

AMERICAN ACADEMY OF PEDIATRICS

Committee on Community Health Services

Health Care for Children of Immigrant Families

ABSTRACT. The intent of this statement is to inform practitioners about the special health care needs and vulnerabilities of immigrant children and their families and to suggest clinical approaches to various aspects of their care. Immigrant children and their families, a large and diverse population group, have numerous risks to physical health and functioning and may be unfamiliar with our health care services. They often face many barriers to care, and their special risks and needs may not be familiar or readily apparent to many health care providers. Recently enacted federal welfare and immigration reform measures may increase the vulnerability of this population by limiting its access to health and social services. For multiple ethical and medical reasons, the American Academy of Pediatrics has historically opposed, and continues to oppose, denying needed services to any child residing within the borders of the United States.

The United States is in the midst of the largest wave of immigration it has ever experienced.^{1,2} One third of all growth in our population during the past decade was attributed to the growth of the immigrant population. The term "immigrant children" includes those who are legal and illegal (undocumented) immigrants, refugees, and international adoptees. This group represents a continually growing part of our childhood population, whose presence in the United States continues the profound tradition of multicultural growth that has been the cornerstone of strength through diversity in our society.

Every child within the geographic boundaries of the United States, regardless of that child's "status," should have full access to all social, educational, and health services that exist at the local, state, and federal levels for the care and benefit of children. In its advocacy role, the American Academy of Pediatrics and its member pediatricians must continue to advance the argument for maintaining access to all services for all children residing in the United States. Such advocacy is consistent with supporting efforts to rationalize and enforce immigration policies. Promoting and regulating legal immigration are essential matters of national policy, and securing our borders similarly represents an important national interest. The national interest also dictates that all children within the United States be well-educated and have their physical and psychosocial well-being

maintained. Allowing any group of children to be uneducated or unhealthy will have adverse consequences for all of us. Therefore, pediatricians should remain committed to the care of all children and their families who reside in our communities.

BACKGROUND

Virtually all new waves of immigrants have been met with ambivalence and concern about what effect the new immigrants might have on those who came before them.^{1,2} Arguments focus on whether immigrants contribute to the economy or create a drain on public and private resources. Concerns, although largely unsubstantiated, also include perceived threats to both the public health and public order from imported infectious diseases, increased crime, and diverse social mores. The current debates about the government's role and expenditures have raised the issue of eligibility of immigrants, both legal and illegal, for health, social, and educational services.^{1,3} Little attention has been directed toward the development of policies and practices that will affect the well-being and future contributions of immigrant children who are unable to choose where they live.⁴

Some have argued that immigrants should not be entitled to any publicly supported benefits. Others alternatively have argued that if such benefits are to be extended, then benefits should be a federal—rather than a state or local—responsibility.¹ In border states such as California, Texas, and Florida, which have experienced a large influx of immigrants, there have been calls for removing access and eligibility for illegal immigrants to publicly supported health, social, and educational services. Some individuals have gone further and advocated the same disenfranchisement of legal immigrants, making eligibility for public education, social services, and health services dependent upon both citizenship and residency and no longer residency alone. This is reflected in the Personal Responsibility and Work Opportunity Act of 1996 (96 Public Law 104-193). It bans most forms of public assistance and social services for legal immigrants who have not become citizens unless the states choose to continue those services. Two thirds of the projected \$60 billion in welfare-spending reductions between 1996 and 2002 will affect legal and illegal immigrants. Although access to some emergency health services for immigrants will be preserved under current federal law (Consolidated Omnibus Budget Reconciliation Act 86 Public Law 99-272), the web of conflicting legal requirements and professional ethics and motivations confronts pediatricians with important moral challenges.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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FACTS ABOUT RECENT IMMIGRANTS

