

Immigrant Elders: New Challenges for North Carolina

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Many new immigrants have arrived in North Carolina in recent decades, changing the face of aging. Among the emerging populations are Latinos, South Asians, Chinese, Vietnamese, Hmong, Africans, and immigrants from Burma and the former Soviet Union. Many of these new residents are older adults. Language barriers and other factors keep them from accessing and navigating resources that other older adults may take for granted. Disparities in health status are real for some, while others experience diminished quality of life due to social isolation or loss of meaningful personal or professional roles in their new homeland. Some have suffered persecution, war, or other trauma in their native countries, increasing the risk of psychological stress or other health conditions. In short, the myriad challenges faced by all older adults are amplified for immigrant elders. Moreover, the health, human service, and aging services communities are ill prepared to respond to the needs of these vulnerable populations. It is time to prepare for the new challenges ahead.

Background

For years, the demographics of North Carolina have been shifting toward greater immigrant diversity. In 2006, the state ranked 15th in the nation for number of admitted foreign immigrants.¹ US Census estimates indicate that Latinos in North Carolina increased by 138,654 between 2000 and 2004, a gain of nearly 37%. The state has experienced an increase of over 25% in the Asian immigrant population during the same years.² Additionally, there are more than 10,000 documented immigrants from the former Soviet

Union, and nearly twice as many from former Warsaw Pact countries, living in North Carolina today.³ Many new immigrants are settling in urban areas, but rural and medically underserved parts of the state have experienced demographic changes as well.⁴

Demographic data most likely underestimate the state's foreign-born population. In large part this is due to issues of documentation and some immigrants not wanting to be counted for fear of legal consequences. Also, information about older immigrants is unreliable and difficult to ascertain. We have learned from recent work in one county that local churches report

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higher numbers of Latino older adults in their congregations than would be expected from official figures. Finally, limited information exists about the needs of aging immigrants and the resources available to them. Without sound data, organizations may be reluctant to provide programs or have difficulty securing

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start-up funds to develop responsive initiatives, even in the face of need.

Access to health care is an issue for some immigrant populations, but little is known about utilization of care among immigrant elders. One study suggests that the foreign-born are less likely than native-born individuals to receive timely care. The length of time a person lives in the United States is positively associated with utilization of health care services,⁵ and naturalized citizens may receive different care than non-citizen immigrants. For example, many non-citizen immigrants experience more barriers to accessing and utilizing ambulatory and emergency care, even when insured, than do citizens.⁶

Lessons from Immigrant Elders and Their Communities

Some local researchers and practitioners have taken note of the need for work in this area. We recently conducted a qualitative research study to document the perceived needs, attitudes about aging, health beliefs, and utilization of health care services among Hmong, Latino, and Russian-speaking immigrant elders in North Carolina. The study was carried out in the spirit of community-based participatory research, an approach that guides researchers and communities to share equitable power and control throughout the research process.

While there are many different ways to think about aging well, most theories underscore the importance of physical and emotional health, security, and engagement with activities and people who bring meaning and support to life.⁷ Our findings fit within this model of successful aging and indicate that individuals, families, and societies influence the aging experience.

We found that physical and emotional health is influenced by a number of factors. Some immigrant elders are at risk for specific health conditions such as depression and post-traumatic stress disorder, as a result of their previous life experiences or high levels of current psychological stress. Many use preventive health services infrequently, if at all, and experience barriers to health care, such as lack of transportation and medical interpreters, distrust of providers and the health care system, cost of care, and in some cases, fear about disclosing immigration status. Low health literacy and lack of familiarity with recommendations and services are additional problems. Also, many immigrant elders are not aware of community-based programs and services available to them and their caregivers.

Insecurities are common among the older immigrants we interviewed. Like other older adults, they are uncertain about the future, question their value to society, and fear losing their independence and becoming burdens to others. Also, financial fears are prevalent. Many receive benefits from the state (SSI and Medicare) but face a discontinuation of these benefits if they fail to become naturalized citizens within 7 years of immigration. In addition to stress about naturalization, many believe they are too old to learn new skills and a new language.

The majority of older immigrants we interviewed experience social isolation. Other than caring for grandchildren, they reported lacking meaningful roles in their communities.

Eliminating Health Disparities among Native-Born Minority Older Adults

Kathryn A. Lanier, MS

Older adults who are members of minority groups or other traditionally underserved populations face many of the same barriers as immigrant elders, including access to services, lack of information, and financial hardships. Many of the health disparities that minority elders encounter begin early in life and influence health status over the course of the lifespan. Several of the key diseases that affect adults in mid to late life such as high blood pressure, stroke, heart disease, diabetes, and certain cancers affect minority communities disproportionately. We know through clinical research these diseases affect minority populations earlier and more dramatically. The reasons why the effects are so much more substantial are the foundation of several studies currently being conducted around the country.¹ Unfortunately, these diseases are often discovered later in the diagnosis process and the “window” of opportunity for minimally invasive techniques are often lost due to timing.

