the United States.<sup>50</sup> The majority of respondents in our study indicated that lack of insurance was their primary barrier to health care. Although local programs are available to provide basic health insurance to the participants, it appears they are failing to reach new immigrants. Some of our respondents were aware of national programs (e.g., WIC and Emergency Medicaid while pregnant), but the majority were unaware of local services. Innovative strategies to reach these new communities are necessary to educate recent immigrants about local services for which they are eligible.

Anxiety about costs was only one piece of how the lack of insurance led to delay in seeking care. Other themes that emerged included the belief that patients without insurance would receive substandard care. In addition, several respondents believed that only with insurance did one have the privilege to make appointments and to receive other interpreter services. These themes point to the need for outreach programs to address and counteract misconceptions.

In addition, many respondents indicated that language barriers increased their anxiety about seeking care. Respondents felt paralyzed and sought out *ad hoc* interpreters or community informants to help navigate the system. We found that most people in our sample were unaware of available interpreter services and that they had a right to request an interpreter. Among the few that had used interpreter services, their initial experiences influenced future use. This finding highlights the importance of training and testing interpreters prior to their employment.<sup>51-54</sup> Previous research shows that *ad hoc* interpretation (e.g., by health care workers, friends, relatives) can lead to adverse clinical consequences.<sup>56</sup> Finally, access to social services depends on bilingual staff availability, underscoring the importance of hiring bilingual staff at government social service agencies and clinics in communities with new immigrant populations.

On a positive note, social workers were clearly viewed as patient advocates. The majority of the respondents were familiar with the role of a social worker. Most (75%) who had enrolled in the county health plan had been assisted by a social worker. These positive attitudes towards community-based social workers seem well-established, suggesting the merit of including social workers as integral partners in future outreach efforts.

Facing multiple barriers to care, respondents have adopted a range of strategies to overcome them. Health professionals and public health initiatives must encourage positive strategies such as the use of interpreter services, use of informed community peers, and educating patients about flexible payment arrangements. Educating new immigrants about these services is vital to addressing their health care needs. Health care professionals must also be aware of alternative strategies that immigrants may be using, including using medications and injections sent from home countries. Adverse effects and medication interactions can result from unsupervised use. In addition, immigrants may be obtaining preventive, primary services from home countries and should be encouraged to bring medications and health records to health care encounters in the United States to limit fragmentation of care.

**Limitations.** We believe we reached thematic saturation in our interviews among this sample of 50 respondents. It is important to note that the study involved a convenience sample of recent Latino immigrants in suburban Michigan who may not be representative of other Latinos in the area or other Midwest communities. However, the principal aim of this qualitative study was to generate themes and to gain more in-depth insights into the experiences and perceptions of these recent Latino immigrants. These themes should be examined in larger, representative samples to determine how widely our findings apply. Moreover, while points of entry into the study varied and provided a cross-sectional sample with varied experiences and opinions, respondents who were likely to participate may have had a particular interest in health care. Immigrants who have not had significant health care needs may not have been as likely to participate

and, thus, their self-exclusion from the sample may bias findings. In addition, those immigrants who had less free time may have been less likely to participate.

**Conclusion.** With the constant influx of new immigrants into the United States, outreach efforts must be continuously renewed and oriented to reach new arrivals. Lack of data focusing specifically on recent Latino immigrants inhibits our collective ability to tailor programs and to recent, possibly isolated immigrant communities most in need of services. As new Latino immigrants continue to emigrate to new communities that historically have not seen significant influxes of Latinos, it is essential to coordinate public health efforts to help address these immigrants' local needs.

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