Demographics

- During the past 10 years, approximately 9 million immigrants legally attained permanent residence in the United States and approximately 3 million entered illegally.² This combined wave of 12 million new arrivals in the past decade exceeds the largest previous wave of approximately 10 million immigrants, which occurred between 1905 and 1914.⁵
- Since the mid-1960s, immigration to the United States has been primarily from Latin America, Asia, and the Caribbean.^{1,2}
- “Linguistically isolated households,” those in which no one over the age of 14 years speaks English, were identified for the first time in the 1990 US Census. Of all US households, 4% are linguistically isolated; this figure includes 30% of Asian households, 23% of Hispanic households, and 28% of all immigrant households with school-age children.⁶ This factor has significant implications for pediatricians, teachers, and others who serve these families, including such difficulties as understanding and communicating basic concerns and instructions. Additional implications involve potential infringements on rights to privacy, confidentiality, and informed consent when translators must be used.^{7,8}
- Illegal immigrants, the majority of whom are from Mexico, are arriving in the United States at a rate of 300 000 to 500 000 per year.^{2,9}

OVERVIEW OF RISK FACTORS

- New immigrants may be without gainful employment and they may be unfamiliar with English. They may have health problems that are often undiagnosed, including tuberculosis, parasites, human immunodeficiency virus infection, and lack of immunizations. They also may have limited understanding of care-seeking behaviors and the US health care system.^{7,10,11}
- International adoptees arrive without adults who can provide information about their medical and social history. They often join families with whom they have no common language or physical similarities and might be adopted by parents who have no experience with child-rearing.¹²
- Many immigrant children have significant problems accessing health care services. Their utilization of medical services often is episodic and frequently occurs in settings such as emergency rooms. This factor limits the provision of comprehensive, longitudinal care. Issues of day-to-day survival that include insecurity about lack of food, clothing, and shelter often override other concerns. Legal immigrants residing in the United States before passage of the Personal Responsibility and Work Opportunity Act of 1996 are eligible for Medicaid unless the state opts to impose a ban. Legal immigrants entering the country after the date of passage of this welfare reform legislation are eligible for Medicaid only after 5 years in residence. Illegal immigrants, however, qualify for

very little public assistance. Legal and illegal immigrants not eligible for Medicaid are covered for emergency services, such as labor and delivery, but not for preventive services, such as prenatal or well-child care.

- Because of cost, language and cultural barriers, and fear of apprehension by immigration authorities, illegal immigrants underutilize health services, especially preventive services such as prenatal care, dental care, immunizations, and health supervision. They also often delay seeking care for minor conditions until those conditions become more serious.⁷ A complicating factor to providing access to health care for immigrant families is the possibility that various family members may have different immigration statuses. When one member of the family is in this country illegally, the entire family may limit access to care for fear of triggering investigation.
- Public health initiatives by intent and design are universal, and the protection of the public health requires access by the entire community. Restrictions on access to services placed on immigrants would seriously limit the effectiveness of outreach, case finding, and prevention and treatment programs related to infectious diseases. Patients needing prenatal care and family planning services would similarly lose access to important preventive care, resulting in increased risks for poor pregnancy outcomes and the major long-term disabilities associated with such outcomes and their subsequent costs. Denying legal and illegal immigrants access to basic health care would not only deprive them of needed services but also disrupt the provision of services to other children by redirecting resources from providing services to sorting and enforcement of more restrictive eligibility standards.

Infectious Diseases

- Immigrant children may harbor infectious diseases that US pediatricians may be inexperienced in diagnosing and treating.^{9,13-19} These include conditions such as malaria, amebiasis, schistosomiasis, and other helminthic infections; congenital syphilis, for which foreign-born children are not necessarily screened at birth; hepatitis A; hepatitis B, particularly in immigrants from Southeast Asia; and tuberculosis. It is possible to screen for many of these infections, and they should be considered in any unusual clinical presentation of a foreign-born child or child whose family travels between the United States and the country of origin.
- International adoptions have increased to the current rate of more than 10 000 per year. These children are for the most part from Korea and Central and South America but are also from Romania, the Balkans, China, Eastern Europe, and the Caribbean. More than 50% of these children have at least one health problem at the time of arrival in the United States.²⁰ Sixty percent of these problems are infectious diseases. As many as 80% of these problems may not be evident by history and physical examination alone; therefore, the use of

screening tests for helminthic infections, syphilis, tuberculosis, and hepatitis B appear to be indicated for these children (routine screening tests for hepatitis A, C, D, and E are not indicated).²¹ Many foreign-born children have not been immunized adequately; therefore, appropriate immunizations should be initiated immediately according to the Academy's recommended schedule for healthy infants and children.^{21,22}