In many cases the lack of medical insurance, distance to health care providers, and/or limited finances to purchase necessary medicines make it extremely difficult for older adults to attain and/or maintain their desired quality of life. Elimination of these disparities has gained national attention and in recent years there have been important education and awareness campaigns such as Closing the Health Gap and Take a Loved One to the Doctor Day.² The use of multimedia has been very beneficial in publicizing information about health issues to various ethnic communities. The importance of utilizing ethnic media, particularly television and radio, cannot be overlooked and probably serves as one of the strongest vehicles of communication next to personal one-on-one contact. The second most important method of conveying information is through the training of peer health coaches and advisors and other trusted individuals in the respective communities to serve as lay health officials. These “health ambassadors” can be members of the clergy, community activists, or even business owners. It is crucial to know who is well thought of and respected in the community because these are the individuals who can provide entrée to the affected populations. In order to be effective, providers must venture beyond the methods they are most familiar with in terms of outreach and treatment. This requires a willingness to engage ethnic communities on both a professional

Limited social outlets outside of religious organizations, lack of job opportunities, and reliance on others for transportation and interpretation contribute to isolation and purposelessness.

Older immigrants also demonstrate notable strengths, including spiritual conviction, a sense of community that is linked to their involvement in religion, and remarkable resilience in the face of continuing life challenges. Many maintain close relationships with family and engage family members in decision making. They are happy to be residents of North Carolina and strive for social integration, civic commitment, and United States citizenship.

Society has a vital role in ensuring successful aging, and some local organizations are doing just that. Our work included interviews with selected community service and health care organizations, through which we learned that some immigrant service organizations assist older adults in bridging the gap between health care providers and community services, while programs organized by the aging services system can reduce isolation and provide instrumental and social support. For example, we observed diverse populations utilizing multicultural literacy and health promotion programs at the Shamrock Senior Center in Charlotte.

Implications and Next Steps

For Practitioners

Health care providers

Based on our findings, we recommend that providers work to mitigate the fear and distrust that often exists between immigrants and all levels of the health care system. That includes striving for greater cultural sensitivity and improved patient-provider communication. Attention to health literacy issues is important and it is imperative that the health care community encourage and facilitate the training of interpreters in medical concepts and terminology.

Aging services

There is a need for aging programs and services to assure adequate outreach to immigrant communities and to develop, design, and deliver culturally appropriate programs, including those for older adults with limited English proficiency. Aging service providers can strengthen this response by partnering with organizations that represent immigrant groups and with other health and human service providers, as well as learning from other communities that are more experienced in this area. Our research has shown that senior centers are not the only place that house programs for seniors; libraries, churches, and other faith-based programs have developed and disseminated services as well.

For Communities

Communities can make a dramatic difference in the lives of their immigrant elders by creating opportunities for them to be involved through engagement in the arts, public service, employment, and religious organizations. Immigrant service organizations are strong advocates and should be involved in

level and a personal level through, for example, participation in health/educational fairs, cultural events, religious observances, and political functions.

The key concept to embrace is the need to meet people where they are, which means understanding the person in a holistic manner. The knowledge needed to serve may begin with meeting them physically in their communities or the settings they are most comfortable. The practitioner has to be aware of the older adults' views about health, sickness, and disease from both a personal and cultural frame of reference. They need to have some degree of understanding that they are not just treating the individual; in many instances they are treating the entire family, literally and figuratively. The elder's role in family dynamics may be pivotal, not only to their own well-being, but also in terms of how well the rest of the family functions. It is important to know how the older adult copes with his or her chronic or acute health care issues because it is going to have a significant impact on their treatment, compliance, and recovery.

Last, but certainly not least, is the psychological aspect of eliminating health disparities. This requires acknowledging past inequities and, in some instances, actual harm that occurred due to lack of service provision. The perception of being treated differently, not being heard, or having one's belief system disrespected have played a major role in the gaps that exist between older adults of various racial and ethnic backgrounds. Mental health issues, most notably depression, are treatable and yet have often times been overlooked as a key to overall well-being among minorities.

These issues can and are being addressed in North Carolina and, with continued effort and perseverance, we will narrow the gaps that currently exist. The measures that are being taken now are necessary because of our country's dramatically changing demographics. It is important to remember that eliminating disparities must be an ongoing effort from the dawn to sunset of life if we are going to be a society that cares for all of its citizens equally.

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providing input to issues and decisions that will affect the communities they serve.

For Planners and Policy Makers

It is clear that we need better in-depth demographic information for our state. In addition to improved data on foreign-born elders, more information is needed about specific racial and ethnic subpopulations. After all, not all people who are classified as “Asian/Pacific Islander” by our institutions are from the same background; many originate from different countries, speak different languages, have different national histories, and are accustomed to varying types of health care. Also, many older immigrants from the former Soviet Union fall within the white population majority, yet their experiences with health care in the United States may differ dramatically from the native-born white population. For example, their health care utilization in this country may be influenced by culturally specific beliefs about care, lack of familiarity with the role of primary care providers, too few programs designed to address their mental health needs, and language barriers.⁸ Thus, it is crucial that

health disparities work and census data continue to provide insight into ethnic and racial complexities.

In addition, we must incorporate health literacy and aging training into health affairs curricula and develop opportunities for continuing education on this topic. Finally, it is necessary to examine critically our immigration and naturalization policies, housing strategies, and health service delivery systems, and to work with immigrant and aging service organizations to bring about positive change wherever possible.

For many years in North Carolina, we have avoided focusing on the needs of older immigrants. We have believed that “there are not many of them here” or “the responsibility to do this work belongs to someone else.” However, the facts suggest that we can no longer ignore these communities. It is time to acknowledge their presence and devise strategies to ensure that, like other older residents, immigrants will age with opportunity, dignity, health, and well-being. **NCMJ**

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