Psychosocial Factors

- Immigration poses unique stresses on children and families.^{7,11,23-30} These include separation from support systems; disparities between social, professional, and economic status in the country of origin and the United States; and ongoing depression, grief, or anxiety resulting from relocation to a new community and culture and traumatic events that may have occurred in the country of origin.
- Immigrant and refugee children may have difficulties adapting to school. Prior education or lack of schooling, lack of proficiency in English, and separation from family while attending school may affect school performance and result in learning disabilities.
- Extended families are prominent in many immigrant cultures. They are an important source of strength, but they also may create conflicts with use of health services and adaptation to American health care customs.
- Many refugees may have been uprooted because of war or persecution. Children and families with this background have often experienced terrible losses and witnessed atrocities and are in need of mental health and social services.^{7,31} Careful attention to possible posttraumatic stress disorder is warranted.

Dental Disease

- Dental problems are more frequent among immigrant children. Immigrant elementary school children have been found to have twice as many dental caries in primary teeth as their US counterparts, with as many as 75% having dental disease identified on first screening in the United States.³²

Nutritional Problems

- Immigrant children have been found to be at risk for being deficient in meeting current height-for-age and weight-for-age measures shortly after entry into the United States.³³ Within 1 year, many have experienced significant catch-up growth. Internationally adopted children, many of whom resided in orphanages or group foster homes before their placement in adoptive homes in the United States, also have high rates of delay in meeting anthropometric measures, in addition to increased rates of developmental delay.³⁴

RECOMMENDATIONS

1. Pediatricians should oppose denying needed services to any child residing within the borders of the United States.
2. Pediatricians should take advantage of educational opportunities and resources to achieve a better understanding of immigrant cultures and the health care needs of immigrant children and families. These can be obtained from local universities, health departments, cultural groups, chapter and district Community Access To Child Health facilitators, as well as through continuing medical education sessions at national meetings held by the American Academy of Pediatrics. Important to the care of these children is an awareness of the family's culture, health beliefs, and the possible use of traditional or folk medicines. Pediatricians may need to ask families to describe or explain their beliefs, values, attitudes, and practices to educate parents and other care takers on safety and health in a way that will complement, rather than replace, existing beliefs and practices. Pediatricians should also explore their own attitudes toward the parents' and child's use of English; eating habits; health practices; folk remedies; understanding and perceptions of illness; use of health care services and medications; and family structure and roles.
3. To provide culturally effective health care, pediatricians should tolerate and respect differences in attitudes and approaches to child-rearing. However, this does not include any traditional practices that are clearly injurious to children and reportable under the Child Abuse Prevention and Treatment Act.
4. Pediatricians should be aware of the special health problems for which immigrant children are at risk. These include vaccine-preventable diseases, eg, hepatitis B; tuberculosis, syphilis, and parasitic infestations; poor nutritional status; delayed growth and development; poor dental health; poor mental health; and school problems.
5. Pediatricians in training and in practice should be educated about the unique stresses that immigration may place on children and families. Education should include information on the availability of local resources that provide services in the language spoken at home.
6. Pediatricians should recognize and support the extended family in health care activities with the approval of the child's parent or legal guardian. In many cases it is useful to identify and communicate with key authority figures in the extended family (who may not be the child's parents). It also is important to be aware of whether the extended family resides nearby or in the country of origin and whether family support still exists. Pediatricians also should be aware of whether the child is living with the extended family and receiving medical care in the country of origin on a part-time basis.
7. Any health screening that immigrants or refugees receive before US entry should be followed up with continuing health supervision and, in many cases, mental health and social services. Academy chapters should familiarize members with linkages between public health and the pri-

vate sector to ensure comprehensive health supervision.

8. In communities where immigrant families reside, health service providers should be encouraged to develop linguistically and culturally-appropriate services in concert with public health, social services, and school systems.
9. Academy chapters should define the health care needs of immigrant children in their areas. In addition, chapters should work with state legislatures and agencies to assess the local impact of welfare and immigration reform measures and advocate responses that assure unimpeded access to all medically necessary services for all children, as well as assure care for catastrophic illness or injury.
10. Pediatricians should be encouraged to support and participate in locally developed, community-based activities that increase access to health care for immigrant children.

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